

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER Throgs Neck Extended Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 707 Throgs Neck Expressway Bronx, NY 10465	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was 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 New York State Department of Health. This was evident for one (1) (Resident #160) of three (3) residents reviewed for accidents out of 39 total sampled residents. Specifically, Resident #160 had an unwitnessed fall on 04/16/2024 when the resident was observed on the floor with decreased range of motion to the right lower extremity and complaints of pain, was transferred to the hospital and was admitted with a diagnosis of right hip fracture. This incident resulted in serious bodily injury that was not reported to the New York State Department of Health. The findings are: The facility's policy titled Abuse, Mistreatment, Neglect, and Misappropriation of Resident's Property with a reviewed date of 02/05/2026, documented that upon receipt of a resident's accident/incident report the Director of Nursing will continue the investigation if there is any suspicion of abuse, mistreatment, neglect or misappropriation of property. The Director of Nursing will coordinate the investigation of alleged violations and report the results to the proper authorities if applicable. All alleged violations and all substantiated incidents will be reported to the New York State Department of Health. Resident #160 had diagnoses of Cerebral Infarction, Right Hemiplegia and Dysarthria. The quarterly Minimum Data Set assessment dated [DATE] documented that Resident #160 had severely impaired cognition and required supervision or touching assistance for bathing, dressing, toileting hygiene, transfer and walking 10 feet. The facility's accident investigation dated 04/16/2024 documented at 8:30 PM, Resident #160 was observed sitting upright on the floor with their back against the wall in their room. Certified Nursing Assistant #7 last saw Resident #160 in bed at 8:10 PM. Resident #160 had limited range of motion and complained of pain to the right hip area. Resident #160 was transferred to the hospital and was admitted due to a fracture of the right hip. The facility's Investigation Summary with a completed date of 04/18/2024 documented that on 04/16/2024 at 8:30 PM, Resident #160 had an accidental fall when staff responded to the resident calling from their room for assistance where they were found on the floor. Resident #106 was noted with decreased range of motion to the right lower extremity and complaints of pain. The Resident was unable to provide a depiction of the event due to their level of cognition. Resident #106 is forgetful and confused at baseline and had a history of attempted unassisted transfer when transfers require extensive assistance of (1) one person. The physician was notified and ordered neurological checks and hip/pelvic x-ray. Resident #106 was transferred to the hospital following x-ray confirmation of right hip fracture. A hospital Discharge summary dated [DATE] documented Resident #106 was admitted to the hospital on [DATE] with a diagnosis of right intertrochanteric fracture. The nursing home reported that the resident had an unwitnessed fall from bed. The nursing home reported Resident #106 had an unwitnessed fall from the bed. The resident underwent a right Cephalon-Medullary Nail implant (an internal fixation device used (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to stabilize fractures around the hip joint) on 04/18/2024. There was no documented evidence that the facility reported to the New York State Department of Health Resident #106's unwitnessed fall that resulted in major injury. On 03/12/2026 at 5:16 PM, Director of Nursing #1 was interviewed and stated they have been employed as the Director of Nursing at the facility on 01/01/2026 and was not the Director when the incident occurred. They stated they reviewed the incident report and investigation for Resident #106 who had an unwitnessed fall and sustained hip fracture on 04/16/2024. They stated that the incident should have been reported to the New York State Department of Health within two (2) hours as the resident sustained a major injury. Director of Nursing #1 further stated they would have reported the incident if they had been the Director of Nursing at the time of the incident. On 03/12/2026 at 5:47 PM, Administrator #1 was interviewed and stated they were recently hired at the facility and was not the Administrator when this incident occurred. They stated that after reviewing the incident and investigation report for Resident #106 they believe that the incident should have been reported to the New York State Department of Health within two (2) hours as the resident sustained hip fracture. Administrator #1 further stated they would have reported the incident if they had been the Administrator at the time of the incident. 10 New York Codes, Rules and Regulations 415.4(b)(2)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure that clinical records were maintained in accordance with accepted professional standards and practices that are complete and accurately documented. This was evident for one (1) (Resident #201) of one (1) resident reviewed for death out of 39 total sampled residents. Specifically, Resident #201's medical record did not contain assessment of the resident's change in condition on 02/19/2026. The findings are: The facility's policy and procedure titled Change in Condition with a last reviewed date of 01/15/2026 documented that at the time a change in condition is identified the nurse will notify the nursing supervisor/Registered Nurse Manager. The Registered Nurse will assess the resident and notify the attending physician and document all findings of the assessment and evaluation in a progress note including interventions and changes in physician's orders. If the resident expires, a physical assessment is done on the absence of apical pulse, respirations, and carotid pulse for 60-90 seconds. Pronouncement: time, date, and name of the nurse or physician who pronounced the death. Notifications: specific times the family, doctor, and funeral home/coroner were called. Conditions: presence of Do Not Resuscitate orders and if the death was expected or unexpected. Post-Mortem Care: documentation of cleaning, dressing, and body positioning. The quarterly Minimum Data Set (a resident assessment tool) dated 01/22/2026 documented Resident #201 had intact cognition and had diagnoses of hypertensive heart disease with heart failure (long-term high blood pressure damages and weakens the heart, causing it to not pump as well as it should), chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breath because airflow in and out of the lungs is blocked), and coronary artery disease (blood vessels that supply the heart become narrowed or blocked). Resident #201's medical orders for life sustaining treatment dated 06/03/2024 included do not intubate and do not resuscitate orders. A social service note dated 02/19/2026 at 3:21 PM documented that Resident #201 passed on 02/19/2026, that the next of kin was notified, and the funeral parlor was contacted to pick up the body. A Certificate of Death documented that Resident #201 passed away on 02/19/2026 at 8:55 AM. A review of Resident #201's medical record revealed there was no documentation of Resident #201's death event on 02/19/2026 that would include the time the resident was found unresponsive, assessment, confirmation of do not resuscitate status, time of death, physician notification, and body release details. On 03/11/2026 at 4:01 PM, Licensed Practical Nurse #4 was interviewed and stated that Registered Nurse #2 who was the nursing supervisor was doing rounds when Resident #201's roommate alerted them that Resident #201 was not feeling well. They stated that Resident #201's oxygen level was low, the resident's blood pressure was taken, and another nurse went to check Resident #201's code. They stated they administered Resident #201's oxygen through a non-rebreather mask, and their oxygen level would not rise. They stated Resident #201 passed away while they were with them. They stated that the nursing supervisors and the Director of Nursing were all in the room. Licensed Practical Nurse #4 stated they did not document Resident #201's change in condition in the progress notes. On 03/11/2026 at 4:32 PM, Registered Nurse #2 who was the nursing supervisor was interviewed and stated Resident #201's roommate alerted them after breakfast that Resident #201 was not feeling well. Resident #201 was uneasy and gasping and holding their chest. They stated they put Resident #201 on oxygen and tried to put an intravenous line in. The Director of Nursing was called and came upstairs right away. They stated they could tell from Resident #201's wrist band that their code status was do not resuscitate, and another nurse also double checked Resident #201's Medical Orders for Life Sustaining Treatment. Physician #1 was on the unit and arrived after Resident #201 was pronounced dead by the Director of Nursing. The Director of Nursing called the family and informed Physician #1 of Resident #201's change in condition and death. Registered Nurse #2 also stated Licensed Practical Nurse #4 should have written a progress note and they could not explain why they had not written a progress note as (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>well about the resident's change in condition. On 03/12/2026 at 5:34 PM, Director of Nursing #1 was interviewed and stated they pronounced Resident #201's death and then immediately went downstairs to their office to write a note in the electronic medical record and called the resident's family. They stated Physician #2 came into Resident #201's room to check on them when resident's condition was declining. The Director of Nursing also stated they called the funeral home and wrote another note in the electronic medical record when the funeral home picked up Resident #201's body. The Medical Director completed the resident's death certificate. 10 New York Codes, Rules and Regulations 415.22(c)</p>