STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that the resident's representative was notified of a change in resident's condition. This was evident in 1 (one) (Resident #143) of 1 resident reviewed out of 35 total sampled residents. Specifically, the facility did not inform Resident #143's family representative that the resident's fourth fingernail on the right hand was detached. The findings include: The facility policy and procedure titled Change in Condition which was last reviewed on 01/2025 documented that the charge nurse/supervisor will notify the resident's family member or designee of any or all change in condition that differs from the resident's baseline. Resident #143 was admitted with diagnoses that included Cerebrovascular Accident and Hypertension. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #143 was severely cognitively impaired. and that resident required substantial assistance with all activities of daily living.On 08/11/2025 at 10:28 AM, Resident #143 was observed resting in bed. The resident's right fourth-digit nail was off, and the nailbed was pink.On 08/08/2025 at 1:07 PM, Resident #143's family representative was interviewed and stated that they received an email from the doctor stating that the resident had an infection on the right 4th finger and that they had put medication on it. The family representative stated on 07/04/2025, their cousin picked up Resident #143 and called them to say that the resident's fingernail was gone. They stated no one had told them that the entire fingernail was gone.A nurse's progress note dated 05/23/2025 at 3:35 PM documented that at approximately 2:00 PM, the assigned certified nursing assistant reported that the resident had blood on their right fourth finger. On assessment, the resident was noted to have mild bleeding from the right-hand fourth fingernail outside the cuticle. The nail on the finger and all other fingernails was intact. Attending Physician #1's progress note dated 05/23/2025 at 2:57 PM documented that Resident #143 was seen at the bedside for fingernail bleeding. The note documented that Resident #143 had fresh blood coming from cuticle on their right finger. Treatment plans included applying Bacitracin two times a day. The resident's family representative was to be notified. A nurse's progress note dated 05/24/2025 at 11:52 PM documented Resident #143's right 4th finger was noted with no fingernail, nail bed was pink, dry, no swelling, no ecchymosis, no bleeding or signs and symptoms of pain.A nurse's progress note dated 05/26/2025 at 12:05 AM documented Resident #143's nail bed was pink, dry, no swelling, ecchymosis, tenderness to the finger.A review of the progress notes from 05/24/2025 to 05/31/2025 showed no documented evidence that Resident #143's family representative was informed that the resident's fingernail was detached.On 08/13/2025 at 11:05 AM, Registered Nurse #4, who was the charge nurse, was interviewed and stated that Resident #143's fingernail was observed bleeding during care. They assessed the resident and noted the fingernail was oozing with blood. Resident #143's family was notified of the bleeding. They stated the next day; the nurse told them that the fingernail was off. The nail bed was pink and not bleeding. Registered Nurse #4 stated they do not remember if the doctor or the supervisor was aware that the fingernail was off.On 08/12/2025 at 11:22 AM, Registered Nurse #5, who was the nurse manager, was interviewed and stated that they were informed that Resident #143 broke their nail and had some (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
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bleeding. They stated the doctor notified Resident #143's family. They stated they were not aware that the fingernail came off and that the resident's family noticed it on 07/04/2025. On 08/12/2025 at 11:38 AM, Attending Physician #1 was interviewed and stated they examined Resident #143's fingernail when they were told that it was bleeding. They stated they ordered Bacitracin ointment and notified the family by email. They stated Resident #143's nail came off, but they did not inform the resident's family. They stated the nurse manager of the social worker can notify the resident's family of change in condition. On 08/14/2025 at 8:28 AM, the Assistant Director of Nursing was interviewed and stated they became aware of Resident #143's bleeding from the cuticle during the morning report. They stated the nurse manager initiated the investigation, but they, the Assistant Director of Nursing did not follow up. They stated they knew about the fingernail being off after a family member visited. The Assistant Director of Nursing stated the nurse manager, and the doctor usually communicates with the family, but this was overlooked. On 08/14/2025 at 10:16 AM, the Director of Nursing was interviewed and stated that the resident's family must be notified of any change in resident's condition and that the nurses, social workers, or doctors are responsible for informing the family. They stated Resident #143's family should have been notified again that the nail was detached. 10 NYCRR 415.3(f)(2)(ii)(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to report all alleged violations involving neglect, abuse, and/or including injuries of unknown source to the State Survey Agency. This was evident for one (1) (Resident #143) of six (6) residents reviewed for abuse out of 35 total sampled residents. Specifically, on 05/23/2025, Resident #143's fourth finger on the right hand was bleeding and was subsequently noted with a detached fingernail on 05/24/2025. The resident was cognitively impaired and could not explain how the injury had occurred This incident was not reported to the New York State Department of Health. Cross Reference: F580 - Notify of ChangesThe findings include: The facility's policy and procedure titled Abuse Prevention Protocol with a last revised date of 06/2025 documented the investigator is trained to report incidents to the New York State Department of Health when there is reasonable cause for resident abuse. The policy stated that federal regulations require reporting of injuries of unknown origin to the Administrator of the facility and when required to the New York State Department of Health. Resident #143 was admitted with diagnoses that included Cerebrovascular Accident and Hypertension. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #143's cognition as severely impaired and had never/rarely made decisions. The resident required substantial assistance with all activities of daily living. On 08/11/2025 at 10:28 AM, Resident #143 was observed resting in bed. The resident's right fourth-digit nail was off, and the nailbed was pink.A nurse's progress note dated 05/23/2025 at 3:35 PM documented that at approximately 2:00 PM, the assigned certified nursing assistant reported that the resident had blood on their right fourth finger. On assessment, the resident was noted to have mild bleeding from the right-hand fourth fingernail outside the cuticle. The nail on the finger and all other fingernails was intact. Attending Physician #1's progress note dated 05/23/2025 at 2:57 PM documented that Resident #143 was seen at the bedside for fingernail bleeding. The note documented that Resident #143 had fresh blood coming from cuticle on their right finger, traumatic. Treatment plans included applying Bacitracin two times a day. The resident's family representative was to be notified. A nurse's progress note dated 05/24/2025 at 11:52 PM documented Resident #143's right 4th finger was noted with no fingernail, nail bed was pink, dry, no swelling, no ecchymosis, no bleeding or signs and symptoms of pain.The facility's occurrence report dated 05/23/2025 documented that Resident #143 was noted with mild bleeding from the right-hand during transfer from bed to wheelchair. The Resident Care Follow-up completed by the Assistant Director of Nursing documented that there was no medical explanation found to cause the right fingernail bleeding and avulsion, and that the investigation was inconclusive. On 08/14/2025 at 10:20 AM, the Director of Nursing was interviewed and stated Resident #143 was unable to tell how they sustained the injury, and they cannot provide evidence of abuse or mistreatment. They stated an injury of unknown origin should have been reported to the New York State Department of Health. 10 NYCRR 415.4(b)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice. This was evident in one (1) (Resident #238) of one (1) resident reviewed out of 35 total sampled residents. Specifically, on 05/16/2025, Resident #238 was observed with thick, brownish, foul smelling penile discharge. The attending physician was not appropriately notified of Resident #238's change in condition resulting to a delay in medical intervention. The findings include:The facility's policy and procedure titled Change in Condition with a reviewed date of 01/2025 documented at the time a change in condition is identified, the nurse will notify the medical doctor, document all findings in the assessment and evaluation in a progress note, and document the change in condition on the 24-hour report.Resident #238 had diagnoses of Non-Alzheimer's Dementia, Coronary Artery Disease, and Benign Prostatic Hyperplasia without lower urinary tract symptoms.The quarterly Minimum Data Set (a resident assessment tool) dated 04/04/2025 documented Resident #238 had moderately impaired cognitive skills for daily decision making, and a short and long-term memory problem. Resident was dependent with activities of daily living and mobility.A comprehensive care plan for elimination/genitourinary was initiated on 10/04/2024 and was last reviewed on 04/01/2025. The care plan documented Resident #238 was incontinent of bladder. The facility interventions included to observe urine output and monitor for foul odor, dark color, cloudy urine, and other abnormalities.A progress note by Attending Physician #1 dated 05/19/2025 at 11:47 AM documented that Resident #238 had thick, penile discharge with a foul odor for 3 days, but changed from white to brownish color. The plan of care included urinalysis with culture, Rapid Plasma [NAME] (test used to screen for syphilis), and Sexually transmitted Infection Panel (screens for multiple sexually transmitted infections). A nurse's note by Registered Nurse #1 dated 05/19/2025 at 2:00 PM documented that Resident #238 was observed with thick, brownish penile discharge on [DATE]. Medical Doctor was made aware, evaluated the resident this morning, and ordered Ceftriaxone 100 milligram intramuscular for 1 dose and Doxycycline 100 milligram by mouth every 12 hours at 10:00 AM & 10:00 PM for 7 days for penile discharge.A review of interdisciplinary progress notes from 05/16/2025 through 05/18/2025 showed no documentation of Resident #238 having penile discharge or that a physician had been notified of Resident #238's foul smelling, abnormal penile discharge.The 24-hour Patient Care Report from 05/16/2025 through 05/18/2025 did not contain any documentation related to Resident #238.On 08/14/2025 at 12:41 PM, Certified Nursing Assistant #3 was interviewed and stated Resident #238 was on their assignment. They stated they could not remember the exact date but when they were taking care of Resident #238, they noticed yellowish, pus like penile discharge and the urine was foul smelling. They stated they spoke with the Registered Nurse, and the nurse came in to look at it. On 08/14/2025 at 9:23 AM, Registered Nurse #1, who was the unit Charge Nurse, was interviewed and stated Resident #238 was observed with abnormal penile discharge on a Friday, 05/16/2025 and verbally notified Attending Physician #1. They stated they do not remember if they followed up with the physician before the end of their shift. On 08/14/2025 at 9:35 AM, Attending Physician #1 was interviewed and stated they were covering on Resident #238's unit on 05/16/2025 and was not notified of Resident #238's brownish, foul smelling penile discharge. They stated they should have been notified right away as they would have examined Resident #238, ordered laboratory, and treated resident with antibiotics that same day. Attending Physician #1 also stated there was a note in the doctor's communication book located at the nurse's station that was dated 05/16/2025 but they checked the book prior to the note being written and therefore did not notice the note until they returned to work on 05/19/2025. Attending Physician #1 stated the Doctor's Communication Book is only meant for non-urgent matters.On 08/14/2025 at 10:59 AM, the Assistant Director of Nursing was interviewed and stated Registered Nurse #1 should have called the doctor on 05/16/2025 to report (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the penile discharge so Resident #238 could have been examined and treated that same day. Non-urgent issues can be communicated in the Doctor's Communication Book, but urgent matters such as this should be communicated directly to the physician and documented in the Electronic Medical Record. They stated Registered Nurse #1 also should have documented the abnormal penile discharge in the 24-hour report which provides communication from nurse to nurse. 10 NYCRR 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interviews during the Recertification and Complaint (#668295) Survey, the facility failed to ensure that food was served at an appetizing temperature during meals. This was evident in one (1) (Unit 4) of five (5) units. Specifically, food served during meal service were not maintained at palatable and appetizing temperatures.The findings include:The facility's policy and procedure titled Food Temperatures with a reviewed date of 02/2024 documented all food is to be prepared, held, and served within the appropriate ranges to provide the highest quality of food and maintain aesthetic value of food. Minimum temperature for hot food is above 140 degrees Fahrenheit. During the Resident Council meeting on 08/08/2025, Residents #138 and #146 stated that food are often served lukewarm, and at times were served cold during meal service. The residents stated staff should not eat their meals prior to serving meals to the residents because meals are served late, not hot, and sometimes run out. Resident #66 stated food are served cold because meals are delivered late. On 08/12/2025 from 11:40 PM to 12:23 PM, food cart arrived in Unit 4. Meal trays were assembled and distributed to residents in the dining room and resident rooms. At 12:23 PM, test trays were conducted with the Food Service Director. It revealed the following: chicken noodle soup at 142.2 degrees Fahrenheit, baked chicken at 144 degrees Fahrenheit, jerk chicken at 150 degrees Fahrenheit, spinach at 126 degrees Fahrenheit, plantains at 116 degrees Fahrenheit, puree green beans at 132.6 degrees Fahrenheit, puree chicken at 128 degrees Fahrenheit, mashed potato at 134 degrees Fahrenheit. On 08/12/2025 at 12:37 PM, the Food Service Director was interviewed and stated in the past resident council meetings, residents brought up the food temperature issues. They stated the temperatures tested were not meeting the minimum temperature and that hot foods should be served above 140 degrees Fahrenheit. On 08/14/2025 at 11:28 AM, the Administrator was interviewed and stated they were not aware of resident concern about food temperature. They stated they are going to address this concern immediately because residents should be getting good quality meals. 10 NYCRR 415.14(d)(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on observation, record review, and interviews during the Recertification Survey, the facility failed to ensure residents, or their designated representatives, were provided appropriate notification at the termination of Medicare Part A benefits. This was evident in three (3) (Residents #187, #212, and #222) of three (3) residents reviewed for Beneficiary Notification out of 35 total sampled residents. Specifically, the facility did not provide residents with Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN- form CMS-10055) at the termination of their Medicare Part A benefits. The residents remained in the facility. The findings include: The facility policy titled Advanced Beneficiary Notice Non-Coverage with a last revised date of 01/2025, documented that the purpose of the policy was to ensure the facility issues, documents, and retains Advance Beneficiary Notices of Non-Coverage in accordance with Medicare/Center for Medicare & Medicaid Services rules so beneficiaries or their representatives are informed when the facility reasonably expects Medicare Fee for Service (MFS) will not pay for a particular item or service, and to protect the facility from improper billing and financial liability.1) Resident #187's last covered day for Medicare Part A skilled services was on 02/24/2025 with 61 benefits days remaining. Resident #187 remained in the facility. Resident #187 received a copy of the Notice of Medicare Non-Coverage form on 02/21/2025. There was no documented evidence that form CMS-10055 was given to the resident, informing them of their potential liability for payment.2) Resident #212's last covered day for Medicare Part A skilled was on 07/25/2025 with 22 benefits days remaining. Resident #212 remained in the facility. The resident's representative received a copy of the Notice of Medicare Non-Coverage form on 07/23/2025. There was no documented evidence that form CMS-10055 was given to the resident, informing them of their potential liability for payment.3) Resident #222's last covered day of Medicare Part A skilled services was on 06/06/2025 with 61 benefits days remaining. Resident #222 remained in the facility. Resident #222 received a copy of the Notice of Medicare Non-Coverage form on 06/03/2025. There was no documented evidence that form CMS-10055 was given to the resident, informing them of their potential liability for payment.On 08/12/2025 at 3:05 PM, the Director of Social Services was interviewed and stated that they give Notice of Medicare Non-Coverage to the residents two days before they are discharged from services. They stated they do not issue the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage to the resident or their representative.On 08/12/2025 at 3:13 PM, the Minimum Data Set Coordinator was interviewed and stated they do not issue the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage to the residents because they had not filed an appeal. They stated the residents are given Notice of Medicare Non-Coverage and that there is a phone number for them to call to file an appeal. On 08/14/2025 at 9:50 AM, the Director of Nursing Services was interviewed and stated that according to the Minimum Data Set Coordinator, the residents are issued Notice of Medicare Non-Coverage on admission. The Director of Nursing further stated that according to the social worker, they only give the residents Notice of Medicare Non-Coverage, and not the Advance Beneficiary Notice. The Minimum Data Set Coordinator and the social worker are responsible for providing appropriate forms. The Director of Nursing stated that the Minimum Data Set Coordinator provides the proper forms. On 08/14/2025 at 2:55 PM, the Administrator was interviewed and stated that the Minimum Data Set Coordinator gives the Notice of Medicare Non-Coverage forms to the social worker. The social worker explains the notice to the resident and asks the resident to sign the form.10 NYCRR 415.3(h)(2)(iii)