STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335659	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fordham Nursing and Rehabilitation Center	2678 Kingsbridge Terrace Bronx, NY 10463

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, interviews, and record review conducted during an Abbreviated Survey (2582483), the facility did not ensure a resident received adequate supervision and assistance consistent with the resident's needs to prevent accidents. This was evident for one (1), (Resident #2) out of five (5) residents reviewed and sampled. Specifically, during a review of the facility's surveillance video footage dated from 07/10/2025 at 07:58 PM to 07/12/2025 at 03:29 PM, showed on 07/10/2025 from 08:36 PM to 08:42 PM for six minutes, Resident #2 entered and exited Resident #1's room unsupervised. Three other residents reside in the room with Resident #2 (Resident #3, Resident #4, and Resident #5). No staff were seen on the surveillance redirecting Resident #2 from going into other Residents' rooms.The findings are: The facility's Policy and Procedure entitled Behavior Management Strategies, dated 08/05/2020, documented that it is the policy of the facility to provide the best quality of life and quality of care to residents with behavioral health needs. The purpose of the policy is to manage residents' behavior, direct and motivate residents to change their actions or interactions in certain settings, and guide staff on effective interventions to de-escalate behaviors. Behavioral symptoms which residents may exhibit include but are not limited to wandering into others' rooms/spaces.Resident #2 was admitted to the facility with diagnoses including vascular dementia (decline in mental abilities, such as memory and thinking), alcohol dependence, and adult failure to thrive (a syndrome characterized by weight loss, decreased appetite, reduced physical activity, and decline in overall health in older adults). The Minimum Data Set (a resident assessment tool) dated 07/10/2025, documented that Resident #2 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information), documenting that Resident #2's cognition was severely impaired.A Care Plan for Resident #2 titled elopement risk /wanderer was initiated on 11/4/2021, with a target date 10/14/2025, documented interventions that included hourly check and wander alert. A Behavior Care Plan initiated on 08/04/2022, documented Resident #2 exhibited physical and verbal aggression with interventions to provide a calm structural environment, and to offer diversional activities. A review of the Documentation Survey Report (Certified Nursing Assistant Accountability) dated 07/01/2025 to 07/31/2025 documented Resident #2 was monitored hourly every shift for unsafe wandering/elopement. A review of video footage recorded on 07/10/2025 at 7:58 PM showed that Resident #1(female) was brought from the hospital via stretcher by two attendants. Resident #2 (male) wandered into Resident #1's room at 8:36 PM and exited at 8:42 PM. Resident #2 was in the room for six minutes unsupervised. No staff member redirected Resident #2. Resident #1's three roommates (all cognitively impaired) were in the room at the time. Resident #2 was observed entering approximately one minute on multiple occasions Resident #1's room on 07/11/2025 at 10:45 AM, at 10:51 AM, at 11:07 AM, at 11:20 AM, at 02:11 PM, at 02:58 PM, at 03:09 PM, at 03:14 PM, at 03:39 PM, at 03:44 PM, at 03:50 PM, at 04:12 PM, at 04:39 PM, at 04:43 PM, at 04:50 PM, at 05:01 PM, at 05:06 PM, at 05:10 PM, at 05:15 PM, at 05:25 PM, at 05:29 PM, at 05:37 PM, at 05:43 PM, at 05:48 PM, at 07:48 PM, at 07:55 PM. On 07/12/2025: at 07:21 AM, at 11:51 AM, at 12:16 PM, 12:39 PM, and 12:45 PM. Resident #2 (male) was also observed going in and out of other residents' rooms. During an interview on 08/08/2025 at 2:45 PM, Certified Nursing Assistant #3, who was assigned to Resident #2 on 07/10/2025 and 07/11/2025, 3-11 shift, stated that Resident #2 has wandering behavior and enters other residents' rooms. Certified Nursing Assistant #3 stated that they know Resident #2 goes to their room to look in the window but does not bother anyone. Certified Nursing Assistant #3 stated that Resident #2 starts walking around as soon as they wake up, and they are monitoring them hourly. Certified Nursing Assistant #3 stated that they are responsible for monitoring Resident #2 and preventing them from entering other rooms. Certified Nursing Assistant #3 stated they redirected Resident #2 when they saw them entering another room. During an interview on 08/08/2025 at 04:45 PM, Resident #1's roommate (Resident #3), who had moderately impaired cognition, stated that a man was coming to their room, and looked out the window. Resident #3 stated that the man did not bother them and never touched them. Resident #3 stated that they shouted at the man, and they left the room. Resident #3 stated that the man is good, but they do not want the man to come into their room because they do not know what the man will do. During an interview on 08/08/2025 at 11:15 AM, Registered Nurse #2 stated Resident #2 has a Dementia diagnosis, ambulates independently, and likes to go to other residents' rooms to look in the window. Registered Nurse #2 stated that Resident #2 was on hourly monitoring, and if staff saw Resident #2 go to other rooms, they would redirect them. Registered Nurse #2 stated that all Certified Nursing Assistants on the unit are responsible for monitoring Resident #2's