STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335644	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kings Harbor Multicare Center	2000 E Gunhill Road Bronx, NY 10469

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 0600 Level of Harm - Minimal harm or potential for 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. 39365 Based on observations, interviews, and record review during the Abbreviated Survey (NY 00351995), the facility failed to protect residents' rights to be free from physical abuse by nursing home staff. This was evident in one out of six residents (Resident #1) reviewed for abuse. Specifically, on 08/20/2024 at approximately 4:45 PM, Certified Nursing Assistant #2 reported to Registered Nurse Supervisor #1 that at 6:53 AM, Certified Nursing Assistant #2 assisted Certified Nursing Assistant #1, in the care of Resident #1. During care, Resident #1 held on tightly to Certified Nursing Assistant #1's hand, sinking their fingers into Certified Nursing Assistant #1's arm. Certified Nursing Assistant #1 raised their hand and with a deliberate, forceful slap to Resident #1's face between their forehead and eyes. The findings are: The Facility's Policy and Procedure titled Combative Resident with revision date 08/2023, documented it is the policy of the facility to maintain the safety of residents and staff during resident combative behavior/outburst. Any physical or verbal behavior/outburst from residents is to be reported to the Registered Nurse Manager or Nursing Supervisor immediately. The Facility's Policy and Procedure titled Abuse Reporting with revision date 12/2023, documented the residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. All personnel must promptly report any incident or suspected incident of resident abuse, including injury of unknown source. An Occurrence Note dated 08/20/2024 at 05:12 PM, written by the Assistant Director of Nursing, documented that Certified Nursing Assistant #2 reported on 08/20/2024 at approximately 4:45 PM, they witnessed during care, Resident #1 held on tightly to Certified Nursing Assistant #1's hand, sinking their fingers into Certified Nursing Assistant #1's arm. Certified Nursing Assistant #1 raised their hand and with a deliberate, forceful slap to Resident #1's face between their forehead and eyes. Resident #1 responded by letting go immediately of the Certified Nursing Assistant #1's hand. Resident #1 did not scream or try to fight back. Resident #1 was assessed with no apparent injury. Facility Summary of Investigation dated 08/20/2024, documented Law Enforcement was called, but no arrest was made. Certified Nurse Assistant #1 neither admitted nor denied slapping Resident #1. Certified Nursing Assistant #1 was suspended and terminated. The facility concluded that abuse may have occurred during the time Certified Nursing Assistant #1 cared for Resident #1. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kings Harbor Multicare Center	2000 E Gunhill Road Bronx, NY 10469

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted to the facility with diagnoses including Dementia, Alcohol Abuse, and Delirium. A Minimum Data Set (a resident assessment tool) dated 05/31/2024, identified that Resident #1 had a Brief Interview of Mental Status and scored 0/15 indicating Resident #1 was cognitively impaired. Resident #1 required supervision or touching assistance with bed mobility, transfer, and toileting. A Care Plan Titled Resident Abuser/Victim initiated on 02/22/2024, documented interventions to separate the victim from the abuser and affirm appropriate behavior. A Care Plan Titled Alteration in Behavior effective date 02/22/2024, documented interventions to maintain a calm environment, and use behavior modification techniques. The care plan notes from 05/09/2024 to 08/20/2024, documented Resident #1 was physically aggressive and resisted care at times. Nursing progress notes from 05/01/2024 to 08/20/2024, documented that Resident #1 was observed to be physically aggressive toward staff, resisting care, hitting staff, and yelling at staff at times. A New York Police Department Omni form System-Complaint dated 08/20/2024, documented the classification of the occurrence as Harassment and no arrest. During an interview on 08/27/2024 at 12:17 PM, Assigned Certified Nursing Assistant #1 stated that they provided care to Resident #1 on 08/20/2024 at around 6:30 AM. Certified Nursing Assistant #1 stated that they knew that Resident# 1 might be combative when trying to change them. Certified Nursing Assistant #1 stated that the nurse on the unit told them to get help when they were going to provide care to Resident #1. Certified Nursing Assistant #1 stated they asked Certified Nursing Assistant #2 to assist them. Certified Nursing Assistant #1 stated that when they attempted to change Resident #1, Resident#1 put their fingernails on Certified Nursing Assistant #1's arm in the wrist area. Certified Nursing Assistant #1 stated it was hurting, and Certified Nursing Assistant #1 released Resident #1's hand. Certified Nursing Assistant #1 stated they did not hurt Resident #1. Certified Nursing Assistant #1 also stated that they did not slap Resident #1 in the face. They moved Resident #1's hand and continued to provide care. Certified Nursing Assistant #1 stated that they should have notified the nurse that Resident #1 was combative. During an interview on 08/27/2024 at 12:53 PM, Certified Nursing Assistant #2 stated that on 08/20/2024 around 6:50 AM, Certified Nursing Assistant #1 asked them to assist with Resident #1 care. Certified Nursing Assistant #2 stated that when they went to the room, they observed Resident #1 hitting Certified Nursing Assistant #1 over the upper body with both hands while they were changing Resident #1. Certified Nursing Assistant #2 stated Certified Nursing Assistant #1 stopped providing care and asked them to help turn Resident #1. Certified Nursing Assistant #2 stated they helped to turn Resident #1, but the resident was still fighting and moving their hands toward Certified Nursing Assistant #1. Certified Nursing Assistant #2 stated that they should stop providing care and call the nurse if the resident resisted or was fighting, but in Resident #1's case, they did not want to leave them unchanged. Certified Nursing Assistant #2 stated that when Certified Nursing Assistant #1 was washing Resident #1's back, Resident #1 held Certified Nursing Assistant #1 's hand around the wrist area and sank their fingernails in their skin. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 gave Resident #1 a forceful slap in the face between the eye and forehead. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kings Harbor Multicare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 E Gunhill Road Bronx, NY 10469	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/2024 at 11:44 PM, Licensed Practical Nurse #1 stated they worked on 08/20/2024 11 pm-7 am shift, and no staff reported any abuse. Licensed Practical Nurse #1 also stated that no staff had reported to them that Resident #1 was resistant to care and combative. During an interview on 08/27/2024 at 3:50 PM, Registered Nurse Manager #1 stated they were responsible for updating the care plan and Resident Nursing Instructions. Registered Nurse Manager #1 stated that Resident #1 was resistant and combative at times, when the resident moves/transfers. Registered Nurse Manager #1 stated that staff was instructed that when Resident #1 became resistant, they should stand back, report to the nurse or supervisor, and get help from another staff member. Registered Nurse Manager #1 stated that it should be documented in Resident Nursing Instructions to notify the nurse and get a second person if the resident became combative, and it was omitted. Registered Nurse Manager #1 also stated staff cannot retaliate if the resident hits or hurts the staff. During an interview on 08/28/24 at 2:56 PM, the Risk Manager #1 stated that Resident Nursing Instructions should include instructions to the Certified Nursing Assistants on what they should do if Resident #1 resists care or is combative/ aggressive. During an interview on 08/29/2024 at 12:25 PM, Assistant Director of Nursing #1 stated they were informed about the alleged abuse on 08/2024 at 4:45 PM and investigated the incident. Assistant Director of Nursing #1 stated Certified Nursing Assistant #2 reported witnessing Certified Nursing Assistant #1 slapped Resident #1 in the face at 6:53 AM. Assistant Director of Nursing #1 stated they interviewed Certified Nursing Assistant #1 over the phone, and they did not acknowledge or deny if they slapped Resident #1. Assistant Director of Nursing #1 stated according to Certified Nursing Assistant #1, Resident #1 was combative and hit them. Assistant Director of Nursing #1 stated Certified Nursing Assistant #1 was supposed to stop providing care and report to the nurse immediately. Assistant Director of Nursing #1 stated that calling the nurse or having a second person assist was not documented in Resident#1's instructions prior to the incident. Assistant Director of Nursing #1 stated that Certified Nursing Assistant #1 was terminated for abuse based on an incident witnessed by Certified Nursing Assistant #2. During an interview on 08/29/2024 at 2:29 PM, the Administrator stated that they were notified immediately and were physically present. The Administrator stated they met with the Director of Nursing and Risk Manager to discuss the incident and concluded that abuse may have occurred. The Administrator stated that law enforcement came to the facility, no arrest was made, and Certified Nursing Assistant #1 was terminated. 10 NYC RR 415.4(b)(1)(i)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 39365 Based on record review and interviews conducted during the abbreviated survey (NY00341680) on 08/27/2024-08/29/2024, the facility failed to ensure the resident was free of significant medication errors. This was evident for one out of five sampled residents (Resident #2). Specifically, on 05/08/2024 at approximately 10:50 PM, Registered Nurse # 1 administered 24 units of insulin Lantus (long-acting insulin) to Resident #2, who was not on insulin therapy. The Medical Doctor was made aware and immediately ordered dextrose 5 % and 0.45 % sodium chloride intravenous solution to be infused at 70 ml/hour for 24 hours. Fingerstick Blood Sugar and vital signs (blood pressure, pulse, and temperature), monitor every four hours for 24 hours. The findings are: The facility Policy and Procedure titled, Administration of Insulin Injection and Preparation with revision date 01/2018, documented it is the facility policy to administer insulin preparations safely and appropriately. The nurse responsibility included. Review medication order, identify resident, explain procedures, and follow the rights for medication administration. Resident #2 was admitted to the facility with a diagnosis of Type 2 Diabetes Mellitus, Peripheral Vascular Disease, and chronic kidney disease. The Minimum Data Set (an assessment tool) dated 04/13/2024, documented that Resident #2 had intact cognition. A Physician Order Activity Detail Report dated 05/01/2024 to 05/08/2024, revealed there were no Physician Order for insulin Lantus. A Care Plan Alteration in Blood Glucose Level effective date 05/03/2023, documented interventions, including monitoring blood glucose levels as ordered and notifying the Medical Doctor of changes. The Facility's Fall/Occurrence Report dated 05/08/2024, documented at 10:50 PM, License Practical Nurse #1 reported to Registered Nurse Supervisor #1 that Resident #2 was given insulin in error. A complete assessment was done. Emotional support was provided. The Medical Doctor and family were notified. Intravenous fluid was administered as ordered by the Medical Doctor. A Medication Error Incident Report dated 05/08/2024, documented that Licensed Practical Nurse #1 asked Registered Nurse # 1 to administer Lantus to Resident #3. Registered Nurse #1 failed to identify the resident prior to administering the medication and inadvertently administered 24 units of Lantus to Resident #2, who has a diagnosis of Diabetes, but is not on insulin therapy. Resident #2 remained asymptomatic. Registered Nurse #1's employment was terminated. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Situation Background Assessment Recommendation Note dated 05/09/2024 at 02:55 AM, written by Registered Nurse #1 documented that on 05/08/2024 at approximately 10:50 PM, they incidentally administered Insulin to Resident #2. Registered Nurse #1 immediately told Licensed Practical Nurse #1, who called Registered Nurse Supervisor #1. Resident #2 was alert and responsive. Resident #2 was not in any acute distress with Blood Sugar 136 milligram/deciliter, Blood Pressure 165/81, Pulse 94, Respiration 19, Temperature 98.0, Oxygen saturation 95% Room Air. The Medical Doctor was made aware immediately and ordered dextrose 5 % and 0.45 % sodium chloride intravenous solution infuse by intravenous route 70 ml per hour for 24 hours. Monitor Fingerstick Blood Sugar and vital signs every 4 hours for 24 hours. The orders were implemented. The vital signs were re-checked at 11:25 PM and were within normal limits. The Blood Sugar was 136 milligram/deciliter. A Situation Background Assessment Recommendation Note dated 05/09/2024 at 01:49 AM, written by Registered Nurse Supervisor #1 documented that Registered Nurse #1 incidentally administered insulin Lantus 24 units to Resident #2 at 10:50 PM. Resident #2 stated in an interview that the nurse gave them insulin injection, and they know they don't get any insulin. A Physician Order Activity Detail Report dated 05/09/2024, documented the orders for dextrose 5 % and 0. 45 % sodium chloride intravenous solution, infuse 70 milliliters by intravenous route immediately 70 ml/hour for 24 hours. Fingerstick Blood Sugar every 4 hours for 24 hours. Call the Medical Doctor for blood sugar below 75 mg/dl. A Medical Interim Progress Note dated 05/15/2024 at 12:05 AM, documented Resident #2 received a dose of long-acting insulin by error last week. Today, 05/15/2024, the resident states that they did not feel too well yesterday, which could have been secondary to the sustained effect of the long-acting insulin dose. During a telephone interview on 08/28/2024 at 1:49 PM, Resident #2 stated that the incident happened around 11:00 PM, and they were dosing off. Resident #2 stated that the room was dark, and they felt someone uncovering them and saying something, but they were wearing masks, and they did not hear what the staff said. Resident #2 stated that they thought it was a nurse administering cream for the rash on their tummy, and they allowed to uncover them. Resident #2 stated that they felt that the nurse injected something in their tummy, woke up fully, and asked what they were doing. Resident #2 stated the nurse said it was their insulin. Resident #2 stated that they told the nurse that they were not taking insulin, and the nurse said, yes. Resident #2 stated that after they convinced the nurse that they had the wrong resident, the nurse left. Resident #2 stated a Licensed Practical Nurse #1 came into the room and said everything would be all right and checked their blood pressure and glucose. Resident #2 stated that they texted their adult child and notified them of what happened. During an interview on 08/28/2024 at 2:05 PM, Licensed Practical Nurse #1 stated that the incident happened on 05/08/2024 during the 3-11 shift, they asked Registered Nurse #1 to give Resident #3 their insulin. Licensed Practical Nurse #1 stated they already prepared the insulin with a pen and told Registered Nurse #1 the name of the resident and showed them the Medication Administration Record for Resident #3. Licensed Practical Nurse #1 stated that later Registered Nurse #1 told them that they thought they made a mistake by giving insulin to the wrong resident. Licensed Practical Nurse #1 stated they notified the supervisor and Medical Doctor. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/2024 at 2:38 PM, Registered Nurse #1 stated on 05/08/2024, around 10:30 PM -10:45 PM, Licensed Practical Nurse #1 asked them to administer insulin to Resident #3 and said it had already been prefilled. Registered Nurse #1 stated that they were very busy and fixated on another resident under their care and had a lot of pressure in their head. Registered Nurse #1 stated that they did not check the Electronical Medical Administration Record as they were supposed to and went to the wrong room. Registered Nurse #1 stated that the room was dark and they did not open the light, and they did not check the resident's wristband as they were supposed to. Registered Nurse #1 stated that after the resident told them that they were not taking insulin, they realized that they had administered the insulin to the wrong resident. Registered Nurse #1 stated that they immediately told the Licensed Practical Nurse #1, Nursing Supervisor and called the Medical Doctor. During an interview on 08/29/2024 at 11:19 AM, Registered Nurse Supervisor #1 stated they were called to the unit by Registered Nurse #1, who notified them that they administered insulin to the wrong resident. Registered Nurse Supervisor #1 stated that they assessed and interviewed Resident #2. Registered Nurse Supervisor #1 stated Resident #2 told them that they got injections, and they were not receiving any insulin. Emotional support was provided. Registered Nurse Supervisor #1 stated they did not observe any adverse reaction, vital signs were normal, and the Medical Doctor was notified. Registered Nurse Supervisor #1 stated Registered Nurse #1 did not follow the five rights of medication administration and assumed that it was the right resident without checking the resident's wristband as a part of identification. During an interview on 08/28/2024 at 1:22 PM, the Medical Doctor stated Resident #2 had no order for insulin. The Medical Doctor stated they evaluated Resident #2 after the incident on 05/08/2024. The Medical Doctor stated that Resident #2 did not sustain any harm, emotional or physical, due to the one-dose injection of the insulin Lantus. Resident #2 was monitored and received dextrose 5% intravenously, and it was discontinued due to the increase in blood glucose level. During an interview on 08/29/2024 at 2:36 PM, the Administrator stated that they were informed about Registered Nurse #1 not following facility policy on medication administration, which resulted in administering insulin to the wrong resident. The Administrator stated Registered Nurse #1 and was terminated from employment. 10 NYCRR 415.12 (m)(2)