STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335725	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Center for H I V and Nursing Care	1401 University Avenue Bronx, NY 10452

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285 Based on observations, record review, and interviews conducted during an abbreviated survey (NY00332540), the facility did not ensure that a resident was able to exercise their rights as a resident in the facility and as a citizen or resident of the United States. This was evident in one out of four residents sampled (Resident #1). Specially, on 01/25/2024 at 11:00 AM, Recreational Aide #1 reported to Recreational Supervisor #1 that Resident #1 refused to have their hair cut and become agitated and combative. The Director of Social Work instructed License Practical Nurse #1, and Home Health Aide #1 to hold Resident #1's arms and legs against Resident #1's will and cut Resident #1's hair. The findings are: The facility's Policy titled Resident Rights dated 05/28/2024, documented Healthcare Personnel shall treat all residents with kindness, respect, and dignity. The policy further documented resident has the right to exercise his or her rights as a resident of the facility and as a resident or citizen of the United States and be supported by the facility in exercising his or her rights. The facility's Policy titled Abuse and Neglect dated 12/2022, documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends, and residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and or misappropriation of property. Resident # 1 was admitted to the facility on [DATE], with diagnoses of Antiviral Disease, Major Depressive Disorder and Dementia. The Minimum Data Set (an assessment tool), dated 11/25/2023, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of six associated with severe impaired cognition. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Investigative Form dated 01/29/2024, documented on 01/25/2024 at 11:00 AM, Recreational Aide #1 reported to their supervisor, the Recreational Supervisor, Resident #1 was refusing their hair cut and become agitated and combative and staff held Resident #1 and continued with the haircut. Staff then stop the haircut with the intention of return and to continue Resident #1's hair cut later. License Practical Nurse #1 informed the Director of Social Service that Resident #1 was refusing the haircut and the Director of Social Service responded by going to the unit to see how they could assist. Resident #1 was moved to their room where the environment was less stimulating to continue with the haircut. Resident #1 once again become agitated, kicking, shouting, and screaming. The staff tried to console Resident #1 and held their hands, shoulders, and legs to complete the haircut. The hair cut was completed without any physical harm to the resident. The Facility's conclusion documented that after conducting a thorough investigation, it was concluded that Resident #1 although not harmed in the process was provided a haircut against their will. During an interview on 10/17/2024 at 3:02 PM, Home Health Aide #1 stated they were asked by Social Worker Director to assist them in getting Resident #1's hair cut by Barber #1. Home Health Aide #1 stated that Resident #1 was removed from Barber #1's chair, and was taken to their room by Licensed Practical Nurse #1 because other residents were making a lot of noise. Home Health Aide #1 stated that Barber #1 came to Resident #1's room to complete cutting Resident #1's hair. Home Health Aide #1 stated that while Resident #1 was sitting in their wheelchair Resident #1 started swing to their right hand and they held on to Resident #1's right hand and was stroking and talking to Resident #1 to calm Resident #1 down. Home Health Aide #1 stated Social Worker Director was present and they placed their hands on Resident #1 thigh and Licensed Practical Nurse #1 was holding Resident #1's shoulder so that Resident #1 can get their haircut. During an interview on 10/17/2024 3:29 PM, Licensed Practical Nurse #1 stated Social Worker Director asked them to assist them in getting Resident #1's haircut done. Licensed Practical Nurse #1 stated they were informed by Social Worker Director that Resident #1's Guardian was coming to visit and Resident #1's hair was too long and unkept. Licensed Practical Nurse #1 stated Resident was removed from the barber in their wheelchair and taken to their room. Licensed Practical Nurse #1 stated that Barber #1, Social Worker Director, and Home Health Aide #1 was present in the room with Resident #1. Licensed Practical Nurse #1 stated that they placed their hands gently holding Resident #1's shoulder to keep Resident #1 steady because Resident #1 was combative, and they were concerns for Resident # 1's safety. Licensed Practical Nurse #1 stated that Home Health Aide #1 held on to Resident #1's right hand to keep Resident #1 calm while Social Worker Director placed their hands on Resident #1's thighs. During an interview on 10/17/2024 at 3:45 PM, Registered Nursing Supervisor #1 stated that they never receive any calls from the staffs on the second floor informing them that Resident #1 was refusing their haircut. Registered Nursing Supervisor #1 stated that they become aware of the incident when they were doing staffing the following day. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 3:45 PM, Director of Nursing stated that they become aware of the alleged incident on 01/25/2024 at approximately 11:00 AM by the Recreational Supervisor. Director of Nursing stated that they were informed that Resident #1 was schedule for a haircut and while doing the procedure, Resident #1 become combative and did not want the haircut anymore. Director of Nursing stated that Resident #1's hair was not completely shaved but could visually see that Resident #1's hair and bread was trimmed. Director of Nursing stated that Barber #1 is a contractor and was informed by recreational staff if resident become combative during cutting their hair, they should stop. The Director of Nursing stated that recreational staff was present, and reported the alleged incident to their supervisor and their supervisor reported it to them. Director of Nursing stated that the Social Worker Director informed Licensed Practical Nurse #1 if Resident #1's refused the haircut they should call them. The Director of Nursing stated that the staffs held down Resident #1 and cut Resident #1's hair against Resident #1's will. During a phone interview on 10/18/2024 at 4:13 PM, Barber #1 stated that they are a Licensed Barber and has been scheduled to cut Resident #1' s hair in the facility. Barber #1 stated that Resident #1 had given their consent for the haircut. Barber #1 stated after they started cutting Resident #1's hair, Resident #1 become combative and was removed from the barber 's chair. Barber #1 stated that Social Worker Director was notified and arrived on the unit and informed them that Resident #1 hair must cut because Resident #1 is looking unkept. Barber #1 stated that Resident #1 was [NAME] to their room and a second attempt was made to perform the haircut. Barber #1 stated three other staff members was holding Resident #1 to prevent Resident #1 from harming themself in the process. Barber #1 stated it was three people trying to assist in helping to get Resident #1 haircut but Resident #1 was still combative, cursing and kicking; therefore, they did not complete the haircut. A statement dated 01/26/2024 (no time), written by Social Worker Director documented License Practical Nurse #1 informed the Social Worker Director that Resident #1 was getting a haircut and Resident #1 was kicking, cursing, and using profanities at staff. Social Worker Director went to the unit to assist staff with Resident #1. Social Worker Director documented at first Resident #1 was observed calm and relaxed and was not in distress. Social Worker Director informed Resident #1 that they were going to get a haircut, as Resident #1 was observed to be unkept, with their hair going into their mouth. Resident #1 agreed and said, yes. Social Worker Director took Resident #1 to their room where there was less stimulation because there were loud music playing and many other residents were gathered for a haircut. Social Worker Director, Licensed Practical #1 and Home Health Aide were present. The hair cut was performed by Barber #1 where Resident #1 was still calm, after a little while Resident #1 continued using profanity and stated they wanted a cigarette. Barber #1 kept shaving Resident #1's hair, and moustache. Social Worker Director, Licensed Practical Nurse #1 and Home Health Aide #1 was providing emotional support and Barber #1 cut Resident #1 hair without incident or any accident. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 2:04 PM, Recreational Staff #1 stated that on 01/25/2024 at approximately 11:00 AM Resident #1 give their consent to get their hair cut. Recreational Staff #1 stated that while Resident #1 was on the 2nd floor getting their hair cut, in the middle of the hair cut Resident #1 tell Barber #1 to stop. Recreational Staff #1 stated Resident #1 was kicking, cursing, and waving their hands. Recreational Staff #1 stated they informed Barber #1 to stop, and Resident #1 was taken away from Barber #1 by Licensed Practical Nurse #1. Recreational Staff #1 stated when to inform their supervisor and when they returned to the unit, they heard Resident #1 yelling in their room, and they went to see what was happening. Recreational Staff #1 stated that they observed Social Worker Director crossed Resident #1 leg to prevent Resident #1 from kicking and Licensed Practical Nurse #1 and Home Health Aide #1 was each standing on one side of Resident #1 holding down Resident #1 to get their hair cut. 10 NYCRR 483.10 (a)(1)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285 Based on observations, record review, and interviews conducted during an abbreviated survey (NY00332540), the facility failed to ensure a resident was free from physical or chemical restraints imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. This was evident for one out of four residents sampled (Resident #1). Specifically, on 01/25/2024, Recreational Aide #1 reported to their Recreation Supervisor that Resident #1 was refusing their hair cut and become agitated and combative. The Director of Social Work instructed License Practical Nurse #1, and Home Health Aide #1 to hold Resident #1's arms and legs against Resident #1's will and cut Resident #1's hair. There was no documented evidence that restraints were medically necessary, nor that alternatives were attempted prior to holding down Resident #1's arms and legs for a haircut. Findings are: The Facility's Policy titled Use of Restraints, dated 12/2022, documented the nursing center will promote a restraint-free environment in accordance with State and Federal regulations for the resident to attain and maintain his or her highest level of practical wellbeing. Also, documented restraints shall only be use for the safety and well-being of the resident and only after alternative have been attempted unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and shall not be imposed for the purposes of discipline, staff convenience or that unnecessarily inhibits a resident's freedom of movement or activity. Resident # 1 was admitted to the facility on [DATE] with diagnoses of Antiviral Disease, Major Depressive Disorder and Dementia. The Minimum Data Set (an assessment tool), dated 11/25/2023, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of six associated with severe impaired cognition. The Facility's Initial Event Documentation dated 01/26/2024 at 12:15 PM, documented on 01/25/2024 at 11:30 AM, Resident #1 noted to be agitated, hitting, and kicking at the barber, while receiving a haircut in the presence of recreational staff. The barber stopped the process and later approached the resident who was placed in their room in a less stimulating environment to complete their haircut with three staff members present to aid in keeping resident calm. Resident was asked by the Social Worker Director if their haircut could be performed and resident gave their consent, however during the process resident started to become agitated and moving their arms in an upward manner, kicking and cursing. Staff held their hand, shoulder, and their feet to prevent resident from hurting themselves. There were no Physician's Orders or justification for the restraint use or restraint assessment. There was no documentation to show that the restraints were medically necessary, nor that alternatives were attempted prior to holding down Resident #1 for haircut. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plans for Resident #1 revealed no care plans for restraint was developed. The Facility Investigative Form dated 01/29/2024, documented on 01/25/2024 at 11:00 AM, Recreational Aide #1 reported to their supervisor, Recreation Supervisor, that Resident #1 was refusing their hair cut and become agitated and combative during the procedure and that staff held Resident #1 and continued with the haircut. Staff at that the time stopped the haircut with the intention of returning to Resident #1 later. License Pratical Nurse informed the Director of Social Service that Resident #1 was refusing the haircut and the Director of Social Service responded by going to the unit to see how they could assist. Resident #1 was moved to their room where the environment was less stimulating to continue with the haircut. Resident #1 once again become agitated, kicking, shouting, and screaming. Staff tried consoling Resident #1 and held their hands, shoulders, and legs to complete the haircut. Hair cut was completed without any physical harm to the resident. Facility's conclusion documented after a thorough investigation Resident #1 although not harmed was provided a haircut against their will. During an interview on 10/17/2024 at 3:02 pm, Home Health Aide #1 stated they were asked by Social Worker Director to assist with getting Resident #1 a haircut. Home Health Aide #1 stated that Barber #1 was cutting Resident #1's hair in the Barber's room when Resident #1 become combative and asked Barber #1 to stop cutting their hair. Home Health Aides #1 stated Resident #1 was taken to their room and Barber #1 came to Resident #1's room to complete cutting Resident #1's hair. Home Health Aide #1 stated that while Resident #1 was sitting in their wheelchair, Resident #1 started swing their right hand and they held on to Resident #1 ' s right hand and was stroking and talking to Resident #1 to calm Resident #1 down. Home Health Aide #1 stated that Social Worker Director was present, and they placed their hands on Resident #1 thigh and Licensed Practical Nurse #1 was holding Resident #1's shoulder. Home Health Aide #1 stated that Barber #1 was able to trim Resident #1's hair, However, because Resident #1 was combative Barber #1 stop cutting Resident #1's hair and Resident #1 was left in their room after they were finished. During a telephone interview on 10/18/2024 at 4:13 PM, Barber #1 stated that they are a licensed Barber and has been scheduled to cut resident ' s hair in the facility. Barber #1 stated that Resident #1 had given their consent for the haircut. Barber #1 stated after they started cutting Resident #1's hair, Resident #1 become combative and was removed from the barber 's chair. Barber #1 stated that Social Worker Director was notified and arrived on the unit and informed them that Resident #1 hair must cut because Resident #1 is looking unkept. Barber #1 stated that Resident #1 was [NAME] to their room and a second attempt was made to perform the haircut. Barber #1 stated three other staff members was holding Resident #1 to prevent Resident #1 from harming themself in the process. Barber #1 stated even though three people was trying to assist in helping to get Resident #1 haircut, Resident #1 was still combative, cursing and kicking and they were not able to complete the haircut. (continued on next page)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 2:04 PM, Recreational Staff #1 stated on 01/25/2024 at approximately 11:00 AM Resident #1 give their consent to get their hair cut. Recreational Staff #1 stated that while Resident #1 was on the 2nd floor getting their hair cut, in the middle of the hair cut Resident #1 tell Barber #1 to stop. Recreational Staff #1 stated Resident #1 was kicking, cursing, and waving their hands. Recreational Staff #1 stated they informed Barber #1 to stop, and Resident #1 was taken away from Barber #1 by Licensed Practical Nurse #1. Recreational Staff #1 stated they informed their Recreation Supervisor and when they returned to the unit, they heard Resident #1 yelling in their room, and they went to see what was happening. Recreational Staff #1 stated that they observed Social Worker Director crossed Resident #1 leg to prevent Resident #1 from kicking and Licensed Practical Nurse #1 and Home Health Aide #1 was each standing on one side of Resident #1 holding down Resident #1 for their hair to get cut. The Social Worker Director was not available to be interviewed. The Social Worker Director 's statement dated 01/26/2024 (no time), documented Licensed Practical Nurse #1 informed Social Worker Director that Resident #1 was getting a haircut and Resident #1 was kicking, cursing, and using profanities at staff. Documented, Social Worker Director went to the unit to assist staff and resident. Social Worker Director documented first Resident #1 was observed calm and relaxed and no distress noted or observed during the visit. Social Worker Director informed Resident #1 that they were going to get a haircut, as Resident #1 was observed and noted to be very unkept, with their hair going into their mouth and very disheveled and required activities of daily living care. Resident #1 was agreeable. Social Worker Director took Resident #1 to their room where there was less stimulation because there were loud music playing and many other residents were gathered for a haircut. Social Worker Director, Licensed Practical #1 and Home Health Aide #1 were present. The haircut was performed by Barber #1 where Resident #1 was still calm, after a little while Resident #1 continued using profanity and stated they wanted cigarette. Social Worker Director, Licensed Practical Nurse #1 and Home Health Aide #1 was providing emotional support and Barber #1 cut Resident #1 hair without incident or any accident. During an interview on 10/17/2024 at 3:45 PM, Director of Nursing stated they become aware of the alleged incident on 01/25/2024 at approximately 11:00 AM by Recreational Supervisor. Director of Nursing stated that they were informed that Resident #1 was schedule for a haircut and while doing the procedure, Resident #1 become combative and did not want the haircut anymore. Director of Nursing stated Resident #1's hair was not completely shave, but you could visually see that Resident #1's hair and bread was trimmed. Director of Nursing stated that Barber #1 is a contractor and was informed by Recreational staff #1 if Resident #1 become combative during cutting their hair, they should stop. Director of Nursing stated that the Social Worker Director informed Licensed Practical Nurse #1 if Resident #1's refused the haircut they should call them. Director of Nursing stated that the staff held Resident #1 and cut Resident #1's hair against Resident #1's will. 10 NYCRR 415.4(a) (2-7)