STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335493	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concourse Rehabilitation and Nursing Center Inc	1072 Grand Concourse Bronx, NY 10456

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, record review, and interviews conducted during a Recertification and Abbreviated (NY00331425) survey from 4/7/2024 to 4/12/2024, the facility did not ensure all alleged violations involving abuse were reported to the New York State Department of Health immediately or within 2 hours after the allegation was made. This was evident for 2 (Resident #80 and #119) of 38 total sampled residents. Specifically, 1) Resident #80 had a fall resulting in a fracture that was not reported to the New York State Department of Health, and 2) Resident #119 had an unwitnessed fall resulting in a fracture that was not reported to the New York State Department of Health. The findings are: The facility policy titled Prevention of Mistreatment, Neglect and Abuse and Misappropriation of Resident Property dated 10/4/2022 documented the Director of Nursing will report any accident or incident where there is reasonable cause to believe that resident abuse occurred to the New York State Department of Health. The facility policy titled Accident Prevention and Reporting dated 6/2023 documented the Director of Nursing reported any suspected incidence of abuse, neglect, or mistreatment to the New York State Department of Health. 1) Resident #80 had diagnoses of dementia and seizure disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #80 had moderately impaired cognition and required the assistance of 1 person for rolling in bed. The facility Accident Report dated 1/10/2024 documented Resident #80 fell out of bed during care when Certified Nursing Assistant #1 rolled the resident to one side and was unable to hold onto the resident. Resident #80 sustained a left femoral (thigh bone) fracture as a result of the fall. There was no documented evidence Resident #80's fall and fracture were reported to the New York State Department of Health. 2) Resident #119 had diagnoses of congestive heart failure and anxiety disorder. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Concourse Rehabilitation and Nursing Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1072 Grand Concourse Bronx, NY 10456	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #119 was moderately cognitively impaired and required extensive assistance of 2 people for transfers and personal hygiene. The facility Accident Report dated 3/4/2024 documented staff heard a scream coming from Resident #119's room. Upon entering the room, Resident #119 was found on the floor with their left leg rotated inwards. Resident #119 was found to have a left fibula (ankle) and tibia (shin bone) fracture. There was no documented evidence Resident #119's fall and subsequent fracture was reported to the New York State Department of Health. On 4/11/2024 at 11:06 AM, an interview conducted with the Director of Nursing who stated allegations of abuse were reported immediately to the New York State Department of Health. The Director of Nursing stated they investigated abuse allegations within the first 2 hours of the occurrence and ruled out abuse before deciding if they needed to be reported to the New York State Department of Health. Resident #80's fall and fracture were not reported because it was a witnessed fall. Resident #119's fall and fracture were not reported because the resident was able to give an account of the incident that took place. 10 NYCRR 415.4(b)(2)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, record review, and interviews conducted during a Recertification and Abbreviated survey (NY00331425) from 4/6/2024 to 4/12/2024, the resident received inadequate supervision to prevent an accident. This was evident for one (Resident #80) of three residents reviewed for accidents out of 38 total sampled residents. Specifically, the plan of care did not clearly indicate Resident #80 required 2-person assistance with activities of daily living. Subsequently, Resident #80 fell and sustained a left distal femoral neck fracture (thigh bone broken at the knee) when Certified Nursing Assistant #1 rolled the resident on their side during care without a 2nd staff member's assistance. This resulted in actual harm to Resident #80 that was not immediate jeopardy. Finding is: The facility policy and procedure titled Fall Prevention and Management Program dated 8/2023 documented the staff will follow the resident fall prevention plan of care to ensure resident safety. Resident #80 had diagnoses of dementia and cerebrovascular accident (a stroke). The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #80 was rarely/never understood and exhibited moderate cognitive impairment. Resident #80 required substantial/maximal assistance where the helper does more than half of the effort when rolling in bed and performing personal hygiene. The Certified Nursing Assistant Accountability Record for 1/2024 documented Resident #80 was provided with bed mobility assistance a total of 30 times between 1/1/2024 and 1/10/2024. The record documented 10 out of the 30 times bed mobility was performed, Resident #80 scored a 4 in performance, indicating they were totally dependent, and a 3 in support provided, indicating 2-person assistance was required. In 8 out of the 30 times bed mobility was performed, Resident #80 scored a 3 in performance, indicating they required extensive assistance, and a 3 in support provided, indicating 2-person assistance was required. The facility Accident Report dated 1/10/24 documented Certified Nursing Assistant #1 notified Registered Nurse #1 that Resident #80 fell from the bed onto the floor during care. Certified Nursing Assistant #1 lost their grip on Resident #80 when they rolled the resident onto their right side and the resident fell . The Accident Report documented a risk management plan for staff to observe the care protocol for two staff to assist with total care residents. The facility Write-Up Form dated 1/11/2024 documented Certified Nursing Assistant #1 was suspended for 3 weeks due to Resident #80's fall during care resulting in a diagnosis of left femur fracture. The write-up form documented that Certified Nursing Assistant #1 must always follow the Certified Nursing Assistant records prior to giving care to any resident. A Nursing Note dated 1/10/2024 documented a left knee x-ray showed Resident #80 had a moderately displaced comminuted fracture of the distal femur supracondylar region (thigh bone broken at the knee). Resident #80 was transferred to the hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan related to activities of daily living initiated 2/7/2024 documented reposition Resident #80 in bed with total assistance every 2-4 hours using a turning sheet. There was no documented evidence Certified Nursing Assistant #1 was provided with definitive instruction to provide Resident #80 with 2-person assistance when performing activities of daily living. This resulted in Resident #80's fall and fracture on 1/10/2024 when Certified Nursing Assistant #1 rolled the resident in bed without a 2nd person to assist. During an interview conducted on 4/10/2024 at 4:33 PM, Certified Nursing Assistant #1 stated they provided Resident #80 with care on 1/10/2024. Certified Nursing Assistant #1 rolled the resident to one side to provide care and lost their grasp on the resident, causing Resident #80 to fall on the floor. Certified Nursing Assistant #1 stated they were unaware Resident #80 required 2 people to assist with activities of daily living as they were regularly assigned to Resident #80 prior to the incident and provided one person assistance to perform hygiene and bed mobility. On 4/11/2024 at 3:21 PM, an interview conducted with the Acting Assistant Director of Nursing who stated Certified Nursing Assistants checked the task list in the medical record for their assigned residents prior to providing care. Any changes in resident condition and care required were discussed during report given to the Certified Nursing Assistants prior to the start of their shift. The Acting Assistant Director of Nursing stated they did not supervise Certified Nursing Assistants by observing the care they provided to residents. Supervision took place by discussing and reinforcing the Certified Nursing Assistant's tasks and responsibilities with them during report. During an interview on 4/11/2024 at 11:06 AM, Director of Nursing #1 stated Certified Nursing Assistants were in-serviced and performed competencies regarding their responsibility for checking the Accountability Record in the medical record prior to performing tasks with residents. Resident #80 required 2-person assistance at the time of the incident on 1/10/2024. Certified Nursing Assistant #1 did not follow protocol for performing activities of daily living and was taken off the schedule until the investigation was completed. During an interview on 4/12/2024 at 11:03 AM, the Rehabilitation Director stated Resident #80 required the extensive assistance of two people to perform activities of daily living prior to their fall on 1/10/2024. During an interview on 4/10/2024 at 2:41 PM, Medical Doctor #1 stated they were aware Resident #80 had a fall and fracture on 1/10/2024. Resident #80 was non-ambulatory prior to the fall incident and their activity of daily living status did not significantly change upon readmission from the hospital. 10 NYCRR 415.12(h)(2)