STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025
NAME OF PROVIDER OR SUPPLIER: Pinnacle Multicare Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 801 CO Op City Blvd, Bronx, NY 10475	

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 - Some	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** 39365 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00366573 & NY00364335), the facility failed to ensure that an alleged violation involving abuse, neglect, exploitation or mistreatment are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident for two out of seven residents (Resident #1 and Resident #3) sampled for abuse. Specifically, On 12/18/2024 at 3:35 PM, Resident #1's adult child reported to Nurse Manager #1, on 12/18/2024, that they witnessed Certified Nursing Assistant #1 used the dining room table to shove Resident #1 to sit in their wheelchair on 12/18/2024 at 3:28 PM. The facility investigated the alleged allegation of abuse and concluded that abuse did not occur. The facility did not report the alleged allegation of abuse to New York State Department of Health within two hours. Additionally, the facility did not report the suspicion of abuse to local law enforcement within two hours. The facility reported the alleged abuse to New York State Department of Health and to local law enforcement on 01/03/2025 at 5:04 PM while the Department of Health Surveyors were onsite. On 12/10/2024 at 3:50 PM, Resident #3 was observed with swelling and discoloration to their left middle finger. An x-ray result dated 12/10/2024 documented an acute comminuted fracture (a broken bone splintered into more than two pieces) of the 3rd proximal phalanx shaft extending to the base. Resident #3 was transferred to the hospital on 12/10/2024 for further evaluation. The facility became aware of the fracture on 12/10/2024 and reported it to New York State Department of Health on 01/03/2025 at 7:15 PM while New York State Department of Health surveyors were onsite conducting the investigation. The findings are: (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	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Multicare Nursing and Rehab Center	801 CO Op City Blvd Bronx, NY 10475

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The facility Policy and Procedure titled Abuse Prevention superseded on 10/2022 documented the Director of Nursing, Administrator or designee will notify local law enforcement and the New York State Department of Health immediately but no later than two hours if the alleged violation involves abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property after the allegation is made which involves abuse or resulted in serious bodily injury.

Resident #1 was admitted to the facility with diagnoses including Dementia, Persistent Mood Disorder, and Depression.

A Social Service assessment dated [DATE] documented Resident #1 had severe cognitive impairment.

An Incident/Event Intake Form dated 12/18/2024 documented Resident #1's child reported on 12/18/2024 at 3:35 PM that they witnessed Certified Nursing Assistant #1 pushed a table against Resident #1 in the day room. Nurse Manager #1 conducted an assessment, and there were no visible injuries. Certified Nursing Assistant #1 was removed from the schedule the pending investigation. Certified Nurse Assistant #1 was interviewed on 12/20/2024 and stated Resident #1 was assisted to sit down due to the risk of falls. Based on investigation and re-enactment, the facility concluded there were no evidence of abuse.

An email with Resident's #1 child feedback dated 12/18/2024 at 6:00 PM documented they came to the day room and witnessed Certified Nursing Assistant #1 shoved Resident #1 with a table. Certified Nursing Assistant #1 shoved Resident #1 with the table to show the resident how to sit in their wheelchair.

A Webform Submission from: Nursing Home Facility Incident Report dated 01/03/2025 showed the facility submitted the report to the New York State Department of Health on 01/03/2024 at 5:04 PM.

A Security Log dated 01/03/2024 documented two Police Officers came on site at 6:52 PM.

During an interview on 01/02/2024 at 1:07 PM, the Director of Nursing stated Nurse Manager #1 reported the allegation to them on 12/18/2024 after 3:30 PM and the Administrator was notified on 12/18/2024 at around 3:47 PM. The Director of Nursing stated they immediately removed Certified Nursing Assistant #1 from the schedule. The Director of Nursing stated that a re-enactment of the incident was done on 12/20/2024 by Certified Nurse Assistant #1. The Director of Nursing Stated Certified Nursing Assistant #1's body did not move the table forward when Certified Nursing Assistant #1 leaned over the table. The Director of Nursing stated the allegation was investigated and they concluded there was no evidence of abuse after the re-enactment. The Director of Nursing stated Certified Nurse Assistant #1 was terminated because they did not report the family's allegation of abuse to the nurse. The Director of Nursing stated they did not suspect that a crime had occurred, therefore, they did not report the alleged abuse to New York State Department of Health or to local law enforcement.

During an interview on 01/03/2024 at 1:15 PM, the Administrator stated they became aware of the alleged incident on 12/18/2024 at around 3:47 PM. The Administrator stated they did not call the police or report the incident to New York Department of Health because there was no evidence of abuse.

Resident #3 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia, Anxiety Disorder, and Depression.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Minimum Data Set, dated dated dated [DATE] documented that Resident #3 had severe cognitive impairment. A Nursing Progress Note dated 12/10/2024 dated 12/10/2024 at 3:50 PM, by Registered Nurse #1, documented Resident #3 was observed with a slight swelling and discoloration to their left middle finger. An x-ray result dated 12/10/2024 documented an acute comminuted fracture of the 3rd proximal phalanx shaft extending to the base. Resident #3 was transferred to the hospital on 12/10/2024 for further evaluation. An Incident /Event Intake Form dated 12/16/2024 documented abuse did not occur and that Resident #3 most likely sustained injury to their left hand while ambulating without assistance looking for their wheelchair. Resident #3 reenacted the fall event, and it appears that Resident #3 broke their fall by grabbing on to an object (table). Resident #3 could have either squeezed or bent their finger causing them to sustain a fracture. Resident #3 was transferred to the hospital and returned with a splint and orthopedic follow-up. A Webform Submission from the Nursing Home Facility Incident Report showed the facility reported the fracture to the New York State Department of Health on 01/03/2025 at 7:15 PM. During an interview on 01/03/2025 at 12:50 PM, the Director of Nursing stated when Resident #3 returned from the hospital, the discharge summary documented Resident #3's fracture was due to abuse. The Director of Nursing stated the facility did an investigation but did not call the police, and they do not recall calling the Department of Health. The Director of Nursing stated the Risk Manager is responsible for reporting abuse to the Department of Health. During an interview on 01/03/2025 at 1:25 PM, the Administrator stated they are obligated to report all abuse allegations to the Department of Health. The Administrator stated the hospital discharged paperwork alleged Resident #3 was abuse in the facility, therefore, the facility should have reported the allegation of abuse to the Department of Health. During an interview on 01/03/2025 at 2:30 PM, the Risk Manager stated they did not report abuse to the Department of Health because they did not suspect abuse. The Risk Manager stated Resident #3 was interviewed and they reported they fell prior to going to the hospital. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00366573), the facility failed to thoroughly investigate an alleged violation of abuse. This was evident for one out of seven residents (Resident #1) sampled for abuse. Specifically, Resident #1's adult child reported to Registered Nurse Supervisor #1, on 12/18/2024, that they witnessed Certified Nursing Assistant #1 used the dining room table to shove Resident #1 to sit in their wheelchair on 12/18/2024 at 3:28 PM. The facility investigated the alleged allegation of abuse and concluded that abuse did not occur. The facility did not interview residents that were in the dining room and other staff that were on the unit to ascertain if there were any potential witness. The findings are: The facility Policy and Procedure titled Abuse Prevention supersedes on 10/2022 states that allegations of resident abuse, neglect, mistreatment, exploitation, and/or misappropriation of property will be thoroughly investigated; documented by the Administrator (or designee) and reported to the appropriate state agencies, physicians, families and /or representative. The Director of Nursing /designee will conduct the interviews with potential witnesses or staff who might be able to share needed information in a private room to establish lines of communication. Resident #1 was admitted to the facility with diagnoses including Dementia, Persistent Mood Disorder, and Depression. A Social Service assessment dated [DATE] documented Resident #1 had long and short-term memory problems and severely impaired cognition. An Incident/Event Intake Form dated 12/18/2024 documented Resident #1's child reported on 12/18/2024 at 3:35 PM that they witnessed Certified Nursing Assistant #1 pushed a table against Resident #1 in the day room. Nurse Manager #1 conducted an assessment, and there were no visible injuries. Certified Nursing Assistant #1 was removed from the schedule the pending investigation. Certified Nurse Assistant #1 was interviewed on 12/20/2024 and stated Resident #1 was assisted to sit down due to the risk of falls. Based on investigation and re-enactment, the facility concluded there was no evidence of abuse. An email, with Resident's #1 child feedback, dated 12/18/2024 at 6:00 PM documented they came to the day room and witnessed Certified Nursing Assistant #1 shoved Resident #1 with a table. Certified Nursing Assistant #1 shoved Resident #1 with the table to show the resident how to sit in their wheelchair. The Resident Demographic Detail Report revealed there were 12 residents in the day room on 12/18/2024. Resident #2 was alert and oriented x3. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/02/2024 at 1:07 PM, the Director of Nursing stated Nurse Manager #1 reported the allegation to them on 12/18/2024 after 3:30 PM and they immediately removed Certified Nursing Assistant #1 from the schedule. The Director of Nursing stated that they did a re-enactment of the incident and Certified Nurse Assistant #1's body did not move the table forward. The Director of Nursing stated the investigation concluded there was no evidence of abuse. The Director of Nursing stated they did not interview other residents who were sitting in the dining room, nor did they interview other staff members before ruling out abuse. During an interview on 01/03/2024 at 1:15 PM, the Administrator stated they became aware of the alleged abuse incident on 12/18/2024 at around 3:47 PM. The Administrator stated that the Director of Nursing is responsible for the investigation and should have interviewed residents who were in the dining room and other staff members. 10 NYCRR 415.4 (b)(3)