STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335653	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah Home & Hospital for Aged & Infirm	1516 Oriental Blvd Brooklyn, NY 11235

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28196 Based on observation, record review, and interviews during an abbreviated survey (NY00320606), the facility failed to protect a resident's right to be free from physical abuse by a nursing home staff. This was evident in one out of three residents sampled for abuse (Resident #1). Specifically, on 07/22/2023 at approximately 8:50 PM, Resident #1 told Registered Nurse #1 that Certified Nursing Assistant #1 threw them in the bed from the wheelchair and they hit their head on the headboard. Resident #1 was assessed by Registered Nurse #1 and there were no visible injuries. This resulted in Past Noncompliance with no potential for serious harm. The findings include: The facility's policy and procedure on Abuse Prohibition dated 10/24/2022, documented the facility shall not use or permit verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion of residents/patients, misappropriation of resident property, exploitation or other mistreatment or neglect. It also stated, the facility will report no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious body injury. Resident #1 was admitted to the facility on [DATE], with diagnoses of Dementia, Depression, Cancer of stomach and kidney. The Minimum Data Set (an assessment tool), dated 06/25/2023, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of three associated with severe impaired cognition. The Facility's investigation dated 07/22/2023, documented Resident #1 requested to go to the bathroom because they were wet. Certified Nursing Assistant #1 toileted them and when returning them back to the bed, Certified Nursing Assistant #1 threw them in the bed from the wheelchair and they hit their head on the headboard. Resident #1 reported to Registered Nursing Supervisor #1 that when they asked Certified Nursing Assistant #1 why you hit them, Certified Nursing Assistant #1 replied you hit yourself. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Risk for Victimization Care Plan dated 06/22/2023, with interventions to anticipate resident's needs, to approach calmly, speak slowly clearly and allow resident to guide activities to the extent capable. A Nursing Progress Note dated 07/22/2023 at 10:30 PM, written by Registered Nurse #1 documented at approximately 8:50 PM, Registered Nurse #1 called to report that Resident #1 stated they were transferred to the bed roughly by Certified Nursing Assistant #1. Registered Nurse #1 interviewed Resident #1 and they stated that when Certified Nursing Assistant #1 placed them in the bed after toileting, Certified Nursing Assistant #1 placed them in the bed in a rough manner and they hit their head on the headboard. A head-to-toe assessment of Resident #1 revealed no visible injuries. A Physician's progress note dated 07/23/2023 at 9:51 AM, documented Resident #1 was seen Resident #1 was awake, alert, verbally responsive. Denied pain. Resident #1 had no visible signs of injury. Certified Nursing Assistant #1 provided a written statement to the facility dated 07/22/2023, documented that they were working on the morning shift and was assigned to Resident #1. Certified Nursing Assistant #1 documented that Registered Nurse #1 informed them that Resident #1 wanted to use the bathroom. Certified Nursing Assistant #1 documented that they went to Resident #1's room and assisted Resident #1 to the bathroom. Certified Nursing Assistant #1 documented that they assisted Resident #1 in the bathroom and after Resident #1 was finished using the bathroom they provide care to Resident #1, then assisted Resident #1 back to their bed. Certified Nursing Assistant #1 documented Resident #1 sat on the edge of the bed, and they lift Resident #1 feet in the bed. During an interview on 10/25/2024 at 3:20 PM, Registered Nursing #1 stated that on 07/22/2023 at 11:20 AM, they responded to Resident #1's call bell and Resident #1 requested to go to the bathroom. Registered Nursing #1 stated that they informed Certified Nursing Assistant #1 who was assigned to Resident #1. Registered Nursing #1 stated that Certified Nursing Assistant #1 immediately went to Resident #1's room. Registered Nursing #1 stated that at approximately 11:55 AM, they observer Certified Nursing Assistant #1 serving trays and there was no mention of any incident. Registered Nursing #1 stated that they also saw Resident #1 and talk with Resident #1 after Certified Nursing Assistant #1 completed care to Resident #1. Registered Nursing #1 stated Resident never complain about Certified Nursing Assistant #1 being rough and hit their head. Resident #1 never reported anything during the shift. Registered Nurse #1 stated body assessment was done and there were no discoloration, redness or injuries observed and Resident #1 denied having any pain or discomfort. Registered Nurse #1 stated that they make frequent rounds on the unit to monitor staff and residents to ensure staff members are providing timely care and that there was no abuse. During an interview on 10/24/2024 at 2.55 pm, Director of Nursing stated they were informed by Registered Nursing Supervisor #1 on 07/22/2023 (not sure of the time), Resident #1 reported that they were rough handled by Certified Nursing Assistant #1. Director of Nursing stated that Resident #1 was assessed by Registered Nursing Supervisor #1 and the Medical Doctor and there were no visible signs of redness, discoloration, or injuries. Director of Nursing stated that facility investigated the alleged incident and determined that Resident #1 was mishandled by Certified Nursing Assistant #1. The Director of Nursing stated that Certified Nursing Assistant #1 was removed from the schedule and Resident #1 was placed on two people approach and staff members were re-educated on abuse prevention. The Director of Nursing stated the unit nurse and the nursing supervisor monitored residents and staff on the unit to ensure that there is no abuse. Director of Nursing stated that they make rounds twice daily to monitor the staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the following corrective actions taken, there were sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 07/15/2024. A Plan of Correction is not required for this citation. The facility implemented the following corrective action prior to surveyor entrance on 07/15/2024. The facility's Director of Nursing investigated the allegation of abuse and the team concluded that abuse did occur. The facility developed an action plan on 07/22/2023 which includes the following: On 07/22/2023 Resident #1 was assessed by Registered Nursing Supervisor #1 and Medical Doctor and there were no visible injuries. 0n 07/22/2023 Resident #1's abuse care plan was updated to reflect on the allegation of abuse. Additional interventions included two people during care and ensure that resident is always transferred safely. Local law enforcement was called on 07/22/2023 and responded. Neuro Checked was implemented for 48 hours. Facility interviewed and assessed other residents on Certified Nursing Assistant #1 assignment for evidence for abuse. Certified Nursing Assistant #1 was removed from schedule pending investigation and subsequently terminated. On 07/23/2023, Policy/Procedure on Abuse Prohibition was reviewed. No revisions were done to the policy. On 07/26/2023, the Quality Assurance Committee held a meeting where the incident was discussed. Attendees included the Administrator, Director of Nursing, Assistant Director of Nursing, and other departmental heads. On 07/23/2023, multiple residents on Certified Nursing Assistant #1's assignment was interviewed by Social Worker and there were no abuse, neglect, or mistreatment issues identified. The facility re-in-service staff members on 07/23/2023. Lesson plan: Abuse Facility has 385 nursing staff of which 86% was in-serviced by the Assistant Director of Nursing. In-service on-going on a monthly and annually. 201 out of 236 Certified Nursing Assistants were in-serviced. 61 out of 61 License Practical Nurses were in-serviced. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	70 out of 88 Registered Nurses were in-serviced. During interviews with multiple staff members including 10 Certified Nursing Assistants, 3 License Practical Nurses and 3 Registered Nurses stated knowledgeable of the abuse policy. 10 NYCRR 415.4(b)(1)(i)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. 48907 Based on observation, record review, and interviews during an abbreviated survey (NY 00328412), the facility did not ensure that all residents received the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This was evident in two out of three residents sampled (Resident #1 and Resident #2). Specifically, on 11/16/2023, Resident #1 reported to Registered Nurse Supervisor #1 they requested pain medication at 7:30 PM and did not receive it. Resident #2 informed Registered Nurse Supervisor #1 they received some medication at 5:00 PM on 11/16/2023 but did not receive the blue tablet (sleeping medication). In both instances, the narcotic logbook documented the medications were dispensed, but there was no documentation that the medications were administered on the electronic medication administration record. All residents were assessed and there were no adverse reactions. The facility took immediate corrective actions and was found to be in substantial compliance on 11/17/2023 at 9:00 AM prior to the Surveyor's onsite visit on 07/15/2024 at 9:00 AM. This resulted in Past Noncompliance with no potential for serious harm. The findings include: The facility's policy and procedure on Medication Administration-General Procedure dated 08/07/2022, documented medications will be administered following standard procedures and infection control policies. The policy further documented the Licensed Nurse's responsibility are to administer the medication and remain with the resident until it is swallowed and document the medication administration immediately after administration on the electronic medication administration record. Resident #1 was admitted to the facility with diagnoses including Hypertension, Diabetes Mellitus, Hyponatremia, and Malignant Neoplasm. The Minimum Data Set (an assessment tool), dated 01/07/2023, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderately impaired cognition. Risk for victimization care plan dated 11/03/2023, included intervention to anticipate resident's needs and explain all procedures. Resident #2 was admitted to the facility with diagnoses including Hypertension (high blood pressure), and Fracture. The Minimum Data Set (an assessment tool), dated 11/03/2023, documented Resident #2 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 13 associated with intact cognition. Risk for victimization care plan dated 10/31/2023, included intervention to anticipate Resident #2's needs. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's investigation dated 12/15/2023 documented Registered Nurse Supervisor #1 informed Director of Nursing on 11/17/2023 at 12:34 AM, Resident #1 and Resident #2 reported they did not receive their medications. While investigating the above incident, other affected residents were identified with medication not administered. The facility concluded Licensed Practical Nurse #1 did not administer the medications to multiple assigned residents. Based on the investigation and resident's statements, narcotic diversion could not be excluded. Licensed Practical Nurse #1 was terminated. During an interview on 07/15/2024 at 5:48 PM, Director of Nursing stated two residents (Resident #1 and #2), complained of not receiving their medications and investigation was initiated. Director of Nursing stated an audit of other residents were done after the complaints were made and the Medication Administration Record reveal that the medications were not electronically signed. The Director of Nursing stated Licensed Practical Nurse #1 dispensed the narcotics as the count was accurate but Resident #1 and Resident #2 reported they did not receive it and the electronic record was not signed. During a telephone interview on 10/22/2024 at 10:15 AM, Registered Nurse Supervisor #1 stated they were called by Licensed Practical Nurse #3 (night shift) to the unit about Resident #1's complaint of not receiving their sleeping medication. Registered Nurse Supervisor #1 stated it was a little before midnight when they responded to the unit and Resident #2 had also made the same complaint about not receiving pain medication. Registered Nurse Supervisor #1 stated the residents were describing the medication by color. They checked the narcotic record log and observed that Licensed Practical Nurse #1 signed the medication out, the count was accurate, however, Licensed Practical Nurse #1 did not sign the electronic medication administration record to indicate they administered the medication. Registered Nurse Supervisor #1 stated they called Licensed Practical Nurse #1 to inquire about Resident #1 and #2's complaint of not receiving their medication and they stated, all medications were administered to the residents. Registered Nurse Supervisor #1 stated they checked the electronic medication administration record system, and observed many medications were not documented for other residents. Registered Nurse Supervisor #1 stated they called and inform the Director of Nursing and the Medical Doctor Based on the following corrective actions taken, there were sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to this survey. A Plan of Correction is not required for this citation. The facility took immediate corrective actions and was found to be in substantial compliance on 11/17/2023 at 9:00 AM prior to the Surveyor's onsite visit on 07/15/2024 at 9:00 AM. Facility started in-service on 11/17/2023 and completed in-services for all Nurses. Lesson plan included the six medication rights, compliance, and narcotic administration. All residents were assessed and there were no adverse reactions. Audit of other residents' medical records done and there was no adverse reaction for missing medications. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	94% of Licensed Practical and Registered Nurses were in-serviced on Medication Administration. Licensed Practical Nurse #1 was terminated and reported to the Department of Health, New York City Police Department, the Bureau of Narcotic Enforcement and Office of Professions. Quality Assurance and Performance Improvement meeting was conducted 11/20/2023, addressing medication administration error audit results and ongoing audits. During interviews four License Practical Nurses and three Registered Nurses, stated understanding of the six medication rights, medication compliance, and narcotic administration. They were knowledgeable of the medication administration policy and the importance of documentation. 10 NYCRR 415.12