

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335734	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Friedwald Center for Rehab and Nursing, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 475 New Hempstead Road New City, NY 10956	

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 - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review, observations and interviews conducted during an abbreviated survey (NY00349754, NY00348426) the facility did not ensure that each resident was free from abuse for 1 of 4 residents (Resident #1) reviewed for abuse. Specifically, on 7/30/2024 Licensed Practical Nurse #1 was seen on surveillance video picking up a water pitcher with water off their medication cart and throw the pitcher and water in Resident #1's direction. Licensed Practical Nurse #1 then threw a small water bottle at Resident #1. An assessment of Resident #1 was conducted, and no injuries were identified.</p> <p>Findings include:</p> <p>The facility Abuse, Neglect and Exploitation policy dated 6/1/2021 and last reviewed/revised 10/1/2023 documented it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, causing physical harm, pain or mental anguish includes verbal abuse, physical abuse, and mental abuse.</p> <p>Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including but not limited to Bipolar disorder, Depression and Chronic Pain Syndrome.</p> <p>A Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #1 had a BIMS score of 15. No behaviors noted. The resident required set up assistance for meals, supervision for bed mobility and required maximal assistance for toileting. The resident had lower extremity impairment on one side, used a wheelchair for locomotion and needed moderate assistance for transfer.</p> <p>Review of a risk for abuse care plan dated 2/21/24 and revised on 5/22/24 documented Resident #1 was at risk for potential abuse related to aggressive behavior. Resident #1 was verbally abusive towards staff and the goal was, Resident #1 will be kept safe and free from abuse through the next review date. Interventions included to create a home like environment as much as possible and encourage diversion activities, refer to psychologist and psychiatrist as needed.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a behavior care plan dated 4/24/24 and revised 8/5/24 documented Resident #1 uses abusive verbal language, is resistant to activities for daily living, and exhibits aggressive behaviors. The goal was for Resident #1 to display no negative behaviors through the review date. Interventions included to provide a safe environment, psychological consult and follow up as needed.</p> <p>Review of a behavior symptoms physical abuse care plan dated 6/4/24 documented Resident #1 exhibits physically aggressive behavior towards staff and others. The goal was Resident #1 will show a decrease in the number of episodes of physically aggressive behavior. Interventions included to administer medications as ordered by physician, allow time to de-escalate when agitated, assess/evaluate comfort level and medicate as necessary, document in medical record the intensity, duration or frequency of behavior, notify and report behavior changes to the physician, redirect negative behaviors, , remove from situation triggering behavior and social service evaluation and follow up as needed.</p> <p>A Review of the surveillance video dated 7/30/2024 with no audio was completed during the onsite visit. Resident #1 is seen in the dining room seated around a table with Resident #2 and Resident #3. Licensed Practical Nurse #1 is seen at the medication cart in the doorway between the dining room and the hallway. Licensed Practical Nurse #1 walked over to Resident #1 and handed them a pill cup with medication. Resident #1 took the medication. There is an inaudible dialogue back and forth between Resident #1 and Licensed Practical Nurse #1. Resident #1 is seen throwing water from their cup in Licensed Practical Nurse #1's direction, landing on Resident #3. Licensed Practical Nurse #1 then proceeded to walk towards Resident #1, and the dialogue continues. Licensed Practical Nurse #1 was seen leaning towards Resident #1 and say something. Resident #1 jerked back in their wheelchair at what was said to them and is seen throwing water at Licensed Practical Nurse #1. Licensed Practical Nurse #1 was seen going to the medication cart, take a bottle of water and [NAME] the water towards Resident #1 and threw the empty bottle at the resident. Licensed Practical Nurse #1 was seen at their medication cart, picking up the water pitcher with water off their medication cart and [NAME] the entire pitcher and water in Resident #1's direction. Licensed Practical Nurse #1 was seen throwing the top of the pitcher in Resident #1's direction. Resident #1 left and headed towards their room. Certified Nurse Assistant #1 appears on the scene and is seen speaking to Resident #1 as they enter their room. Licensed Practical Nurse #1 is seen exiting the video.</p> <p>Review of Accident/Incident Report dated 7/30/2024 documented the incident that occurred on 7/30/2024 at 6:00 PM. Licensed Practical Nurse #1 threw water and a small plastic water bottle at Resident # 1 after Resident # 1 threw water at Licensed Practical Nurse #1. Resident #1 with no injury noted at the time of the incident. Physician notified at 6:30 PM. Licensed Practical Nurse # 1 was terminated to prevent recurrence.</p> <p>Review of a Resident #2' s (witness) statement dated 7/30/2024 documented they saw Licensed Practical Nurse #1 and Resident #1 throwing water at each other. The statement documented the incident got more intense and the anger intensified, and Licensed Practical Nurse #1 threw the pitcher at Resident #1, and it broke. Resident #1 also threw water at the Licensed Practical Nurse.</p> <p>Resident #3 had hearing impairment and was not interview able.</p> <p>Review of Registered Nurse Supervisor #1's note dated 7/30/2024 at 9PM documented Resident #1 stated they did not sustain any injury from the confrontation. However, Resident #1 stated they felt very anxious and nervous as a result. Therapeutic communication was applied to calm Resident #1 and assure them of their safety.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Incident/Accident report conclusion dated 8/1/2024 documented statements were obtained from all residents present at the time of the incident as well as staff assigned to the unit. Video of the incident was obtained from the facility camera system. After review of the statements and video, the facility concluded the complaint was verified, the employee was immediately terminated, a professional discipline complaint form was filed by the facility with New York State office of the professions.</p> <p>During an interview on 8/6/2024 at 12:24PM Resident #1 stated they have been in the facility for 5 years. Stated they were due for a pain medication, and they asked Licensed Practical Nurse #1 for it, and they stated they were not ready to give it to them yet. Stated Licensed Practical Nurse #1 came and spoke with Resident #2 and Resident #3 and was giving them their pain medications which they are not supposed to get until bedtime, and it was about 6:00 PM. Resident #1 stated they then told Licensed Practical Nurse #1 that they cannot do that, and they stated, do not tell them what to do, I do what I want. Licensed Practical Nurse #1 got in their face and stated, they do what they want to do bitch faggot and if they want to give others their medications now, they will, and Resident #1 will wait. Resident #1 stated they had a little cup of water, and they threw it at Licensed Practical Nurse #1. Resident #1 stated Licensed Practical Nurse #1 then went back to their medication cart and grabbed the water pitcher and threw it at Resident #1 and it shattered against the wall and broke into pieces. Resident #1 stated they had a little water bottle on the table in front of them and they threw that at Licensed Practical Nurse #1 and Licensed Practical Nurse #1 started charging towards them and the certified nurse assistant held Licensed Practical Nurse #1 back and told them to go back to their room. Resident #1 stated they were scared and shaking. Resident #1 stated Licensed Practical Nurse #1 lost it and was out of control. Resident #1 stated Licensed Practical Nurse #1 told them they do not need this job and that they will kill Resident #1, and you could see it in their eyes. Resident #1 stated they have had arguments with staff prior, but no one had ever threatened them before. Resident #1 stated they were very nervous following the incident and they felt as if they could not defend themselves in the wheelchair. they would kill them, and they believed it and could see it in their eyes.</p> <p>During an interview on 8/6/2024 at 1:20 PM, the Administrator stated they were informed about the incident on 7/30/24. They reviewed the surveillance video and Resident #1 pushed Licensed Practical Nurse #1's buttons and they lost it. Licensed Practical Nurse #1 exited the building, and they could not speak with them. The Administrator stated they tried to contact Licensed Practical Nurse #1 via telephone but have not been to reach them. The Administrator Stated Licensed Practical Nurse #1 was an agency employee who started in the facility on 7/25/2024. The day of the incident was Licensed Practical Nurse #1's first day on the floor and they had only worked 3 shifts prior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 8/6/2024 at 2:10 PM Licensed Practical Nurse #1 stated they had only been working in the facility for a couple of days and it was their first time on the unit. Licensed Practical Nurse #1 stated they were switched from the south side to work on the north side where Resident #1 resides. Resident #1 asked them for their pain medication. Licensed Practical Nurse #1 stated the outgoing nurse reported that d just given Resident #1 their medication at 3:00 PM and they informed Resident #1 of that. Resident #1 stated they can have the medication 1 hour early, and they informed Resident #1 that it does not apply to nonscheduled (as needed) medications. Resident #1 was told that the last time they were given the pain medication was at 3:00 PM and when they could only receive their medication at 6PM. Licensed Practical Nurse #1 stated Resident #1 stated Resident #1 called them a piece of shit because they will not give them their meds before the due time. Other nurses on the unit told them they do not deal with Resident #1 and that no one does. Licensed Practical Nurse #1 stated Resident #1 stated insisted to be given their medication when they were administering medications to other residents. Licensed Practical Nurse #1 stated Resident #1 started to try to stand up, and they stepped away from Resident #1 towards their cart. Resident #1 continued talking while they administered medications to others. Licensed Practical Nurse #1 stated Resident #1 had a pitcher of water and they spit in the pitcher and threw it at them. Licensed Practical Nurse #1 stated they had a pitcher of water and threw it back at Resident #1. Licensed Practical Nurse #1 stated they engaged in the back and forth with Resident #. For Resident #1 to spit in the water and throw it at them triggered them.</p> <p>During an interview on 8/7/2024 at 5:00 PM, Resident #2 stated they have been in the facility for a year. Resident #2 stated they were in their room, and they heard screaming and cursing. They went out and saw Licensed Practical Nurse #1 in Resident #1's face. Resident #2 stated Licensed Practical Nurse #1 stated they do not need this fucking job and they would kill Resident #1. Resident #2 stated Licensed Practical Nurse #1 went and got their water pitcher and threw it at Resident #1 and some of the water got on them. Resident #2 stated Resident #1 wanted their medications and they did not want to wait for it. Resident #1 saw Licensed Practical Nurse #1 give them their medications and Resident #1 asked why Resident #2 is receiving their meds and not them. Licensed Practical Nurse #1 told Resident #1 it was not time for their medications. Resident #2 stated the facility has a lot of new staff. Resident #2 stated Resident #1 is always in excruciating pain and they get irate at times. Stated Resident #1 cries like a baby at times asking for her pain med and the nurses will tell them, you have 3 minutes left before you can receive your medications.</p> <p>10NYCRR 415.4(b)(1)(i)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00349754, NY00348426) the facility did not ensure that the comprehensive care plan was reviewed and revised timely for 2 out of 4 residents (Resident #1, Resident #4) reviewed for abuse. Specifically, (1) Resident # 1 with a history of known behaviors, had an incident on 7/30/2024 with Licensed Practical Nurse #1 and the risk for abuse, behavioral symptoms care plans were not updated to reflect the 7/30/2024 incident. (2) Resident # 4 reported to the Director of Social Services on 7/16/2024 that Registered Nurse # 1 had cursed at them and called them a name. Resident #4's risk for abuse care plan was not updated to reflect the allegation.</p> <p>Findings include:</p> <p>The facility's undated as comprehensive care plan policy documented it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.</p> <p>Resident # 1 was admitted to the facility with diagnoses including but not limited to Bipolar disorder, Depression and Chronic Pain Syndrome.</p> <p>A Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident # 1 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15 (associated with intact cognition). No behaviors noted. The resident required set up assistance for meals, maximal assistance for toileting, supervision for bed mobility and moderate assistance for transferring. Resident #1 had lower extremity impairment on one side and used a wheelchair for locomotion.</p> <p>Review of a behavior care plan dated 4/24/2024 and revised 8/5/2024 documented Resident #1 uses abusive verbal language, is resistant to activities of daily living, and exhibits aggressive behaviors. The goal was Resident #1 will display no negative behaviors through the review date. Interventions listed included provide a safe environment and psychological consult and follow up as needed.</p> <p>Review of a risk for abuse care plan dated 2/21/2024 and revised on 5/22/2024 documented Resident #1 is at risk for potential abuse related to aggressive behavior, verbally abusive towards staff and a diagnosis of bipolar disorder. The goal was Resident #1 will be kept safe and free from abuse through the next review date. Interventions listed included create a home like environment as much as possible and encourage diversion activities, refer to psychologist and psychiatrist as needed, staff to ensure that Resident #1 understands what constitutes resident abuse such as verbal, physical, emotional, and sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a behavior symptoms: physical abuse care plan dated 6/4/2024 documented Resident #1 exhibits physically aggressive behavior towards staff and others. The goal was Resident #1 will show a decrease in the number of episodes of physically aggressive behavior. There were no revisions/interventions documented after the incident on 7/30/2024.</p> <p>Review of the surveillance video dated 7/30/2024 revealed Resident #1 having a verbal altercation with Licensed Practical Nurse #1 back and forth. Resident #1 throws water from their cup in the direction of Licensed Practical Nurse #1, which landed on 2 other residents. Licensed Practical Nurse #1 while at their medication cart picked up the pitcher of water from the medication cart and flung the entire pitcher and water in Resident #1's direction. Licensed Practical Nurse #1 then threw the top to the pitcher in Resident #1's direction. Licensed Practical Nurse #1 picks up a water bottle and flings it at the resident and throws the empty bottle towards Resident #1</p> <p>A review of the at risk for Abuse Care Plan initiated on 02/21/2024 and last revised on 5/22/2024 revealed no updates/revisions after the occurrence on 7/30/2024.</p> <p>There was no documented evidence of the risk for abuse, behavior or behavior symptoms care plans being updated to reflect the incident that occurred on 7/30/2024.</p> <p>2)Resident # 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, and Muscle Weakness.</p> <p>A Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident # 4 has a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of score of 12/15, associated with moderate cognitive impairment with no behaviors present. Resident #4 had limited range of motion to both lower extremities. The resident required supervision with eating, needed partial /moderate assist with bed mobility and required maximal assistance with transfers. Resident #4 was dependent with toileting and uses the wheelchair for locomotion.</p> <p>A review of at risk for abuse care plan dated 1/20/2024 documented Resident #4 is at risk for potential abuse related to the dependence of staff for assistance of activities of daily living. The goal was Resident #4 will be kept safe and free from abuse through the next review date.</p> <p>Review of a grievance form dated 7/16/2024 documented Resident #4 self-reported to the Director of Social Services that Registered Nurse #1 verbally abused them. The Administrator was made aware and was responsible for investigating and following up with the issue. Resident #4 was interviewed by the Administrator, and an abuse investigation was initiated. The form documented the corrective action taken was Registered Nurse #1 was re-assigned to prevent further interaction with the resident and that Resident #4 was happy with the resolution. The form also indicated that a follow up was done on 7/19/2024 with the concerned party. Attached to the grievance form were statements from the Director of Social Services, three other alert and oriented residents from the same unit and Registered Nurse #1.</p> <p>There was no documented /update/revision to the risk for abuse care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/7/2024, the Registered Nurse Unit Manager of the 3rd floor stated they are responsible for updating the residents care plans. The Registered Nurse Manager stated on 7/30/2024 when the incident occurred between Resident # 1 and Licensed Practical Nurse #1, they were not in the building. Registered Nurse Unit Manager of the 3rd floor stated the abuse care plan should have been updated and any negative psychological indications would be updated. Registered Nurse Unit Manager 3rd floor acknowledged that they did not update the care plans for Resident #1 and Resident #4 because when the incident occurred, they were not in the building, but they should have completed the updates to the care plan upon return.</p> <p>10 NYCRR 415.11 (c)(2)(ii)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00349754, NY00348426) the facility did not ensure that nursing staff were in serviced in behavioral health care needs of residents for 1 of 4 residents. Specifically, the facility was unable to provide documented evidence that they provided education on behavioral health to Licensed Practical Nurse #1 before they were assigned to the dementia unit on 7/30/2024. Licensed Practical Nurse #1 engaged in a verbal altercation with Resident #1 with known verbal/physical aggressive behavior, and Licensed Practical Nurse #1 threw a pitcher of water at the resident during the verbal exchange.</p> <p>Finding include:</p> <p>A review of the Behavioral Health Policy dated 9/1/2022 documented it is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment.</p> <p>Review of a course completion list dated 8/7/2024 with completion dates 2/7/2024-8/7/2024 for caring for residents with cognitive impairment and management of behavioral challenges documented out of 85 employees, only 9 facility staff had completed both the cognitive and behavioral portions of the curriculum.38 employees had completed the behavioral portion and 38 employees had completed the cognitive portion of the training.</p> <p>Resident # 1 was admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including Bipolar disorder, Depression and Chronic Pain Syndrome.</p> <p>A Quarterly Minimum Data Set, dated dated [DATE] documented that Resident # 1 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15, associated with intact cognition. No behaviors noted. Resident #1 required set up assistance for meals, supervision for bed mobility and moderate assistance for transferring and maximal assistance for toileting.</p> <p>Review of a behavior care plan initially dated 4/24/2024 and revised 8/5/2024 documented Resident #1 used abusive language, resistant to activities for daily living, and exhibits aggressive behaviors. The goal is Resident #1 will display no negative behaviors through the review date. Interventions listed included provide a safe environment and psychological consult and follow up as needed.</p> <p>Review of a risk for abuse care plan initially dated 2/21/2024 and revised on 5/22/2024 documented Resident #1 is at risk for potential abuse related to aggressive behavior, verbally abusive towards staff and a diagnosis of bipolar disorder. The goal is Resident #1 will be kept safe and free from abuse through the next review date. Interventions listed included create a home like environment as much as possible and encourage diversion activities.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of behavior symptoms: physical abuse care plan dated 6/4/24 documented Resident #1 exhibits physically aggressive behavior towards staff and others. The goal is Resident #1 will show a decrease in the number of episodes of physically aggressive behavior. Interventions listed included to administer medications as ordered by physician, allow time to de-escalate when agitated, notify and report behavior changes to the physician, redirect negative behaviors.</p> <p>During a telephone interview on 8/6/2024 at 2:10 PM Licensed Practical Nurse #1 stated they have had dementia training from a previous employer but Resident #1 was upset and wanted their pain medications to be given right away. Licensed Practical Nurse #1 stated they were warned about Resident #1 before the beginning of their shift that Resident #1 can be aggressive. The Registered Nurse Unit Manager told them that the North side of the unit had a lot more psychiatric residents than dementia. Licensed Practical Nurse #1 stated the facility may give an orientation on combative residents or residents with behaviors, but they had not received the training before their assignment to the 3rd floor North unit.</p> <p>During an interview on 8/6/2024 at 2:55 PM, the Director of Nursing stated they have been working in the facility since July 22, 2024. The Director of Nursing stated the behavior training is conducted during the general orientation. If new staff start on a day that the general orientation is not held, they will not receive the training. There is now a new onboarding process where new staff are now receiving abuse, resident rights, Corporate Compliance, HIPPA, Fire Safety and Evacuation Plan and Emergency Codes Behavioral/Cognitive trainings.</p> <p>During an interview on 8/06/2024 at 3:30 PM the Registered Nurse Staff Development Coordinator stated they started working in the facility at the end of June 2024. Stated In orientation all staff are trained on how to handle combative residents and residents with behaviors. The Registered Nurse Staff Coordinator stated the last orientation was completed August 1, 2024, and the last mandatory training was completed before they arrived in the facility. Abuse In-service after the incident with Resident #1 is still ongoing and they have to come in on off hours to complete the abuse in service with the other shifts.</p> <p>During an interview on 8/7/2024 at 9:20 AM the Administrator stated the incident that occurred on 7/30/2024 revealed that there was a systematic failure. A new systemic process since the incident has been put in place. New orientation in service packets during on boarding for nurses now include all mandatory trainings which include the cognitive and behavioral trainings. Licensed Practical Nurse #1 had not received their training and was scheduled for the training two days after the incident occurred. The Administrator stated that even if the nurse had received abuse training prior to the incident they are not sure it would have prevented the nurse from losing their cool.</p> <p>During an interview on 8/7/2024 at 5:20 PM Licensed Practical Nurse #2 stated the facility does not train them on dealing with residents and their behaviors. Licensed Practical Nurse #2 stated the unit manager would just inform the assigned nurse that the resident is drug seeker. Stated the facility does not do an official training for agency nurses in the facility</p> <p>10 NYCRR 415.4(g)(2)</p>		