

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335726	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/14/2024
NAME OF PROVIDER OR SUPPLIER  Beacon Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  140 Beach 113th Street Rockaway Park, NY 11694	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285</b></p> <p>Based on observation, record review, and interviews conducted during an abbreviated survey (NY00334677), the facility failed to protect a resident from physical abuse by nursing home staff. This was evident in 1 out of 3 residents sampled for abuse (Resident #1). Specifically, on 02/28/24 at approximately 7:00 pm, Resident #1 reported to Nursing Supervisor #1 that they were kicked in the scrotal area by Certified Nursing Assistant #2. Resident #1 reported that when they were kicked in the groin, they screamed out in pain. Certified Nursing Assistant #1 also reported to Nursing Supervisor #1 they witnessed Certified Nursing Assistant #2 kick Resident #1 in their private area and that Resident #1 screamed out in pain. A nursing note, by Nursing Supervisor #1, dated 02/28/24 at 6:33 pm documented that a head-to-toe assessment was done immediately and revealed no visible injuries.</p> <p>This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.</p> <p>The findings are: The facility's Policy and Procedure entitled Abuse Prohibition reviewed on 01/15/24, documented that all residents will be protected from abuse, neglect, mistreatment, exploitation, or misappropriation of property in accordance with State and Federal Regulations. It also states that the facility will report any incident or violation where abuse, neglect, or mistreatment is suspected to the New York State Department of Health according to protocol. Federal Law (1150B of the Social Security Act) requires that any individual employee having reasonable suspicion that a crime has occurred against a resident is required to report the suspicion to Law Enforcement and the State Survey Agency. If the crime involves serious bodily injury, it must be reported immediately, but no later than 2 hours after forming the suspicion or if the crime does not appear to cause serious bodily injury it must be reported within 24 hours of forming the suspicion.</p> <p>The policy did not indicate who staff should call in the event of an abuse or suspicion of abuse.</p> <p>Resident #1 was admitted to the facility with diagnoses including Diabetes, Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), and Major Depressive disorder. It was documented that Resident #1 had blindness in their right eye.</p> <p>The Minimum Data Set assessment dated [DATE] documented that Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 10 associated with moderately impaired cognition.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Comprehensive Care Plan dated 02/20/24 documented that Resident #1 was at potential risk for abuse. The interventions documented that the Social Worker to provide supportive counseling, listen to resident and family concerns, explain facility goals, and measures to provide a safe environment.</p> <p>A Nursing Progress Note, by Nursing Supervisor #1, dated 02/29/24 at 6:30 pm documented that Resident #1 reported Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area. A head-to-toe assessment was done immediately and revealed no visible injuries. Resident #1 denied pain and discomfort. Certified Nursing Assistant #2 was removed from the scene.</p> <p>The facility's Investigation Summary dated 02/29/24 documented that on 02/29/24 at around 3:30 pm, Nursing Supervisor #1 informed the Assistant Director of Nursing and Director of Nursing that on 02/28/24 at approximately 7:00 pm, Resident #1, who had moderately impaired cognition, reported that Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area on 02/28/24. This occurred while Certified Nursing Assistant #1 was providing evening care to Resident #1. According to Certified Nursing Assistant #1, Certified Nursing Assistant #2 entered Resident #1's room on 02/28/24 at around 7:00 pm and Resident #1 and Certified Nursing Assistant #2 engaged in regular conversation that developed into a verbal argument. Certified Nursing Assistant #1 went on to say that they witnessed Certified Nursing Assistant #2 lift their left foot and kick Resident #1 in their private area causing Resident #1 to scream out. The facility concluded that there was evidence to support the allegation of abuse, and that mistreatment had occurred.</p> <p>A physician progress note dated 02/29/24 at 10:00 pm documented that a staff member (Certified Nursing Assistant #2) kicked Resident #1 on 02/28/24. It is documented that Resident #1 was assessed with no pain, no injuries, and mood and behavior were calm. Resident #1 refused to further discuss and claimed that they were okay.</p> <p>A Psychiatry evaluation and consultation note dated 03/01/24 documented that on 02/29/24 Resident #1 reported that Certified Nursing Assistant #2 kicked at them when Certified Nursing Assistant #2 came in their room to drop off their dinner. Resident #1 confirmed that they and Certified Nursing Assistant #2 had exchanged words and Certified Nursing Assistant #2 got upset and kicked at them while they were in bed. Resident #1 stated that they did not want to discuss the incident. Resident #1 reported that they were stable mentally. No traumatic feelings or ill will was expressed regarding the incident. Resident #1 did not appear to be in distress. Resident #1 presented with a euthymic (a feeling of being optimistic and in control, where a person is doing well, tranquil, and functioning) mood, showing no signs of depression or manic symptoms. Resident #1 appeared relaxed and attentive.</p> <p>During an interview on 03/12/24 at 10:45 am, Resident #1 stated that on 02/28/24 at approximately 7:00 pm while they were being provided with evening care by Certified Nursing Assistant #1, Certified Nursing Assistant #2 knocked and entered the room stating that they brought Resident #1's food. Resident #1 stated that they do not recall what preceded an argument between them and Certified Nursing Assistant #2, but that Resident #1 told Certified Nursing Assistant #2 that Certified Nursing Assistant #2 should drop dead. Resident #1 stated that they are blind in their right eye (normal vision in left eye) and did not see when Certified Nursing Assistant #2 kicked them, but that they felt a kick in their groin. Resident #1 stated that the kick was painful and that they screamed out in pain. Resident #1 stated that they were lying in bed on their left side facing the door when they were kicked in the groin. Resident #1 stated that they did not sustain any redness or swelling.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 03/12/24 at 11:00 am, Certified Nursing Assistant #2 stated that on 02/28/24 at approximately 7:00 pm they entered Resident #1's room and dropped off their dinner. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 was in Resident #1's room providing care to Resident #1. Certified Nursing Assistant #2 stated that they were engaged in an argument with Resident #1 and that Resident #1 told Certified Nursing Assistant #2 that they should drop dead. Certified Nursing Assistant #2 stated that they were in the process of leaving the room when Resident #1 started throwing multiple items at Certified Nursing Assistant #2. Certified Nursing Assistant #2 stated that Resident #1's bed was in a high position and Certified Nursing Assistant #2 kicked the mattress on the bed and left the room. Certified Nursing Assistant #2 stated that they did not kick Resident #1.</p> <p>During a telephone interview on 03/12/24 at 2:00 pm, Certified Nursing Assistant #1 stated that on 02/28/24 between 7:00 pm and 8:00 pm (not sure of the time) while giving care to Resident #1, Certified Nursing Assistant #2 entered Resident #1's room. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 and Resident #1 engaged in regular conversation that developed into an argument. Certified Nursing Assistant #1 stated that Resident #1 told Certified Nursing Assistant #2 to drop dead and Certified Nursing Assistant #2 got upset and lifted their left foot and kicked Resident #1 in their private area. Certified Nursing Assistant #1 stated that Resident #1 screamed out in pain and said, what the hell. Certified Nursing Assistant #1 stated that they instructed Certified Nursing Assistant #2 to leave the room. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 was wearing a Women's Crocs shoe and Resident #1 was wearing a night gown and was lying on their left side. Certified Nursing Assistant #1 stated that Resident #1 was upset and was in pain. Certified Nursing Assistant #1 stated that they handed Resident #1 the phone to call Nursing Supervisor #1 while Certified Nursing Assistant #1 instructed Certified Nursing Assistant #2 to leave the room. Certified Nursing Assistant #1 stated that Nursing Supervisor #1 came to the room immediately and Certified Nursing Assistant #1 informed Nursing Supervisor #1 that they witnessed Certified Nursing Assistant #2 kick Resident #1 in their groin and that Resident #1 screamed out in pain.</p> <p>During an interview on 03/12/24 at 12:21 pm, Nursing Supervisor #1 stated that on 02/28/24 at approximately 7:00 pm Resident #1 reported that Certified Nursing Assistant #2 kicked Resident #1 in the scrotum. Nursing Supervisor #1 also stated that Certified Nursing Assistant #1 informed them that they witnessed Certified Nursing Assistant #2 kicked Resident #1 in the groin and Resident #1 screamed out in pain. Nursing Supervisor #1 stated that they immediately conducted a head-to-toe assessment and there was no bruising, no redness, discoloration, or swelling on Resident #1's scrotum area or other body area. Nursing Supervisor #1 stated that during the assessment Resident #1 stated that they did not have any pain or discomfort. Nursing Supervisor #1 stated that they spoke with Certified Nursing Assistant #2 and Certified Nursing Assistant #2 stated that they raised their leg and kicked Resident #1's bed. Nursing Supervisor #1 stated that Certified Nursing Assistant #2 stated that they did not kick Resident #1. Nursing Supervisor #1 stated that Certified Nursing Assistant #2 was informed to leave the floor and do not return to Resident #1's unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/12/24 at 2:42 pm, the Administrator stated that they were informed of the incident on 02/29/24 at approximately 4:00 pm. The Administrator went on to say that Resident #1 was reassessed immediately on 02/29/24 and there were no visible injuries. The Administrator stated when they first spoke with Resident #1, Resident #1 was reluctant to talk, but stated that Certified Nursing Assistant #2 threw something at Resident #1. The Administrator stated Resident #1 stated that they are visually impaired and did not see what hit them. The Administrator stated they immediately called the Police Precinct for officers to come to the facility for report. The Administrator stated that the police arrived at 5:30 pm on 02/29/24 and interviewed Resident #1 who stated that they did not want to press any charges.</p> <p>During an interview on 03/12/24 at 5:00 pm, the Director of Nursing stated on 02/29/24 at approximately 4:00 pm they were informed about the incident by the Assistant Director of Nursing. The Director of Nursing stated they were informed that Resident #1 reported Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area. The Director of Nursing stated there was an exchange of words between Resident #1 and Certified Nursing Assistant #2. The Director of Nursing stated Resident #1 reported Certified Nursing Assistant #2 got upset and kicked Resident #1 in the scrotal area. The Director of Nursing stated Nursing Supervisor #1 reported they were overwhelmed and had forgotten to immediately report the incident to the Assistant Director of Nursing. The Director of Nursing stated the investigation concluded that abuse had occurred.</p> <p>During an interview on 03/13/24 at 3:24 pm, the Medical Director stated they received a call (unable to recall the time) on 02/28/24 from Nursing Supervisor #2 who notified them of Resident #1's allegation of abuse. The Medical Director went on to say they assessed Resident #1 on 02/29/24 and there was no redness, discoloration, or injuries observed. The Medical Director stated Resident #1 did not exhibit any changes in mood or mental status. The Medical Director further stated Resident #1 did not want to give them any details of the abuse.</p> <p>Immediate Jeopardy was not identified. Facility Past Noncompliance was identified on 03/12/24.</p> <p>Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the Past Noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyor's onsite visit on 03/12/24.</p> <p>The facility implemented the following corrective action prior to surveyor entrance on 03/12/24.</p> <p>The facility Assistant Director of Nursing investigated the allegation of abuse and the team concluded that abuse did occur.</p> <p>The facility developed an action plan which includes the following:</p> <p>On 02/28/24 and 02/29/24 Resident #1 was assessed with no visible signs of injuries and no complaints of pain.</p> <p>The police were called and responded to facility on 02/29/24.</p> <p>On 02/29/24 Resident #1's abuse care plan was updated. Additional interventions included monitoring for changes, 1:1 visit from Social Worker, and Psych/Psychotherapy consults were implemented.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/29/24 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.</p> <p>On 02/29/24, Policy/Procedure on Abuse, Neglect, Mistreatment, and Reporting was reviewed. No revisions were done to the policy.</p> <p>On 02/29/24, Certified Nursing Assistant #2 was suspended and subsequently terminated.</p> <p>On 02/29/24 Nursing Supervisor #1 and Nursing Supervisor #2 were both re-educated on abuse, reporting of abuse immediately to the Administrator, Director of Nursing, and Assistant Director of Nursing. The topic also covered removing staff from resident care pending investigation outcome.</p> <p>On 03/01/24 the facility's Social Worker interviewed multiple residents on Certified Nursing Assistant #2's assignment and there were no abuse, neglect, or mistreatment issues identified.</p> <p>On 03/01/24 the facility developed an audit tool to track if residents are being abused. No other residents were identified. The audit is ongoing monthly for four months. Any issues identified will be corrected.</p> <p>The facility started re-in-servicing staff on 02/29/24, ongoing. Lesson Plan: Prohibition of Resident Abuse that discussed the seven steps of abuse including prevention, protecting, and reporting.</p> <p>Facility has 116 staff of which 97 percent were in-serviced by the Assistant Director of Nursing (also in-service coordinator).</p> <ul style="list-style-type: none"> <li>o 41 out of 43 CNAs in-serviced</li> <li>o 17 out of 18 LPNs in-serviced</li> <li>o 7 out of 8 RNS in-serviced</li> <li>o 3 out of 3 Recreation staff in-serviced</li> <li>o 18 out of 19 housekeeping and maintenance staff in-serviced</li> <li>o 13 out of 15 dietary staff in-serviced</li> <li>o 13 out of 13 department head in-serviced</li> <li>o 7 out of 8 Physical Therapist/Occupational Therapist in-serviced.</li> </ul> <p>The Assistant Director of Nursing will contact the remaining 3 percent of staff for in-servicing prior to their return to work.</p> <p>The facility was back in compliance on 03/01/24.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43285</p> <p>Based on observation, record review, and interviews during an abbreviated survey (NY00334677), the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, was reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident in 1 out of 3 residents sampled for abuse (Resident #1). Specifically, Resident #1 and Certified Nursing Assistant #1 reported to Nursing Supervisor #1 on 02/28/24 at approximately 7:00 pm that Certified Nursing Assistant #2 kicked Resident #1 in the scrotal area. The allegation of abuse was not reported to New York State Department of Health within 2 hours after the report was made. The Department of Health was notified on 02/29/24 at 5:00 pm. Additionally, local law enforcement was not notified within 2 hours, local law enforcement was notified on 02/29/24 at 4:00 pm.</p> <p>The findings are:</p> <p>The facility's Abuse Prevention Policy and Procedure dated 01/15/24, states that the facility will report any incident or violation where abuse, neglect, or mistreatment is suspected to the New York State Department of Health according to protocol. Federal Law (1150B of the Social Security Act) requires that any individual employee having reasonable suspicion that a crime has occurred against a resident is required to report the suspicion to Law Enforcement and the State Survey Agency. If the crime involves serious bodily injury, it must be reported immediately, but no later than 2 hours after forming the suspicion or if the crime does not appear to cause serious bodily injury it must be reported within 24 hours of forming the suspicion.</p> <p>The policy did not indicate who staff should call in the event of an abuse or suspicion of abuse.</p> <p>Resident #1 was admitted to the facility with diagnoses including Diabetes, Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), and Major Depressive disorder. It was documented that Resident #1 had blindness in their right eye.</p> <p>The Minimum Data Set assessment dated [DATE] documented that Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 10 associated with moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Investigation Summary dated 02/29/24 documented that on 02/29/24 at around 3:30 pm, Nursing Supervisor #1 informed the Assistant Director of Nursing and Director of Nursing that on 02/28/24 at approximately 7:00 pm, Resident #1, who had moderately impaired cognition, reported that Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area on 02/28/24. This occurred while Certified Nursing Assistant #1 was providing evening care to Resident #1. According to Certified Nursing Assistant #1, Certified Nursing Assistant #2 entered Resident #1's room on 02/28/24 at around 7:00 pm and Resident #1 and Certified Nursing Assistant #2 engaged in regular conversation that developed into a verbal argument. Certified Nursing Assistant #1 went on to say that they witnessed Certified Nursing Assistant #2 lift their left foot and kick Resident #1 in their private area causing Resident #1 to scream out. The facility concluded that there was evidence to support the allegation of abuse had occurred.</p> <p>A nursing progress note, by Nursing Supervisor #2, dated 02/28/24 at 6:33 pm documented Resident #1 was alert and conversant. Resident #1 reported that they had a disagreement with Certified Nursing Assistant #2. Resident #1 denied being hit by Certified Nursing Assistant #2. Resident #1 was calm and collective. No signs of injury and no obvious distress. Resident #1 denies pain. Resident #1 stated that they do not want to report nor file a complaint against Certified Nursing Assistant #2.</p> <p>A Nursing Progress Note, by Nursing Supervisor #1, dated 02/29/24 at 6:30 pm documented that Resident #1 reported Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area. A head-to-toe assessment was done immediately and revealed no visible injuries. Resident #1 denied pain and discomfort. Certified Nursing Assistant #2 was removed from the scene.</p> <p>A Webform submission from the Nursing Home Facility Incident Report dated 02/29/24, revealed that the facility notified New York State Department of Health at 5:00 pm on 02/29/24.</p> <p>During an interview on 03/12/24 at 10:45 am, Resident #1 stated that on 02/28/24 at approximately 7:00 pm while they were being provided with evening care by Certified Nursing Assistant #1, Certified Nursing Assistant #2 knocked and entered the room stating that they brought Resident #1's food. Resident #1 stated that they do not recall what preceded an argument between them and Certified Nursing Assistant #2, but that Resident #1 told Certified Nursing Assistant #2 that Certified Nursing Assistant #2 should drop dead. Resident #1 stated that they are blind in their right eye (normal vision in left eye) and did not see when Certified Nursing Assistant #2 kicked them, but that they felt a kick in their groin. Resident #1 stated that the kick was painful and that they screamed out in pain. Resident #1 stated that they were lying in bed on their left side facing the door when they were kicked in the groin. Resident #1 stated that they did not sustain any redness or swelling.</p> <p>During a telephone interview on 03/12/24 at 11:00 am, Certified Nursing Assistant #2 stated that on 02/28/24 at approximately 7:00 pm they entered Resident #1's room and dropped off their dinner. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 was in Resident #1's room providing care to Resident #1. Certified Nursing Assistant #2 stated that they were engaged in an argument with Resident #1 and that Resident #1 told Certified Nursing Assistant #2 that they should drop dead. Certified Nursing Assistant #2 stated that they were in the process of leaving the room when Resident #1 started throwing multiple items at Certified Nursing Assistant #2. Certified Nursing Assistant #2 stated that Resident #1's bed was in a high position and Certified Nursing Assistant #2 kicked the mattress on the bed and left the room. Certified Nursing Assistant #2 stated that they did not kick Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 03/12/24 at 2:00 pm, Certified Nursing Assistant #1 stated that on 02/28/24 between 7:00 pm and 8:00 pm (not sure of the time) while giving care to Resident #1, Certified Nursing Assistant #2 entered Resident #1's room. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 and Resident #1 engaged in regular conversation that developed into an argument. Certified Nursing Assistant #1 stated that Resident #1 told Certified Nursing Assistant #2 to drop dead and Certified Nursing Assistant #2 got upset and lifted their left foot and kicked Resident #1 in their private area. Certified Nursing Assistant #1 stated that Resident #1 screamed out in pain and said, what the hell. Certified Nursing Assistant #1 stated that they instructed Certified Nursing Assistant #2 to leave the room. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 was wearing a Women's Crocs shoe and Resident #1 was wearing a night gown and was lying on their left side. Certified Nursing Assistant #1 stated that Resident #1 was upset and was in pain. Certified Nursing Assistant #1 stated that they handed Resident #1 the phone to call Nursing Supervisor #1 while Certified Nursing Assistant #1 instructed Certified Nursing Assistant #2 to leave the room. Certified Nursing Assistant #1 stated that Nursing Supervisor #1 came to the room immediately and Certified Nursing Assistant #1 informed Nursing Supervisor #1 that they witnessed Certified Nursing Assistant #2 kick Resident #1 in their groin and that Resident #1 screamed out in pain.</p> <p>During an interview on 03/12/24 at 12:21 pm, Nursing Supervisor #1 stated that on 02/28/24 at approximately 7:00 pm Resident #1 reported that Certified Nursing Assistant #2 kicked Resident #1 in the scrotum. Nursing Supervisor #1 also stated that Certified Nursing Assistant #1 informed them that they witnessed Certified Nursing Assistant #2 kicked Resident #1 in the groin and Resident #1 screamed out in pain. Nursing Supervisor #1 stated that they immediately conducted a head-to-toe assessment and there was no bruising, no redness, discoloration, or swelling on Resident #1's scrotum area or other body area. Nursing Supervisor #1 stated that during the assessment Resident #1 stated that they did not have any pain or discomfort. Nursing Supervisor #1 stated that they spoke with Certified Nursing Assistant #2 and Certified Nursing Assistant #2 stated that they raised their leg and kicked Resident #1's bed. Nursing Supervisor #1 stated that Certified Nursing Assistant #2 stated that they did not kick Resident #1. Nursing Supervisor #1 stated that Certified Nursing Assistant #2 was informed to leave the floor and do not return to Resident #1's unit. Nursing Supervisor #1 stated that Certified Nursing Assistant #2 went back to the 3rd floor and completed their assigned resident tasks and went home at the end of their shift (3:00 pm - 11:00 pm). Nursing Supervisor #1 stated that they were aware that the police should have been called immediately and that the Director of Nursing should have been immediately notified. Nursing Supervisor #1 stated that they reported the incident to incoming evening shift Nursing Supervisor #2. Nursing Supervisor #1 stated that they thought removing Certified Nursing Assistant #2 from Resident #1's unit would be okay.</p> <p>During a telephone interview on 03/12/24 at 04:32 pm, Nursing Supervisor #2 stated they worked on the 3:00 pm -11:00 pm shift on 02/28/24. Nursing Supervisor #2 stated they were informed by Nursing Supervisor #1 (7:00 am - 3:00 pm off-going supervisor) that Resident #1 reported they were kicked by Certified Nursing Assistant #2 in their scrotal area. Nursing Supervisor #2 stated they did not report the allegation of abuse to the Director of Nursing or the police because Nursing Supervisor #1 said that they would take care of it the following day.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/12/2024 at 2:42pm, the Administrator stated they were informed of the incident on 02/29/24 at approximately 4:00pm. The Administrator went on to say Resident #1 was reassessed immediately on 02/29/24 and there were no visible injuries. The Administrator stated that when they first spoke with Resident #1, Resident #1 was reluctant to talk, but stated that Certified Nursing Assistant #2 threw something at Resident #1. The Administrator stated that Resident #1 reported that they are visually impaired and did not see what hit them. The Administrator stated they immediately called the Police Precinct and the Police arrived at the facility at 5:30 pm on 02/29/24. The Administrator stated tht the police interviewed Resident #1 who stated that they did not want to press charges. The Administrator stated that Nursing Supervisor #1 did not follow protocol and report the incident to the Director of Nursing or the Assistant Director of Nursing and call the police.</p> <p>During an interview on 03/12/24 at 5:00 pm, the Director of Nursing stated on 02/29/24 at approximately 4:00 pm they were informed about the incident by the Assistant Director of Nursing. The Director of Nursing stated they were informed that Resident #1 reported Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area. The Director of Nursing stated there was an exchange of words between Resident #1 and Certified Nursing Assistant #2. The Director of Nursing stated Resident #1 reported Certified Nursing Assistant #2 got upset and kicked Resident #1 in the scrotal area. The Director of Nursing stated Nursing Supervisor #1 reported they were overwhelmed and had forgotten to immediately report the incident to the Assistant Director of Nursing. The Director of Nursing stated the investigation concluded that abuse had occurred. The Director of Nursing stated that Nursing Supervisor #1 should have immediately reported the allegation to the Director of Nursing, or Assistant Director of Nursing, and report to law enforcement. The Director of Nursing stated that the investigation concluded that abuse had occurred.</p> <p>During a telephone interview on 03/13/24 at 3:24 pm, the Medical Director stated that they received a call (unable to recall the time) on 02/28/24 from Nursing Supervisor #2 who notified them of Resident #1's allegation of abuse. The Medical Director went on to say they assessed Resident #1 on 02/29/24 and there was no redness, discoloration, or injuries observed. The Medical Director stated Resident #1 did not exhibit any changes in mood or mental status. The Medical Director further stated Resident #1 did not want to give them any details of the abuse. The Medical Director stated that they thought that Nursing Supervisor #2 followed the facility's abuse protocol and that they did not offer any instructions to Nursing Supervisor #2.</p> <p>Facility Past Non-compliance was identified on 03/12/24.</p> <p>Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyor's onsite visit on 03/12/2024.</p> <p>The facility implemented the following corrective action prior to surveyor entrance on 03/12/24.</p> <p>The facility Assistant Director of Nursing investigated the allegation of abuse and the team concluded that abuse did occur.</p> <p>The facility developed an action plan which includes the following:</p> <p>On 02/28/24 and 02/29/24 Resident #1 was assessed with no visible signs of injury and no complaints of pain.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The police were called and responded to facility on 02/29/24.</p> <p>On 02/29/24 Resident #1's abuse care plan was updated. Additional interventions including monitoring for changes, 1:1 visit from Social Worker, and Psych/Psychotherapy consults were implemented.</p> <p>On 02/29/24 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.</p> <p>On 02/29/24, Policy/Procedure on Abuse, Neglect, Mistreatment, and Reporting was reviewed. No revisions were done to the policy.</p> <p>On 02/29/24, Certified Nursing Assistant #2 was suspended and subsequently terminated.</p> <p>On 02/29/24 Nursing Supervisor #1 and Nursing Supervisor #2 were both re-educated on abuse, reporting of abuse immediately to the Administrator, Director of Nursing, and Assistant Director of Nursing. The topic also covered removing staff from resident care pending investigation outcome.</p> <p>On 03/01/24 the facility's Social Worker interviewed multiple residents on Certified Nursing Assistant #2's assignment and there were no abuse, neglect, or mistreatment issues identified.</p> <p>On 03/01/24 the facility developed an audit tool to track if residents are being abused. No other residents were identified. The audit is ongoing monthly for four months. Any issues identified will be corrected.</p> <p>The facility started re-in-servicing staff on 02/29/24, ongoing. Lesson Plan: Prohibition of Resident Abuse that discussed the seven steps of abuse including prevention, protecting, and reporting.</p> <p>Facility has 116 staff of which 97 percent were in-serviced by the Assistant Director of Nursing (also in-service coordinator).</p> <ul style="list-style-type: none"> <li>o 41 out of 43 CNAs in-serviced</li> <li>o 17 out of 18 LPNs in-serviced</li> <li>o 7 out of 8 RNS in-serviced</li> <li>o 3 out of 3 Recreation staff in-serviced</li> <li>o 18 out of 19 housekeeping and maintenance staff in-serviced</li> <li>o 13 out of 15 dietary staff in-serviced</li> <li>o 13 out of 13 department head in-serviced</li> <li>o 7 out of 8 Physical Therapist/Occupational Therapist in-serviced.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Assistant Director of Nursing will contact the remaining 3 percent of staff for in-servicing prior to their return to work.</p> <p>The Facility was back in compliance on 03/01/24.</p> <p>10 NYCRR 415.4(b)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285</b></p> <p>Based on observation, record review and interviews during an abbreviated survey (NY00334677), the facility failed to protect residents from potential abuse while an investigation was in progress. This was evident in 1 out of 3 residents sampled for abuse (Resident #1). Specifically, Resident #1 and Certified Nursing Assistant #1 reported to Nursing Supervisor #1 on 02/28/24 at approximately 7:00 pm, that Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area. Nursing Supervisor #1 instructed Certified Nursing Assistant #2 to leave Resident #1's unit and to return to their unit on the 3rd floor. Certified Nursing Assistant #2 was allowed to complete their resident care assignment until their shift ended at 11:00 pm on 02/28/24. Certified Nursing Assistant #2 was removed from the schedule on 02/29/24. This occurred when the Director of Nursing and Assistant Director of Nursing became aware of the allegation of abuse on 02/29/24.</p> <p>The findings are:</p> <p>The facility's Abuse Prevention Policy and Procedure dated 01/15/24 documented that the facility will investigate all incidents, grievances, and complaints. The facility will protect all residents during an investigation by reassigning staff. In the event of suspicion of abuse, the staff will be suspended or reassigned until the investigation is completed.</p> <p>Resident #1 was admitted to the facility with diagnoses including Diabetes, Congestive Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), and Major Depressive disorder. It was documented that Resident #1 had blindness in their right eye.</p> <p>The Minimum Data Set assessment dated [DATE] documented that Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 10 associated with moderately impaired cognition.</p> <p>The facility's Investigation Summary dated 02/29/24 documented that on 02/29/24 at around 3:30 pm, Nursing Supervisor #1 informed the Assistant Director of Nursing and Director of Nursing that on 02/28/24 at approximately 7:00 pm, Resident #1, who had moderately impaired cognition, reported that Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area on 02/28/24. This occurred while Certified Nursing Assistant #1 was providing evening care to Resident #1. According to Certified Nursing Assistant #1, Certified Nursing Assistant #2 entered Resident #1's room on 02/28/24 at around 7:00 pm and Resident #1 and Certified Nursing Assistant #2 engaged in regular conversation that developed into a verbal argument. Certified Nursing Assistant #1 went on to say that they witnessed Certified Nursing Assistant #2 lift their left foot and kick Resident #1 in their private area causing Resident #1 to scream out. The facility concluded that there was evidence to support the allegation of abuse had occurred.</p> <p>A nursing note, by Nursing Supervisor #1, dated 02/29/24 at 06:30 pm documented that Resident #1 reported that Certified Nursing Assistant #2 kicked Resident #1 in their scrotal area.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/12/24 at 10:45 am, Resident #1 stated that on 02/28/24 at approximately 7:00 pm while they were being provided with evening care by Certified Nursing Assistant #1, Certified Nursing Assistant #2 knocked and entered the room stating that they brought Resident #1's food. Resident #1 stated that they do not recall what preceded an argument between them and Certified Nursing Assistant #2, but that Resident #1 told Certified Nursing Assistant #2 that Certified Nursing Assistant #2 should drop dead. Resident #1 stated that they are blind in their right eye (normal vision in left eye) and did not see when Certified Nursing Assistant #2 kicked them, but that they felt a kick in their groin. Resident #1 stated that the kick was painful and that they screamed out in pain. Resident #1 stated that they were lying in bed on their left side facing the door when they were kicked in the groin. Resident #1 stated that they did not sustain any redness or swelling.</p> <p>During a telephone interview on 03/12/24 at 11:00 am, Certified Nursing Assistant #2 stated that on 02/28/24 at approximately 7:00 pm they entered Resident #1's room and dropped off their dinner. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 was in Resident #1's room providing care to Resident #1. Certified Nursing Assistant #2 stated that they were engaged in an argument with Resident #1 and that Resident #1 told Certified Nursing Assistant #2 that they should drop dead. Certified Nursing Assistant #2 stated that they were in the process of leaving the room when Resident #1 started throwing multiple items at Certified Nursing Assistant #2. Certified Nursing Assistant #2 stated that Resident #1's bed was in a high position and Certified Nursing Assistant #2 kicked the mattress on the bed and left the room. Certified Nursing Assistant #2 stated that they did not kick Resident #1.</p> <p>During a telephone interview on 03/12/24 at 2:00 pm, Certified Nursing Assistant #1 stated that on 02/28/24 between 7:00 pm and 8:00 pm (not sure of the time) while giving care to Resident #1, Certified Nursing Assistant #2 entered Resident #1's room. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 and Resident #1 engaged in regular conversation that developed into an argument. Certified Nursing Assistant #1 stated that Resident #1 told Certified Nursing Assistant #2 to drop dead and Certified Nursing Assistant #2 got upset and lifted their left foot and kicked Resident #1 in their private area. Certified Nursing Assistant #1 stated that Resident #1 screamed out in pain and said, what the hell. Certified Nursing Assistant #1 stated that they instructed Certified Nursing Assistant #2 to leave the room. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 was wearing a Women's Crocs shoe and Resident #1 was wearing a night gown and was lying on their left side. Certified Nursing Assistant #1 stated that Resident #1 was upset and was in pain. Certified Nursing Assistant #1 stated that they handed Resident #1 the phone to call Nursing Supervisor #1 while Certified Nursing Assistant #1 instructed Certified Nursing Assistant #2 to leave the room. Certified Nursing Assistant #1 stated that Nursing Supervisor #1 came to the room immediately and Certified Nursing Assistant #1 informed Nursing Supervisor #1 that they witnessed Certified Nursing Assistant #2 kick Resident #1 in their groin and that Resident #1 screamed out in pain.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/29/24 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.</p> <p>On 02/29/24, Policy/Procedure on Abuse, Neglect, Mistreatment, and Reporting was reviewed. No revisions were done to the policy.</p> <p>On 02/29/24, Certified Nursing Assistant #2 was suspended and subsequently terminated.</p> <p>On 02/29/24 Nursing Supervisor #1 and Nursing Supervisor #2 were both re-educated on abuse, reporting of abuse immediately to the Administrator, Director of Nursing, and Assistant Director of Nursing. The topic also covered removing staff from resident care pending investigation outcome.</p> <p>On 03/01/24 the facility's Social Worker interviewed multiple residents on Certified Nursing Assistant #2's assignment and there were no abuse, neglect, or mistreatment issues identified.</p> <p>On 03/01/24 the facility developed an audit tool to track if residents are being abused. No other residents were identified. The audit is ongoing monthly for four months. Any issues identified will be corrected.</p> <p>The facility started re-in-servicing staff on 02/29/24, ongoing. Lesson Plan: Prohibition of Resident Abuse that discussed the seven steps of abuse including prevention, protecting, and reporting.</p> <p>Facility has 116 staff of which 97 percentage were in-serviced by the Assistant Director of Nursing (also in-service coordinator).</p> <ul style="list-style-type: none"> <li>o 41 out of 43 CNAs in-serviced</li> <li>o 17 out of 18 LPNs in-serviced</li> <li>o 7 out of 8 RNS in-serviced</li> <li>o 3 out of 3 Recreation staff in-serviced</li> <li>o 18 out of 19 housekeeping and maintenance staff in-serviced</li> <li>o 13 out of 15 dietary staff in-serviced</li> <li>o 13 out of 13 department head in-serviced</li> <li>o 7 out of 8 Physical Therapist/Occupational Therapist in-serviced.</li> </ul> <p>The Assistant Director of Nursing will contact the remaining 3 percent of staff for in-servicing prior to their return to work.</p> <p>The facility was back in compliance on 03/01/24.</p> <p>10 NYCRR 415.4(b)</p>		