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 03/05/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record reviews, and interviews conducted during a survey, the facility failed to ensure that each resident receives treatment and care in accordance with professional standards of practice. This was evident in one (1) of three (3) residents sampled (Resident #1). Specifically, facility's investigation dated 02/17/2026 at 5:04 PM, documented Resident #1 vomited undigested foods and there was no documented evidence that Resident #1's vital signs were done, or the Registered Nurse Supervisor #1 or the medical doctor were notified that Resident #1 vomited after dinner.The findings are:The facility's policy titled Notification of Changes dated 12/2024, documented it is the policy of the facility to immediately inform the resident, consults with resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident or incident involving the resident, upon significant change in status or condition, or regarding changes in resident's rights. The members of the interdisciplinary team should address any changes in resident condition/status as appropriate.The facility's policy titled Falls/ Occurrences dated 04/2024, documented all Occurrence will have supportive documentation in interdisciplinary notes describing the occurrence, the vital signs, full physical assessment and therapeutic interventions provided. The note will include notification to the physician, family, Social Work, OT/PT and Maintenance, as applicable.Resident #1 was admitted to the facility with diagnoses including subdural hematoma (a collection of blood in the brain), hydrocephalus (abnormal buildup of fluid in the brain with increased pressure on the skull), and dementia.The Minimum Data Set (a resident assessment tool) dated 12/17/2025, documented Resident #1 had severely impaired cognition.A review of activities of daily living care plan dated 12/13/2025, documented Resident #1 required total assistance of one person with eating and required maximal assistance (helper does more than half the effort) of two persons for bed mobility. The care plan was updated on 02/02/2026, Resident #1 required maximal assistance of one person in bed mobility. On 02/09/2026 that Resident #1 required maximal assistance of one person with eating.A nursing notes dated 02/17/2026 at 9:06 PM by Licensed Practical Nurse #1 documented during dinner time at approximately 4:35 PM, Resident #1 ate dinner in their room assisted by Certified Nursing Assistant #2. During which Resident #1 vomited a small amount of undigested food. Resident #1 remained alert with no distress. At approximately 5:45 PM, Licensed Practical Nurse #1 was called to Resident #1's room and was told Resident #1 accidentally hit their left forehead on the closet when daily care was provided and their clothes were changed. Licensed Practical Nurse #1 attended Resident #1 and observed a laceration to left forehead with no active bleeding. Resident #1 was nonverbal, responsive to touch and their eyes were open. Licensed Practical Nurse #1 notified Registered Nurse Supervisor #1. Registered Nurse Supervisor #1 documented on 02/17/2026 at 5:45 PM, they were called to the unit by Licensed Practical Nurse #1. Resident #1 was observed in bed with a laceration on the left side of their forehead. No active bleeding was noted. Both eyes were open. Resident #1 was alert to tactile stimuli and remained nonverbal. Registered Nurse Supervisor #1 conducted a neurological assessment and noted Resident #1 had changes in communication and mental status. The vital signs were assessed, and the blood pressure was 58/36, heart rate was 59 beats per minute, respiration rate 14 and temperature 98 degrees. Registered Nurse Supervisor #1 immediately called 911 and activated an overhead page for a (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical emergency. Resident #1 became unresponsive and pulseless. Cardiopulmonary resuscitation was initiated until the emergency services 911 arrived (at 5:57 PM) and assumed responsibility. Resident #1 pulse was achieved, and Resident #1 was transported by ambulance at 6:07 PM to the emergency room.A review of investigative statement of Licensed Practical Nurse #1 dated 02/17/2026 documented at approximately 5:07 PM, Licensed Practical Nurse #1 was informed by staff that Resident #1 vomited. Licensed Practical Nurse #1 responded and observed Resident #1 sitting upright in their bed. Licensed Practical Nurse #1 saw a small amount of vomitus on Resident #1's clothing and moderate amount of vomitus on Resident #1's bed linen. Resident #1 was alert and not in distress. Vital signs were collected.A review of Resident #1's medical record revealed there was no documented evidence that vital signs were taken and recorded, and the nursing supervisor or the medical doctor were notified that Resident vomited after dinner.During an interview on 02/26/2026 at 11:50 AM, Certified Nursing Assistant #1 stated on 02/17/2026, Licensed Practical Nurse #1 told them that Resident #1 vomited and need to be clean up. Certified Nursing Assistant #1 stated when they entered Resident 1's room they observed Resident #1 was seated upright, alert, and responsive. Certified Nursing Assistant #1 stated they observed vomitus on Resident #1's clothing and bed linens. Certified Nursing Assistant #1 stated when they turned Resident #1 to the right side towards the closet, they heard a sound, and they turned Resident #1 on to their back and noticed a small laceration to Resident #1's forehead. Care was stopped and Licensed Practical Nurse #1 was informed. Certified Nursing Assistant #1 stated they did not apply unusual force when Resident #1 was turned to their right side. Certified Nursing Assistant #1 stated they used draw sheet underneath when Resident #1 was turned to change the bed linens. Resident #1' s bed was close to the closet.During an interview on 02/26/2026 at 5:50 PM, Certified Nursing Assistant #2 stated they worked on 02/17/2026 in the evening shift (3:00 PM-11:00 PM). Certified Nursing Assistant #2 stated they were assigned to feed Resident #1. Resident 1 ate everything without a problem, was fine and kept talking. Certified Nursing Assistant #2 stated they left Resident #1 seated upright. Certified Nursing Assistant #2 stated when they were picking up trays at approximately 5:04 PM they observed Resident #1 vomited undigested food. Licensed Practical Nurse #1 was called and told they were told to keep the head of Resident's bed elevated.During an interview on 02/26/2026 at 12:16 PM, Licensed Practical Nurse #1 stated on 02/17/2026 at approximately 4:35 PM Resident #1 ate dinner and at approximately 5:07 PM, staff notified them that Resident #1 vomited undigested foods. Licensed Practical Nurse #1 stated they went to the room and observed Resident #1 seated upright, not in distress and they were talking. Licensed Practical Nurse #1 stated the vital signs were stable but not documented. Licensed Practical Nurse #1 stated they knew that if there was any change in condition, they must notify the nursing supervisor and the medical doctor. Licensed Practical Nurse #1 stated they did not notify Registered Nurse Supervisor #1 right away because when they checked Resident #1, they were not in distress and not in an emergency at that time. Licensed Practical Nurse #1 stated at approximately 5:45 PM, Certified Nursing Assistant #3 told them that Resident #1's head hit the closet in their room. Licensed Practical Nurse #1 stated they checked Resident #1 and observed Resident #1 lying in bed with a small laceration to forehead and called the Registered Nurse Supervisor #1 to assess Resident #1.During an interview on 02/26/2026 at 12:31 PM, Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 informed them Resident #1 hit their head on the closet on 02/17/2026 at 5:45 PM. Registered Nurse Supervisor #1 stated Resident #1 was assessed and had a laceration and hematoma to forehead. Neurological assessments were done there were changes in communication and mental status. Registered Nurse Supervisor #1 stated they took vital signs. Resident #1 suddenly had no pulse and was unresponsive, cardiopulmonary resuscitation was initiated and 911 called. Emergency Medical Services arrived at 5:57 PM and took over. Resident #1's pulse was regained, and Resident #1 was transferred to the emergency room at 6:07 PM.A follow up interview on 03/04/2026 at 12:46 PM, Registered Nurse Supervisor #1 stated they did not receive report from Licensed Practical Nurse #1 that Resident #1 vomited after dinner on 02/17/2026 prior to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident. Registered Nurse Supervisor #1 stated that when residents' condition changes the protocol is to notify the supervisor, and they will come to the unit to assess the resident. Registered Nurse Supervisor #1 stated once they assessed resident, then they will notify the medical doctor. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 should have notified them when Resident #1 vomited. Registered Nurse Supervisor #1 stated they found out from Certified Nursing Assistant #1 when they entered the room that Resident #1 vomited after dinner.During an interview on 02/27/2026 at 12:52 PM, Director of Nursing stated on 02/17/2026 at approximately 6:03 PM, they were notified by the assistant director of nursing that Resident #1 sustained laceration and hematoma to their left forehead when Resident #1 was turned to their right side in bed. The Director of Nursing stated Resident #1 vomited a small amount of undigested foods and was checked by Licensed Practical Nurse #1. Director of Nursing stated Resident #1 was not in acute distress. The Director of Nursing stated they investigated the incident together with assistant director of nursing and they conducted two (2) separate days of reenactments of events and interviewed Certified Nursing Assistant #1 three (3) times, and they were consistent with the sequence of events. Director of Nursing stated during the reenactments Certified Nursing Assistant #1 demonstrated correct standard practice in turning and positioning Resident #1 while in bed during bed linen changes. Director of Nursing stated they did not identify the closet or dressers as potential hazards for residents with similar conditions. Director of Nursing stated the facility concluded the occurrence was accidental and not purposeful or deliberate.A subsequent interview on 03/04/2026 at 9:23 AM, Director of Nursing stated they interviewed Licensed Practical Nurse #1 and stated Resident #1 was stable after they vomited and vital signs were taken but not documented. Director of Nursing stated when Resident #1 had vomited, the Licensed Practical Nurse #1 should have documented the vital signs in their nursing notes and notified the registered nurse supervisor. The nursing supervisor will then assess Resident #1 and notify the medical doctor.During an interview on 03/02/2026 at 10:40 AM, Medical Director stated they reviewed the documentation and interviewed staff and that Resident #1 was not in distress after they vomited, there was no indication of aspiration or trouble breathing. The Medical Director stated if Resident #1 aspirated there would be signs and symptoms, and it would not be a sudden change in mental status. The Medical Director stated they do not think the injury was the reason, given Resident #1 with multiple vascular risk factors leading to cardiac events, the incident was not intentional. The Medical Director stated that this was likely cardiac related because the changes with Resident #1 occurred suddenly. 10 New York Codes, Rules, and Regulations: 415.12