

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33A246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER Elizabeth Seton Children's Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Corporate Blvd South Yonkers, NY 10701	
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** 43478</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00345276) on 6/20/24, the facility did not ensure residents rights to be free from physical for 1 (Resident #1) of 3 residents reviewed for abuse. Specifically, on 6/12/24, two facility staff (Certified Nurse Aide #1 and Speech Therapist #2) witnessed an alleged staff to resident abuse involving Registered Nurse #7 and Resident #1. Registered Nurse #7 was witnessed screaming 25year olds don't behave this way-cut it out and holding Resident #1's hands down in their lap with closed hands over forearms. In an interview with Certified Nurse Aide #1 they stated they heard raised voices and saw Registered Nurse #7 loudly saying stop, are you a baby? Both witnesses did not report the incident on 6/12/24. The Speech Therapist #2 reported the incident to the administration on 6/13/24. Video surveillance revealed Registered Nurse #7 restraining Resident #1 by closing their hands on Resident #1 forearms and saw Registered Nurse #7 pointing a finger close to Resident #1's face.</p> <p>Findings include:</p> <p>The facility policy, 'Prohibition and Prevention of Resident Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property' revised 12/11/23 documented the facility provides on-going oversight and monitoring to ensure that Staff provides care to residents in a safe environment and to ensure that each resident's right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of property of property is maintained. This includes but is not limited to freedom from any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.</p> <p>Resident #1 was admitted with diagnoses which included Lennox-Gastaut syndrome, neurogenic bladder, and G-tube placement.</p> <p>The quarterly minimum data set (resident assessment tool) dated 5/7/24 documented moderately impaired cognition, other behavioral symptoms not directed towards others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily waste, or verbal vocal symptoms like screaming, disruptive sounds. The resident required substantial/maximal assistance with eating and bed mobility was dependent with all other activities of daily living. The resident had impairments to upper and lower extremities on both sides and required supervision or touching assistance with locomotion in manual wheelchair.</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>Impaired Communication dated 11/23/20 updated 6/18/24 documented the Resident will remain free from abuse, neglect exploitation and mistreatment. Interventions included to anticipate and meet resident's needs. Observe and assess for changes in behavior and physical signs that may be indicative of abuse, neglect, exploitation, or mistreatment, provide gestures, visual, auditory, and tactile prompting, and cueing, recognize resident frustration and provide support for communication.</p> <p>Behavioral Symptoms dated 11/23/20 updated 6/18/24 documented Neurological Impairment, Medications, Impaired relationship(s), Frustration in response to condition, Trauma, Environmental factors as evidenced by a danger to self and others, verbal expression, resists ADLs. Aggressive and resistant behaviors will occur during the morning hours and if schedule plan is interrupted due to ADL's. Interventions included maintain least restrictive environment, redirect behaviors, encourage ventilation of negative emotions using an empathetic, supportive approach.</p> <p>Psychologist note dated 6/11/24 documented the psychologist met with charge nurse and nurse manager regarding recent escalation of behavioral issues. It was discussed that small group in-services would be provided to staff to review strategies on behavioral management of Resident #1. Will also work with Resident #1 on restarting his positive reinforcement program to increase his motivation to improve negative moods and behavior.</p> <p>A review of surveillance footage was completed during the onsite visit on 6/20/24 at 12:16 PM. Registered Nurse #7 is observed in the Unit Common Area. Resident #1 is seen wheeling themselves to the Common Area close to Registered Nurse #7. A verbal interaction is observed between them. Resident #1 is seen swinging their arms and hitting their head. Registered Nurse #7 is observed standing up and saying something to the resident and held their arms down with closed hands. Resident #1 is observed rolling backwards in their wheelchair with Registered Nurse #7 continuing to hold Resident #1's arms. Registered Nurse #7 is seen releasing the resident's arms and pointing their index finger close to the resident's face.</p> <p>The completed facility occurrence report dated 6/13/24 concluded that there was reasonable cause to believe abuse occurred.</p> <p>On 6/20/24 at 9:55 AM during an interview, Certified Nurse Aide #1 stated they were in the shower room down the hall from the Common Area when they heard Resident #1 and Registered Nurse #7 using raised voices, they stepped out of the shower room and went toward the common area and from the right side of Resident #1 they saw Registered Nurse #7 standing in front of Resident #1 and holding Resident #1 hands or upper arms, and Registered Nurse #7 loudly saying, 'Stop, are you a baby?' Certified Nurse Aide #1 stated they saw the Speech Therapist approaching Registered Nurse #7 and Resident #1. Certified Nurse Aide #1 stated that the Speech Therapist has a very good relationship with Resident #1 and frequently manages Resident #1 behavioral outbursts, and they were therefore not concerned, so they went back to the shower room.</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 an interview on 6/20/24 at 10:22 AM, the Speech Therapist #2 stated they were in another resident's room across the hall from the Common Area when they heard very loud voices, coming from the common area. They stated they saw Resident #1 sitting in their wheelchair yelling and Registered Nurse #7 standing over Resident #1 holding Resident #1 forearms down in their lap with their hands closed and screaming in a loud voice at Resident #1 saying [AGE] year-olds don't behave this way, cut it out! The Speech Therapist #2 stated they walked towards Resident #1 and Registered Nurse #7 to assist, and Registered Nurse #7 stepped back and removed their hands from Resident #1. The Speech Therapist #2 stated they prompted Resident #1 to take deep breaths and brought Resident #1 to their room to calm down. The Speech Therapist #2 stated they asked Resident #1 what had happened, and Resident #1 informed them that they had called their parents and neither of them picked up the phone. Resident #1 was very emotional and was crying when they explained not been able to reach their parents. The Speech Therapist #2 stated they told Registered Nurse #7 that yelling at residents is unacceptable, but they were unsure if holding down Resident #1's hands was inappropriate, because they could not see if the Registered Nurse #7 was holding down Resident #1's hands with force or if the Registered Nurse #7 was preventing Resident #1 from hurting themselves. The Speech Therapist #2 stated they were trained on abuse prohibition and reporting.</p> <p>During an interview on 6/20/24 at 11:12 AM, Nurse Manager #3 stated that on 6/13/24 at approximately 9:00 AM, the Speech Therapist #2 reported Resident #1's behavioral event and had a concern regarding whether Registered Nurse #7 managed Resident #1's behaviors appropriately. Nurse Manager #3 stated their initial reaction was not one of abuse because Resident #1 has been having more behavioral outbursts lately and the Speech Therapist #2 has preferences as to how Resident #1's behaviors should be managed. Nurse Manager #3 stated that at approximately 1:00 PM, they performed a camera audit to see what had triggered Resident #1 behavioral event and they observed Registered Nurse #7 closing their hands on Resident #1 forearms. Nurse Manager #3 stated the facility policy is to use open-handed gentle touching, and closed hand was unacceptable. Nurse Manager #3 stated they then reported the incident to the Director of Nursing.</p> <p>During an interview on 6/20/24 at 11:55 AM, the Director of Nursing #5 stated they were informed by Nurse Manager #3 on 6/13/24 about the incident that occurred on 6/12/24. The Director of Nursing stated after they viewed the camera footage, they felt concerned because they observed Registered Nurse #7 not addressing Resident #1's behavior in the manner they are taught in the facility. They stated that Registered Nurse #7 was observed on the surveillance holding Resident #1 hands down in a restraining manner, and the facility does not allow restraining residents. Actions to prevent self-injurious behaviors include removing the resident from any potentially harmful objects and from other residents, and if necessary, staff may block a resident from potentially harming themselves using an open hand only, no closed hands or holding or restraining is allowed.</p> <p>During an interview on 6/20/24 at 11:40 AM, facility Administrator stated the incident was reported to them on 6/13/24. When they reviewed the surveillance footage, they felt uncomfortable with Registered Nurse #7's actions towards Resident #1, which included finger pointing and holding Resident #1 forearms with closed hands which are unacceptable interventions. The Administrator stated the police was called on 6/13/24 at 3:23pm. They stated that Registered Nurse #7 is currently suspended, and the facility has yet to determine if they will be terminated.</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>On 6/20/24 at 12:06 PM during an interview, Chief Nursing Officer stated that when they reviewed the surveillance footage, they felt concerned because they observed Registered Nurse #7 not addressing Resident #1 behavior in a manner that was acceptable at their facility. They stated that Registered Nurse #7 was observed holding Resident #1 hands down and restraining Resident #1, and the facility does not allow restraining of residents. The Chief Nursing officer stated that no closed hand holding is allowed.</p> <p>During an interview on 6/20/24 at 3:14 PM, Registered Nurse #7 stated that at approximately 6:20 PM on 6/12/24, Resident #1 came to the nurse's desk to ask who their night nurse would be. Registered Nurse #7 stated as they were checking the schedule, Resident #1 repeatedly asked who the night nurse would be. Resident #1 was upset stated, Want a piece of me? Registered Nurse#7 stated they told Resident #1 to back away and Resident #1 started to scream and began hitting themselves in the face and the head. Registered Nurse #7 stated they grabbed Resident #1 wrists and held Resident #1 arms down by their belly to prevent Resident #1 from injuring themselves. Registered Nurse #7 stated they were talking in a loud voice over Resident #1 yelling to remind Resident #1 that they are not a child and told Resident #1 You are a [AGE] year-old man.</p> <p>10 NYRCC 415.4(b)(1)(i)</p>		

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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>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** 43478</p> <p>Based on record review and interviews during an abbreviated survey (NY00345276), the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than two hours to the New York State Department of Health, and the results of the 5-day investigation to the New York State Department of Health in accordance with state law within 5 working days of the incident. This was identified for 1 (Resident #1) of 3 residents reviewed for abuse. Specifically, on 6/12/24, two facility staff (Certified Nurse Aide #1 and Speech Therapist) witnessed an alleged staff to resident abuse involving Registered Nurse #7 and Resident #1, which was not reported to the facility administration until 6/13/24. Certified Nurse Aide #1 did not report the incident on 6/12/24. The Speech Therapist reported the incident to the administration on 6/13/24. The result of the facility 5-day investigation was not submitted to New York State Department of Health until 6/21/24.</p> <p>Finding include:</p> <p>The facility policy, 'Prohibition and Prevention of Resident Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property' revised 12/11/23 documented the facility requires all staff to immediately report incidents or allegations of abuse, neglect, exploitation, mistreatment, and misappropriation to resident property to the [NAME] President of Operations/Administrator.</p> <p>Resident #1 was admitted with diagnoses which included Lennox-Gastaut syndrome, neurogenic bladder, and G-tube placement.</p> <p>The quarterly minimum data set (resident assessment tool) dated 5/7/24 documented moderately impaired cognition, other behavioral symptoms not directed towards others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily waste, or verbal vocal symptoms like screaming, disruptive sounds. The resident required substantial/maximal assistance with eating and bed mobility was dependent with all other activities of daily living. The resident had impairments to upper and lower extremities on both sides and required supervision or touching assistance with locomotion in manual wheelchair.</p> <p>A review of the facility surveillance video was conducted by the surveyor during the onsite visit on 6/20/24 at 12:16 PM. The footage showed Registered Nurse #7 in the Common Area at the desk. Observed Resident #1 wheel themselves to the Common Area. Registered Nurse #7 and Resident #1 are seen having a verbal interaction. Resident #1 is seen swinging their arms and hitting their head. Registered Nurse #7 is observed standing up and saying something to Resident #1. Registered Nurse #7 is seen holding Resident #1 forearms down with closed hands. Resident #1 is observed in their wheel chair rolling backwards, and Registered Nurse #7 continuing to hold Resident #1 arms. Registered Nurse #7 is observed releasing their hands off Resident #1 forearms and pointing their index finger close to Resident #1 face.</p> <p>The completed facility occurrence report dated 6/13/24 concluded that there was reasonable cause to believe abuse occurred.</p> <p>(continued on next page)</p>		

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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>The facility submitted a report to the New York State Department of Health on 6/13/24 for a witnessed staff to resident abuse allegation which occurred on 6/12/24.</p> <p>The facility submitted their 5-day investigative report to the New York State Department of Health on 6/21/24 for an incident that occurred on 6/12/24.</p> <p>On 6/20/24 at 9:55 AM during an interview, Certified nurse aide #1 stated they were in the shower room down the hall from the Common Area and they heard Resident #1 and Registered Nurse#7 using raised voices, they stepped out of the shower room and went toward the common area and from the right side of Resident #1 they saw Registered Nurse #7 standing in front of Resident #1 and holding Resident #1 hands or upper arms, and heard Staff #7 (Registered Nurse) loudly saying, 'Stop, are you a baby?' Certified Nurse Aide #1 stated they saw the Speech Therapist at the nurse's station with Registered Nurse #7 and Resident #1. Certified Nurse aide #1 stated that Speech Therapist had a very good relationship with Resident #1 and frequently manages Resident #1 behavioral outbursts, and they were therefore not concerned, so they went back to the shower room.</p> <p>On 6/20/24 at 10:22 AM during an interview, Staff #2 (Speech Therapist) stated they were in another resident's room across the hall from the Common Area when they heard very loud voices, coming from the common area. They stated they saw Resident #1 sitting in their wheelchair yelling and Registered Nurse #7 standing over Resident #1 holding Resident #1 forearms down in their lap with their hands closed and screaming in a loud voice at Resident #1 saying [AGE] year-olds don't behave this way, cut it out! The Speech Therapist stated they walked towards Resident #1 and Registered Nurse #7 to assist, and Registered Nurse #7 stepped back and removed their hands from Resident #1. The Speech therapist stated they prompted Resident #1 to take deep breaths and brought Resident #1 to their room to calm down. The Speech Therapist stated they asked Resident #1 what had happened, and Resident #1 informed them that they had called their parents and neither of them picked up the phone. Resident #1 was very emotional and was crying when they explained not been able to reach their parents. The Speech Therapist stated they told Registered Nurse#7 that yelling at residents is unacceptable, but they were unsure if holding down Resident #1's hands was inappropriate, because they could not see it the Registered Nurse #7 was holding down Resident #1's hands with force or the Registered Nurse was preventing Resident #1 from hurting themselves. The Speech Therapist stated they were trained on abuse prohibition and reporting.</p> <p>On 6/20/24 at 11:12 AM during an interview with Nurse Manager for the common area (Staff #3), they stated that on 6/13/24 at approximately 9:00 AM, the Speech Therapist reported Resident #1 behavioral event and had a concern regarding whether Registered Nurse #7 managed the Resident #1's behaviors appropriately. Nurse Manager #3 stated that at approximately 1:00 PM, they performed a camera audit to see what had triggered Resident #1 behavior event and when they performed the audit, they observed Registered Nurse #7 closing their hands on Resident #1 forearms. The facility policy is only open-handed gentle touching of residents is acceptable. Nurse manager #3 stated they reported the incident to the Director of Nursing.</p> <p>On 6/20/24 at 11:40 AM during an interview, facility Administrator stated the incident was reported to them on 6/13/24. When they reviewed the camera footage, they felt uncomfortable with the alleged perpetrator's actions towards Resident #1 which included finger pointing and holding Resident #1 forearms with closed hands which are unacceptable interventions. The Administrator stated the police was called on 6/13/24 at 3:23pm. They stated that the alleged perpetrator is currently suspended, and the facility has yet to determine if the staff will be terminated.</p> <p>(continued on next page)</p>		

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