

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335775	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/17/2025
NAME OF PROVIDER OR SUPPLIER  Bronx Gardens Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2175 Quarry Rd Bronx, NY 10457	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews conducted during an Abbreviated Survey (NY00368174), the facility did not ensure that the alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than two (2) hours after the allegation is made, if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility of the facility and to other officials (including to the State Agency and adult protective services where state law provides for judications in long term care facilities). This was evident for one (1) out of four (4) (Resident #2) residents sampled. Specifically, on 01/03/2025 at around 10:00 AM Resident #2 reported to the Physician Assistant that Resident #3 grabbed their hands then held them by the throat on the morning of 01/02/2025 while they were in their room. The facility investigated the alleged allegation of abuse, but did not report it to New York State Department of Health.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property was reviewed on 01/2025. The policy states that the facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation do not involve abuse or result in serious bodily injury, to administrator of the facility and to other officials (including to State Survey Agency and adult protective services where state law provides for judgement in long-term care facility) in accordance with State Law through established procedures, local enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility.</p> <p>Resident #2 was admitted to the facility on with diagnoses including Intellectual Disability, Seizure Disorder, and Depression.</p> <p>The Minimum Data Set, an assessment tool, dated 10/26/2024 documented Resident #2 had severe cognitive impairment.</p> <p>Resident #3 was admitted to the facility with diagnoses including Alzheimer's Disease and Parkinson's Disease.</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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NAME OF PROVIDER OR SUPPLIER  Bronx Gardens Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2175 Quarry Rd Bronx, NY 10457	
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(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>The Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment.</p> <p>The facility's Investigation Report Summary dated 01/03/2025 documented Resident #2 verbalized to the Physician Assistant that another resident grabbed them by the hand and then held their throat. The facility suspected the alleged perpetrator was Resident #3 who was the only resident that wandered on the unit's hallway. Staff interviews revealed that Resident #3 wanders in the hallway and likes to touch staff and other residents by holding their hand with no harm. An investigation was immediately initiated by interviewing staff members who worked on the morning shift and other residents on the unit. Resident #2's roommate, who was alert and oriented times four reported that no one entered their room, and they did not hear anything going on in the room. Camera review showed Resident #3 ambulating in the hallway. Resident #2 and Resident #3 never made any physical contact and Resident #3 never entered Resident #2's room. They determined within two hours that abuse did not occur. The investigation also concluded that the alleged incident did not happen.</p> <p>During an interview with the Physician Assistant on 01/11/2024 at 11:00 AM, they stated Resident #2 reported to them on 01/03/2025 at 10:00 AM that Resident #3 grabbed their hands and held them by their throat on the morning of 01/02/2025 (not time identified). Resident #2 was unable to identify the alleged resident. The Physician Assistant stated they immediately performed a full body assessment and Resident #2 did not have any redness or bruising at their throat or on their body. The Physician Assistant stated Resident #2 reported that they did not report the incident to anyone, but they are now reporting it to them. The Physician Assistant stated they immediately reported the allegation to the unit Registered Nurse Manager #2 on 01/03/24 at 10:30 AM.</p> <p>During an interview with the Director of Nursing on 03/14/2025 at 11:58 PM, they stated they immediately (does not recall time) informed the Administrator of the alleged incident. The Director of Nursing stated they reviewed the investigation with the Administrator and the Medical Director, and they all decided not to report the alleged incident to New York State Department of Health because the incident did not occur. The Director of Nursing stated they were able to rule out abuse based on camera review, physical assessment of Resident #2, staff members interviews, and other residents including Resident #2's roommate. The Director of Nursing stated they were able to determine within two hours that the alleged incident did not happen. The Director of Nursing stated the nurse managers, and the supervisors are mandated to report allegations of abuse to the New York State Department of Health.</p> <p>During an interview with the Administrator on 03/12/2025 at 11:58 AM, they stated they immediately reviewed the camera for the alleged incident of 01/03/2025 (do not recall the time). The Administrator stated Resident #3 was observed wandering in the hallway and Resident #2 was sitting in their wheelchair. There was no direct physical contact between both residents and Resident #3 never entered Resident #2's room. The Administrator stated that they investigated the allegation quickly and was able to conclude that the alleged incident was unsubstantiated. The Administrator stated they did not report to the New York State Department of Health as per their facility's policy, because the alleged incident did not happen and there was nothing to report. The Administrator stated the allegation of Resident-to-Resident altercation or physical abuse are reportable to law enforcement based the regulation. The Administrator stated they did not save a copy of the camera recording.</p> <p>10 NYCRR 415.4 (b)</p>		