STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335491	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The New Jewish Home, Manhattan	120 West 106th Street New York, NY 10025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review and interviews conducted during an Abbreviated Survey (NY00336486), the facility failed to treat a resident with respect and dignity and care for a resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. This was evident for 1 out of 20 residents reviewed (Resident #11). Specifically, 03/16/2024 at 5:17 PM, the facility's surveillance video recording showed Resident #11 sitting in a lounge chair in the hallway. Resident #11 removed their gown and slid themselves from the lounge chair onto the floor. The Facility's surveillance video recording showed that Resident #1 remained on the floor without clothing (only wearing an adult disposable brief) from 5:24 PM to 5:59 PM (35 minutes). Registered Nurse #1 was on the unit and did not immediately assessed Resident #11. Nursing Supervisor #1 assessed Resident #11 and there were no visible injuries. The findings are: The Facility's policy titled Resident Rights, dated 11/2023, documented residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. This facility treats each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality. Resident #11 was admitted to the facility on [DATE], with a diagnosis of Dementia, Cerebrovascular Disease, Delirium, and a history of failing. Resident #11 was a new admission, and their Minimum Data Set (an assessment tool) was not completed at the time of the incident. An Incident Report dated 03/16/2024 at 5:17 PM, documented Resident #11 was observed sitting on the floor in front of the nursing station. The Medical Doctor and family were notified at 6:00 PM. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Facility investigation dated 03/16/2024 at 5:17 PM, documented during camera review Resident #11 was seen on the floor in front of the nursing station for an extended period. Resident #11 was observed removing their gown and disposable brief. Although Certified Nursing Assistant #1 tried to cover them with their gown, Resident #1 intermittently removing the gown and cover. Registered Nurse #1 reported that Resident #11 was not transferred back to the chair as they were waiting for the Nursing Supervisor #1 to assess Resident #11. Registered Nurse #1 did not realize that Resident #11 was on the floor for an extended period. Resident #11 was transferred back to the chair after Nursing Supervisor #1 arrived at the unit and assessed Resident #11. The facility determined that there is reasonable cause to believe that abuse, neglect, and mistreatment occurred. A Care Plan for Activity of Daily Living and self-care deficit initiated on 03/15/2024, documented Resident #11 required substantial/maximal assistance with upper body dressing and was dependent on lower body dressing. An Abuse Care Plan dated 03/16/2024, documented Resident #11 slipped from their chair and sat on the floor for an extended period. Interventions included assessing for signs of injury and monitoring skin for bruising and changes in behavior/condition. A Nursing Incident Note, late entry, dated 03/16/2024 at 6:14 PM, written by Registered Nurse Supervisor #1, documented status post fall/behavior follow-up: Resident #11 was observed sitting on the floor in front of the nursing station. The staff placed Resident #11 at the nursing station due to placing themselves on the floor. Resident #11 was confused and not able to recall what happened. A full body assessment was done, and the family was notified. A Facility's Surveillance Video recording dated 03/16/2023 from 5:10 PM to 5:59 PM, reviewed with the Security Supervisor and the Assistant Director of Nursing revealed Resident #11 was transferred from the Hoyer lift to the lounge chair by the nursing office. At 5:17 PM, Resident #11 removed their hospital gown and threw it onto the floor. Resident #11 stood up by holding onto the handrail. Certified Nursing Assistants intermittently attended to Resident #11. At 5:24 PM, Resident #11 slowly slid from the chair to the floor, resting their head on the bottom of the chair. Certified Nursing Assistant #1 and Certified Nursing Assistant #2 were standing by and did nothing then left the scene. Resident #11 continued to lie on the floor in a disposable brief. At 5:29 PM, Certified Nurses Assistants slowly appeared from the dining room and attempted to cover Resident #11, who continued to remove the sheet. At 5:30 PM, Registered Nurse #1 approached Resident #11 and went to the nursing office. At 5:33 PM, Registered Nurse #1 came out of the nursing station and stood by Resident #11 with no interventions. At 5:35 PM, all staff left Resident #11 on the floor and disappeared from camera view. At 5:37 PM, Certified Nursing Assistant #1 made attempts to dress Resident #11, but Resident #11 refused. Certified Nursing Assistant #1 went to sit in the dining room and was watching Resident #11 from a distance. At 5:46 PM, Resident #11 removed the disposable brief and continued laying on the floor completely naked. Certified Nursing Assistant #1 continued sitting in the dining room with no attempts to cover Resident #11. Two more staff passed Resident #11 with no attempts to cover Resident #11. At 5:48 PM, Certified Nursing Assistant #2 covered Resident #11's lower part with a sheet and left. At 5:56 PM, Registered Nurse Supervisor #1 came to the unit and assessed Resident #11. At 5:59 PM, Certified Nursing Assistant #1, Registered Nurse Supervisor #1, and Registered Nurse Supervisor #2 assisted Resident #11 to the sitting position. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/01/2024 at 2:29 PM, Certified Nursing Assistant #1 stated they were assigned to Resident #11 on 03/16/2024 during the 3:00 PM to 11:00 PM shift and did not do anything wrong. Certified Nursing Assistant #1 stated Resident #11 was a new admission, had episodes of behavior, and was removing their clothes despite they tried to cover Resident #11. Certified Nursing Assistant #1 stated Resident #11 put themselves on the floor. Registered Nurse #1 was present, called the Nursing Supervisor, and told them to monitor Resident #11. Certified Nursing Assistant #1 also stated they were watching Resident #11, to ensure they did not hurt themselves. Certified Nursing Assistant #1 further stated they are no longer working in the facility. During a telephone interview on 11/01/2024 at 2:02 PM, Certified Nursing Assistant #3 stated they were not assigned Resident #11 but worked on 03/16/2024 3:00 PM -11:00 PM shift. Certified Nursing Assistant #3 stated around dinner time at around 5:00 PM, Resident #11 had behavior and keep removing their clothes and moving from the chair. Certified Nursing Assistant #3 stated Resident #11 was confused and placed themselves on the floor. Certified Nursing Assistant #3 stated Certified Nursing Assistant #1 was attending to Resident #11. Certified Nursing Assistant #3 stated the Registered Nurse was there and staff should have maintained Resident #11's privacy and moved them from the floor. Certified Nursing Assistant #3 stated the Administration told them they neglected Resident #11 and were fired along with other staff on the unit. During a telephone interview on 11/07/2024 at 1:45 PM Registered Nurse #1 stated they were working on 03/16/2024 7:00 AM to 7:00 PM shift and was assigned to Resident #11. Registered Nurse # 1 stated Resident #11 started lowering themselves to the floor in the dining room, and they told Certified Nursing Assistants to put Resident #11 by the nursing station for observation. Registered Nurse #1 stated they called the Registered Nurse Supervisor two times. Registered Nurse #1 stated Resident #11 removed their gown and put themselves on the floor by the nursing station. Registered Nurse #1 stated Certified Nursing Assistant #1 tried to cover Resident #11 multiple times, but Resident #11 refused. Registered Nurse #1 stated they assigned Certified Nursing Assistant #1 to watch Resident #11 and went to attend to another residents. Registered Nurse #1 stated they did not assess Resident #11 but looked at them while on the floor, and there was no visible injury. Registered Nurse #1 further stated they were waiting for the Nursing Supervisor to come and see what Resident #11 was doing and went to give medications. Registered Nurse #1 stated they don't recall if Resident #11 removed their disposable brief. Registered Nurse #1 stated their actions regarding Resident #11 were not enough. Registered Nurse #1 stated they should have instructed staff to maintain Resident #11 privacy, perform body assessment, and move Resident #11 from the floor. Registered Nurse #1 stated they don't recall when they called the Medical Doctor. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2024 at 1:44 PM, Registered Nurse Supervisor #1 stated they were called by Registered Nurse #1 around 5:00 PM on 03/16/2024, Resident #11 was agitated and restless and tried to stand up and wiggle themselves to the floor. Registered Nurse Supervisor #1 stated they were not told Resident #11 was on the floor for a long period. Registered Nurse Supervisor #1 stated they told Registered Nurse #1 that if the behavior persists, Certified Nursing Assistant #1 should be assigned to monitor Resident #11 and call the doctor. Registered Nurse Supervisor #1 stated about five to ten minutes later, they went to assess Resident #11. Registered Nurse Supervisor #1 stated upon arrival, they saw Resident #11 on the floor by the nursing station, was covered with a bed sheet, and seemed comfortable. Registered Nurse Supervisor #1 stated they asked Registered Nurse #1 and other staff how long Resident #11 was on the floor, and they said just now. Registered Nurse Supervisor #1 stated they assessed Resident #1 with no visible injury noted, and Resident #11 denied any pain, and was transferred to their room. Registered Nurse Supervisor #1 stated they reviewed the camera and thought the staff should have stayed with Resident #11 and made sure they were fully covered. Registered Nurse Supervisor #1 stated it was inappropriate and disrespectful to Resident #11 to leave them naked on the floor for a long period of time. Registered Nurse Supervisor #1 stated it was Registered Nurse #1 responsibility to assess Resident #11 on the floor, make sure their privacy and dignity were maintained, instruct staff to continue to redirect the resident, to cover them, and assist Resident #11 from the floor, call Medical Doctor and notify Registered Nurse Supervisor. During an interview on 11/06/2024 at 4:30 PM, the Director of Nursing stated the Assistant Administrator brought to their attention on 03/19/2024 that they reviewed the video dated 03/16/2024 and observed that Resident #11 was noted on the floor for an extended period of the time. The Director of Nursing stated they reviewed the video and observed Resident #11 was on the floor for an extended period while multiple staff going back and forth with no effort to assist Resident #11. The Director of Nursing stated Registered Nurse #1 was present and was expected to assist and direct staff accordingly to ensure the dignity and safety of Resident #11. The Director of Nursing stated Resident #11 removed their disposable brief and was completely naked. The Director of Nursing stated they did not see any attempts to cover Resident #11 or move them away from heavy traffic (there was a food tract and carts in the area). During a telephone interview on 11/08/2024 at 12:18 PM, Assistant Administrator stated on 03/19/2024, while doing a routine random surveillance check, came across the video where they observed Resident #11 on the floor and reviewed it from the beginning to the time Resident #11 was picked up by Registered Nurse Supervisor #1 and other staff from the floor. The Assistant Administrator stated they called the Director of Nursing immediately, reviewed the video together, and started the investigation. The Assistant Administrator further stated their concern were Resident #11 was on the floor for a long period of time and how staff responded to Resident #11 being on the floor. 10 NYCRR 483.10 (a)(1)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43285 Based on observation, record review, and interviews conducted during an abbreviated survey (NY00332607), the facility failed to protect a resident's right to be free from Abuse. This was evident in 1 of 20 residents reviewed (Resident #1). Specifically, the facility's surveillance camera recording, dated 03/16/2024 at 3:16 AM, showed Resident #1 in their wheelchair being brought into the unlighted dining room by Certified Nursing Assistant #1. Resident #1 was not wearing any clothing or undergarment. While Certified Nursing Assistant #1 was pushing Resident #1's wheelchair, Certified Nursing Assistant #1 used their left hand to hold Resident #1's hands across their chest restricting the movements of Resident #1's hands. Once in the dining room, Certified Nursing Assistant #1 pushed Resident #1's wheelchair against the wall, then used three dining room tables (arranged in a row in front of Resident #1) to pin Resident #1's wheelchair against the wall restricting Resident #1's movements. Resident #1 was left sitting naked, in the dark, in the dining room from 3:16 AM to 5:37 AM when Licensed Practical Nurse #1 entered the dining room and turned on the lights. Licensed Practical Nurse #1 took a (personal) cell phone out of their pocket and took multiple pictures of Resident #1. Licensed Practical Nurse #1 then moved the dining room tables that were restraining Resident #1. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings include: The Policy titled, Abuse/Neglect/Mistreatment - Prevention, Assessment & Reporting of these or other crimes against a resident/client in our care, dated 11/04/2022 documents the resident/client has the right to be free from verbal, sexual, physical, and mental abuse, corporal punish, involuntary seclusion, misappropriation of property or any other criminal activity. The organization screens and trains employees in the prevention, protection, identification, investigation and reporting of abuse, neglect, mistreatment, misappropriation of resident/clients' property and any other criminal activity. The policy further documents each resident/client has the right to be free from mental abuse. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). Resident #1 was admitted to the facility with diagnoses that include Alzheimer's Disease, Depression, Restlessness, and Agitation. The Minimum Data Set (an assessment tool), dated 03/13/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored 2 out of 15, indicating severely impaired cognition. A Potential for Abuse, Neglect, and Mistreatment Care Plan dated 06/19/2023 documented interventions that included monitor resident's skin for bruising, skin tears, skin break, injury, and report immediately to nurse or designees. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Summary of Investigation dated 03/16/2024 documented the facility Administrator, Director of Nursing and the IT Director reviewed the video surveillance recording after receiving an anonymous call. The video surveillance review confirmed Resident #1 was sitting in the dining room at 4:30 AM without any clothes on. The video surveillance recording also showed there were three dining room tables in front of Resident #1's wheelchair. The staff were interviewed and stated Resident #1 had a behavior of removing their clothes. Certified Nursing Assistant #1 reported Resident #1 is put in the same position every night, however, most nights Resident #1 was wearing clothes. The Nursing Supervisor was not aware of the incident. The facility investigated the incident and concluded abuse and neglect had occurred. The Facility Surveillance Camera Recording dated 03/16/2024 at 3:10 AM was reviewed with the Assistant Director of Nursing and Security Manager. The video surveillance recording showed at 3:16 AM Resident #1 in their wheelchair being brought into the unlighted dining room by Certified Nursing Assistant #1. Resident #1 was completely naked. Certified Nursing Assistant #1 used their left hand to hold Resident #1's hands down while pushing the wheelchair with their right hand. Once in the dining room, Certified Nursing Assistant #1 pushed Resident #1's wheelchair against the wall and used three dining room tables (tables positioned in a row) to pin the wheelchair against the wall. Resident #1 was struggling to push the dining room tables but was unable to move the tables. Resident #1 was observed with their arms crisscrossed against their upper body. The edge of the table was touching Resident #1's body just below their breasts. Licensed Practical Nurse #1 entered the dining room at 3:19 AM and offered Resident #1 a cup of liquid which Resident #1 refused. Resident #1 was left sitting naked, in the dark, in the dining room from 3:16 AM to 5:37 AM when Licensed Practical Nurse #1 entered the dining room and turned on the lights. Licensed Practical Nurse #1 took a personal cellphone out of their pocket and took multiple pictures of Resident #1. Licensed Practical Nurse #1 put a gown on Resident #1, then moved the dining room tables that were restraining Resident #1. Video ended at 5:40 AM while Licensed Practical Nurse #1 was still with Resident #1. A nursing progress note dated 03/16/2024 at 6:33 AM, by Licensed Practical Nurse #1, documented at around 2:00 AM Resident #1 woke up and was trying to get up from the bed. Certified Nursing Assistant #1 put Resident #1 in their wheelchair and moved Resident #1 to the dining room. Resident #1 was screaming. Close monitoring provided by the night shift staff. A medical note dated 03/18/2024 at 8:05 AM documented Resident #1 was seen at the bedside, calm, and does not recall what happened due to Dementia. Resident #1 denies pain. Small ecchymosis was found on the left anterior wrist. The surveyor made several attempts to contact Certified Nursing Assistant #1 but was unsuccessful. A certified letter was mailed on 11/06/2024 with no response to date. Certified Nursing Assistant #1 gave the facility a telephone interview on 03/20/2024 at 4:53 PM. The interview stated every night Resident #1 is in that position and never in their bed. Resident #1 woke up, they took Resident #1 to the bathroom, and put clothes on Resident #1, but Resident #1 pulled the clothes off. The interview also documents Certified Nursing Assistant #1 put Resident #1 in the dining room and sat there with Resident #1 throughout the night and every night. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/07/2024 at 11:41 AM, Licensed Practical Nurse #1 stated they were working on the floor on 03/16/2024 from 11:30 PM - 7:30 AM. Licensed Practical Nurse #1 stated they made rounds at around 1:00 AM and Resident #1 was in bed and was restless, taking off their gown. Licensed Practical Nurse #1 stated they assisted Certified Nursing Assistant #1 to transfer Resident #1 into their wheelchair and then they left Resident #1's room. Licensed Practical Nurse #1 stated at approximately 3:30 AM they observed Resident #1 sitting in their wheelchair naked in the dining room. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #1 to put a gown on Resident #1. Licensed Practical Nurse #1 stated they went back to the dining room between 5:00 AM and 5:30 AM and Resident #1 was not wearing a gown. Licensed Practical Nurse #1 stated they used their personal cell phone to take pictures of Resident #1 to use as evidence. During an interview on 11/08/2024 at 11:29 AM, the Director of Nursing stated they received an anonymous call prior to arriving at the facility regarding Resident #1 being naked in the dining room. The Director of Nursing stated shortly after arriving at the facility they were informed of the incident regarding Resident #1 by Licensed Practical Nurse #1 (not sure of the time). The Director of Nursing stated they reviewed the video surveillance recording and observed Resident #1 sitting in their wheelchair naked and Certified Nursing Assistant #1 had placed three tables in front of Resident #1 restricting their movement. The Director of Nursing stated Licensed Practical Nurse #1 should have immediately moved the tables and put a gown on Resident #1. The Director of Nursing also stated Licensed Practical Nurse #1 should not have used their personal cell phone to take pictures of Resident #1. During an interview on 11/08/2024 at 11:36 am, the Administrator stated they were notified of the incident by the Director of Nursing on 03/16/2024. The Administrator stated they immediately watched the video surveillance recording and called local Law Enforcement. The Administrator stated two Police Officers arrived at the facility during the day shift and watched the video surveillance recording and interviewed staff. The Administrator stated the nursing staff are aware if a resident displays behavior, they are to call the nursing supervisor and notify the medical doctor to get guidance. During an interview on 11/08/2024 at 12:12 PM, Nurse Practitioner #1 stated they were notified of the incident and examined Resident #1 on 03/20/2024. Nurse Practitioner #1 stated Resident #1 had no discoloration, bruising, redness, or injury. Nurse Practitioner #1 also stated Resident #1 was evaluated by the psychiatrist (03/22/2024 at 5:27 PM) and there was no psychosocial harm documented. Nurse Practitioner #1 also stated Resident #1 has advanced dementia. Nurse Practitioner stated Resident #1 was on Melatonin to help with sleep. 10 NYCRR 415 (b)(1)(i)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285 Based on observation, record review, and interviews during an abbreviated survey (NY00332607), the facility did not ensure that a resident was treated with dignity including being free from physical restraint. This was evident in 1 out of 20 residents reviewed (Resident #1). Specifically, the facility's surveillance camera recording, dated 03/16/2024 at 3:16 AM, showed Resident #1 in their wheelchair being brought into the unlighted dining room by Certified Nursing Assistant #1. Resident #1 was not wearing any clothing or undergarment. While Certified Nursing Assistant #1 was pushing Resident #1's wheelchair, Certified Nursing Assistant #1 used their left hand to hold Resident #1's hands across their chest restricting the movements of Resident #1's hands. Once in the dining room, Certified Nursing Assistant #1 pushed Resident #1's wheelchair against the wall, then used three dining room tables (arranged in a row in front of Resident #1) to pin Resident #1's wheelchair against the wall restricting Resident #1's movements. Resident #1 was left sitting naked, in the dark, in the dining room from 3:16 AM to 5:37 AM when Licensed Practical Nurse #1 entered the dining room and turned on the lights. Licensed Practical Nurse #1 took a (personal) cell phone out of their pocket and took multiple pictures of Resident #1. Licensed Practical Nurse #1 then moved the dining room tables that were restraining Resident #1. This resulted in actual harm to Resident #1 with the potential for serious injury, serious harm, serious impairment, or death to 40 residents on the unit, that was not Immediate Jeopardy. The findings include: The facility's policy on Restraints dated 09/2017 documented Restraint use will be limited to circumstances in which the resident has medical symptoms that warrant such use and only after attempts to use alternatives to restraints have failed. If restraint use is indicated, the least restrictive device will be utilized. Resident #1 was admitted to the facility with diagnoses including of Alzheimer's Disease, Depression, Restlessness, and Agitation. The Minimum Data Set (an assessment tool), dated 03/13/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored 2 out of 15, indicating severely impaired cognition. The Summary of Investigation dated 03/16/2024 documented the facility Administrator, Director of Nursing, and IT Director reviewed the video surveillance recording after receiving an anonymous call. The video surveillance review confirmed Resident #1 was sitting in the dining room at 4:30 AM without any clothes on. The video surveillance recording also showed there were three dining room tables in front of Resident #1's wheelchair. The staff were interviewed and stated Resident #1 had a behavior of removing their clothes. Certified Nursing Assistant #1 reported Resident #1 is put in the same position every night, however, most nights Resident #1 was wearing clothes. The Nursing Supervisor was not aware of the incident. The facility investigated the incident and concluded that abuse and neglect had occurred. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	The Facility Surveillance Camera Recording dated 03/16/2024 at 3:10 AM was reviewed with the Assistant Director of Nursing and Security Manager. The video surveillance recording showed at 3:16 AM Resident #1 in their wheelchair being brought into the unlighted dining room by Certified Nursing Assistant #1. Resident #1 was completely naked. Certified Nursing Assistant #1 used their left hand to hold Resident #1's hands down while pushing the wheelchair with their right hand. Once in the dining room, Certified Nursing Assistant #1 pushed Resident #1's wheelchair against the wall and used three dining room tables (tables positioned in a row) to pin the wheelchair against the wall. Resident #1 was struggling to push the dining room tables but was unable to move the tables. Resident #1 was observed with their arms crisscrossed against their upper body. The edge of the table was touching Resident #1's body just below their breasts. Licensed Practical Nurse #1 entered the dining room at 3:19 AM and offered Resident #1 a cup of liquid which Resident #1 refused. Resident #1 was left sitting naked, in the dark, in the dining room from 3:16 AM to 5:37 AM when Licensed Practical Nurse #1 entered the dining room and turned on the lights. Licensed Practical Nurse #1 took a (personal) cellphone out of their pocket and took multiple pictures of Resident #1. Licensed Practical Nurse #1 put a gown on Resident #1, then moved the dining room tables that were restraining Resident #1. Video ended at 5:40 AM while Licensed Practical Nurse #1 was still with Resident #1. A nursing progress note dated 03/16/2024 at 6:33 AM, by Licensed Practical Nurse #1, did not document that Resident #1 was restrained in the dining room. A medical note dated 03/18/2024 at 8:05 AM documented Resident #1 was seen (at the bedside, calm, and does not recall what happened due to Dementia. Resident #1 denies pain. Small ecchymosis (discoloration of the skin) was found on the left anterior wrist. The surveyor made several attempts to contact Certified Nursing Assistant #1 but was unsuccessful. A certified letter was mailed on 11/06/2024 with no response to date. Certified Nursing Assistant #1 gave a telephone interview to the facility on [DATE] at 4:53 PM. The interview documents every night Resident #1 is in that position and never in their bed. Resident #1 woke up, they took Resident #1 to the bathroom, and put clothes on Resident #1, but Resident #1 pulled the clothes off. The interview also documents Certified Nursing Assistant #1 put Resident #1 in the dining room and sat there with Resident #1 throughout the night and every night. During an interview on 11/07/2024 at 11:41 AM, Licensed Practical Nurse #1 stated they worked on the floor on 03/16/2024 from 11:30 PM - 7:30 AM. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #1 to put a gown on Resident #1 and to remove the restraints when it was first observed at 3:30 AM. Licensed Practical Nurse #1 stated they returned to the dining room (between 5:00 AM and 5:30 AM) and Resident #1 was still restrained and not wearing any clothing. Licensed Practical Nurse #1 stated they did not remove the restraint when it was first noticed because the Certified Nursing Assistants want the nurse to do everything, and they had worked 16 hours. Licensed Practical Nurse #1 stated they waited for the Director of Nursing (before going home) and reported the incident (they do not recall the time). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335491	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The New Jewish Home, Manhattan	120 West 106th Street New York, NY 10025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/08/2024 at 11:29 AM, the Director of Nursing stated they received an anonymous call prior to arriving at the facility regarding Resident #1 being naked in the dining room. The Director of Nursing stated shortly after arriving at the facility they were informed of the incident regarding Resident #1 by Licensed Practical Nurse #1 (not sure of the time). The Director of Nursing stated they reviewed the video surveillance and observed Resident #1 sitting in their wheelchair naked and Certified Nursing Assistant #1 had placed three tables in front of Resident #1 restricting their movement. The Director of Nursing stated Licensed Practical Nurse #1 should have immediately removed the tables and put a gown on Resident #1. During an interview on 11/08/2024 at 11:36 am, the Administrator stated they were notified of the incident by the Director of Nursing on 03/16/2024 (do not recall the time). The Administrator stated they immediately watched the video surveillance recording and called local Law Enforcement. The Administrator stated two Police Officers arrived at the facility during the day shift and watched the video surveillance recording and interviewed staff. The Administrator stated the nursing staff are aware if a resident displays behavior, they are to call the nursing supervisor and notify the medical doctor to get guidance. During an interview on 11/08/2024 at 12:12 PM, Nurse Practitioner #1 stated they were notified of the incident and examined Resident #1 on 03/20/2024 (do not recall the time). Nurse Practitioner #1 stated Resident #1 had no discoloration, bruising, redness, or injury. Nurse Practitioner #1 also stated Resident #1 was evaluated by the psychiatrist and there was no psychosocial harm. Nurse Practitioner #1 also stated Resident #1 has advanced dementia. Nurse Practitioner stated Resident #1 was on Melatonin to help with sleep. 10 NYCHRR 415.4(a) (2-7)