STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335763	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Vincent Depaul Residence	900 Intervale Avenue Bronx, NY 10459

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** 48711 Based on interviews and record review conducted during the Recertification/Complaint Survey (NY00343189) from 01/02/2025 to 01/08/2025, the facility did not ensure all alleged violations involving injuries of unknown source were reported immediately, but not later than 2 hours after the allegations were made, to the State Survey Agency. This was evident in 1 (Resident #96) reviewed for Accidents out of 23 total sampled residents. Specifically, the facility did not report that Resident # 96 was found with injuries of an unknown source to the New York State Department of Health within 2 hours. The findings are: The facility policy titled Clinical, Resident Abuse Reporting and Investigation Protocol, Policy and Procedure with effective date January 11, 2010 and last review date 08/01/2024 documented the source of the injury was not observed by any person or the source of the injury could not be explained by the resident, the facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made. Resident #96 was admitted to the facility with diagnoses which included History of falling, Difficulty Walking, Hypotension, and Generalized Muscle Weakness. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #96 has moderately impaired cognition and supervision with ambulating. The Nursing Progress note dated 5/23/2024 at 03:31AM documented Resident #96 was assessed to have swelling to left side of face by supraorbital region and scant blood on tip of nose. Resident #96 reported pain 8/10 to left arm with limited movement noted to extremity. The Nursing Progress note dated 5/23/2024 at 02:55 AM documented Resident #96 was found lying on the floor laterally to left side by doorway to room [ROOM NUMBER] with mild swelling to left side of their head with swelling and discoloration to the left supraorbital area, noted with scant bleed from nose, left forehead and supraorbital swelling, inability to move left arm and complaint of pain 6/10. Physician was notified and ordered for Resident #96 be transferred to the hospital for further evaluation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medical note dated 5/30/2024 documented Re-Admission Note for Resident #96 for status post fall, closed displaced fracture of proximal end of left humerus. The Accident /Incident Occurrence Report/Investigation form documented the occurrence happened at 11:30 PM on 05/22/2024. The Webform submission from Nursing Home Facility Incident Report emailed to the Administrator documented the incident was submitted to New York State Department of Health at 23:39 on 05/23/2024. During an interview on 1/6/2024 at 03:21 PM, Registered Nurse #5 stated was the nurse on the unit at the time of the incident. Registered Nurse #5 stated was informed by Certified Nurse Assistant #9, Resident #96 is lying on the floor. Upon arrival, observed Resident #96 lying on the floor in the hallway in front of their room. Registered Nurse #5 stated they called for the nurse manager to come to the unit. Resident #96 was assessed with head swelling and left arm with limited movement. The Medical Doctor was called and ordered for Resident #96 be transferred to the hospital. No one witnessed the incident or how Resident #96 came to be lying on the floor. Their roommate at the time was confused and unable to tell what had happened. The bathroom floor was observed to be wet, but when assessing Resident #96, their clothes and socks were dry. Prior to the fall, Resident #96 was on fall precautions such as low bed position and call bell. No known falls since their admission to the facility. No behaviors such as getting up in the middle of the night. Resident #96 was independent with their toileting prior to the incident. Resident #96 is known for sleeping through the night. During an interview on 1/6/2024 at 03:26 PM, Certified Nurse Assistant #9 stated they started their shift on 5/22/2024 around 11:10 PM and saw Resident #96 asleep in their bed. They then went down the hallway to prepare their linen cart for the night shift and when coming down the hall, noticed Resident #96 lying on the floor in the hallway by their room door. Certified Nurse Assistant #9 stated they called for the nurse who came to look at Resident #96 and was taken to the hospital. Certified Nurse Assistant #9 stated that Resident #96 was not able to tell what happened after giving more than one story of what had happened. No one saw how Resident #96 got on the floor. The roommate at the time was unable to tell what happened. Resident #96 did complain of left-hand pain. The bed is always in the low position. The call bell was in her reach, but it was not activated. During an interview on 01/07/25 at 02:36 PM, Minimum Data Set Coordinator stated they were called to file the complaint with the Department of Health. Since they don't have their laptop, the Minimum Data Set Coordinator, who typically completes report submission, is unable to recall what they submitted and when they sent the summary. Additionally, it was mentioned that any occurrence should be reported to the Department of Health within two hours of becoming aware of it. During an interview on 01/06/25 at 10:51 AM, Director of Nursing stated that it was reported that Resident #96 might have gone to use the bathroom and noticed water from the toilet on the floor and went to go to alert the staff and in the process fell and was found by their doorway entrance on the 2nd floor. The incident was unwitnessed. Director of Nursing was interviewed on 01/08/25 at 2:20 PM and stated the process for reporting incidents to the Department of Health is that the Director of Nursing Services will contact the Director of Nursing, who will collect and forward the allegation information to the Department of Health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If it is unwitnessed with injury, falls with major injury are not reportable. After the facility received a report from the hospital that Resident #96 sustained a fracture, the team decided to be safe and report the incident to the Department of Health. On 01/08/2025 at 02:19 PM, the facility Administrator was interviewed and stated, the Director of Nursing obtains the information and/or the supervisor and reports the information to the Department of Health. If it is an abuse case, it gets reported within 2 hours. Falls with injury are reported within 24 hours of the fall. As per the Administrator stated he needs more clarity on the reporting to the Department of Health. Resident #96 was not known to have an injury until the report came back from the hospital that Resident #96 had an injury, and it was then reported to the Department of Health. Stated needs more clarity on reporting of the incidents because not all incidents get reported. The Registered Nurse Supervisor on duty at the time of the incident is no longer employed at the facility and could not be reached for interview. 10 NYCRR 415.4(b)(2)