STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33A246	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Seton Children's Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (NY00381153/462978) from 7/31/25 to 8/7/25, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for one of two residents (Resident #119) reviewed for accidents. Specifically, staff did not perform a time out to double check if all strap eyelets were secured on the mechanical lift hooks prior to raising the lift up and Resident #119 slid out of the sling and dropped to the floor.Findings include:Resident #119 had diagnoses including cerebral palsy, seizure disorder, dependence on respirator, tracheostomy, and gastrostomy. The 12/31/20 Falls Care Plan documented the resident was at risk for falls related to lack of safety awareness, cognitive impairment, impaired balance, lack of voluntary extremity movements, spastic quadriplegia, and psychoactive drug use. The 2/21/25 Annual Minimum Data Set assessment documented Resident #119 had severely impaired cognition, was rarely/never understood, and was dependent on staff for all activities of daily living.The 5/16/25 Fall Assessment documented the resident scored a 12 (moderate risk for falls). The 5/19/25 Investigative Summary documented statements were obtained from Certified Nursing Aides #1 and #2, who were assisting with the transfer involving Resident #119 at the time of the fall. According to their reports, the hook mechanism securing the sling to the mechanical lift became detached from the sling eyelets while the lift was being raised from the wheelchair. Due to the resident's weight distribution, the staff members were unable to prevent the resident from sliding to the floor. The resident's care plan was updated with this occurrence; Re-education, and counseling was provided to both Certified Nurse Aides prior to returning to work; re-education was provided to all direct staff to reinforce the proper use of mechanical lift during transfers; house wide inspection was completed on all mechanical lifts and all were in working order; workflow review for all residents using a mechanical lift transfer while on a mechanical ventilator to have a Registered Nurse or Respiratory Therapy in direct oversight to further support a safe transfer; and transfer audits to be monitored for 60 days. The 5/19/25 Medical Note documented they were called, and it was reported that the resident fell on the floor. On exam noted no bruise or swelling or redness thus far. Clear breathing sound and no increased work of breathing. There was no facial grimacing. Placed cervical collar, then secured the resident's position.The 5/19/25 Hospital Paperwork documented the resident was seen in the emergency department and x-rays and CAT scan were done and both were negative for fracture.The 5/19/25 Employee Statement from Certified Nurse Aide #2 documented that at around 6:05 PM, Certified Nurse Aide #1 and Certified Nurse Aide #2 went to Resident #119's room. Resident #119 was seated in their wheelchair, connected to pulse ox and their feeding. Certified Nurse Aide # 2 documented they disconnected the resident from their pulse ox and feeding. After they were disconnected, they moved the resident's wheelchair and vent alongside the shower bed. Certified Nurse Aide #1 and Certified Nurse Aide #2 communicated to each other to ensure there was enough space for the lift next to the resident's wheelchair. They locked the wheels on the wheelchair and stretcher. They turned on the lift, moved it in position of the other side of resident's wheelchair and began to lower it. Once it was low enough, they attached each of the sling eyelets to the hooks. Certified Nurse Aide #2 was in (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	control of the lift, while Certified Nurse Aide #1 was on the other side of the resident's chair. Once the resident was high enough, Certified Nurse Aide #1 locked the wheelchair on their side, and Certified Nurse Aide #2 unlocked their side. Certified Nurse Aide #1 then pulled out the wheelchair, Certified Nurse Aide #2 continued to lift the resident. Certified Nurse Aide #2 noticed the resident appeared to be sliding out of the sling and called out to Certified Nurse Aide #1 for help. Certified Nurse Aide #1 then pushed the wheelchair and stretcher out of the way to run across the room to the resident. It happened so quickly, and the main thing they can remember is seeing Resident #119's tubing through the sling. It disconnected as Registered Nurse #6, and 2 certified nurse aides came to assist.The 5/20/25 Care Plan Note documented Resident #119 had a fall during transfer from the wheelchair to bed via use of the mechanical lift on 5/19/25 and was sent out to the hospital for evaluation to rule out fracture or bleed. X-ray and CAT scan were negative, and the resident returned to the facility. The 5/20/25 Medical Note documented emergency room visit, status post fall. X-ray of chest, pelvis, bilateral elbow, femur forearm, humerus, knees, as well as CAT scan of brain, head and cervical spine without contract done in the emergency department and were unremarkable.The 5/20/25 In-service and education on mechanical lift transfers documented time out when the staff are to double check all sling eyelets are secured onto the hooks of the mechanical lift. The staff will then count 1,2,3 ready and then will start to raise the resident up in the Arjo Lift. During an interview on 8/04/2025 at 2:18 PM, Certified Nurse Aide #1 stated they followed the transfer protocol. They took off the pulse ox machine and the extension to feeding tube. They further stated they locked the shower bed wheels. When they transferred Resident #119 via mechanical lift the wheels were locked. Certified Nurse Aide #1 stated while the resident was raised up in the lift pad sling, a sling eyelet was not secured from coming off the hook while they were lifting resident in mechanical lift. It appeared the resident tilted to right side and the resident was sliding out. Certified Nurse Aide #1 stated they could not pull the shower bed over to catch the resident quickly because it was locked. Certified Nurse Aide #1 stated they were able to break the resident's fall although they were unable to catch the resident. During an interview on 08/04/2025 at 2:30 PM, Certified Nurse Aide #2 stated Resident #119's wheelchair was positioned toward the bottom of the shower bed and vent toward the top. Certified Nurse Aide #2 was standing by the shower bed and Certified Nurse Aide #1 was standing by the wheelchair. They attached the sling eyelets to the hooks but they did not realize at the time that an eyelet came loose. Then the resident slid through the sling and fell. They called for help verbally yelling out, and pressed call button. Certified Nurse Aide #2 stated when one side of the sling was tightened it made the eyelet on the other side loosen and come off the hook. Certified Nurse Aide #2 stated when the re-education was provided the educator stressed ensuring the sling eyelets were on the hooks and wheel locks were secured in place prior to lifting a resident in a sling. During an interview on 8/04/2025 at 3:05 PM, Registered Nurse #6 stated Resident #119 was being transferred from wheelchair to shower bed by two (2) certified nurse aides. Registered Nurse #6 stated they heard a commotion and somebody calling for help, so they ran over to assist. Registered Nurse # 6 stated Resident #119 had fallen out of the sling and when they ran over the resident was on the floor and Certified Nurse Aide #1 was holding the resident's upper body and head. Registered Nurse #6 stated the mechanical lift sling has eyelets which get latched onto hooks, and they believe something happened with an eyelet and hook to cause the accident. Registered Nurse #6 stated Resident #119 had no injury. During an interview on 8/04/2025 at 3:16 PM, Registered Nurse/Unit Manager #7 stated one of the eyelets came off the hook during the transfer and resident fell to the floor. Registered Nurse/Unit Manager #7 stated the resident did not sustain any injuries. Registered Nurse/Unit Manager #7 stated they observed the sling after the incident and the sling and the mechanical lift were in good condition. Registered Nurse/Unit Manager #7 stated the BioMed Department assessed the mechanical lift and said it was working fine. Registered Nurse/Unit Manager #7 stated that prior to the incident, they were given in-services about how to connect the sling eyelets properly onto the hooks and were also re-educated on ensuring the sling eyelets are secured on the hooks. Registered Nurse/Unit Manager #7 stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	both Certified Nurse Aide #1 and #2 were given written disciplinary action.During a follow up interview on 8/07/2025 at 10:42 AM, Certified Nurse Aide #1 stated they were educated prior to the incident on transfers using mechanical lifts. Certified Nurse Aide #1 stated they realized that they did not do the time out process, which is part of the instructions where they all stop to ensure the sling eyelets are secured to the hooks. Certified Nurse Aide #1 stated after the incident the facility stressed heavily using time out before proceeding with lifting the resident. Certified Nurse Aide #1 stated they were given a disciplinary write up after the incident.During a follow up interview on 8/07/2025 at 12:38 PM, Certified Nurse Aide #2 stated they did not call time out during the incident. They stated they were not sure if they checked everything they should have the day of the incident. Certified Nurse Aide #2 stated they were given transfer training education on the mechanical lift prior to the incident. Certified Nurse Aide #2 stated they were re-educated to call time out, to check that the sling eyelets were secured on the hooks, and that all cords and tubing are in safe position and all count 1,2,3 together before they lift the resident up. 10NYCRR 415.12(h)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interviews during the recertification survey from 7/31/25 to 8/7/25, the facility did not ensure that staff maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #72) reviewed for infection control. Specifically, Resident #72 was on contact precautions until 8/1/25 and a housekeeper was observed doing a terminal cleaning of Resident #72's room and did not use the proper personal protective equipment while removing a privacy/cubicle curtain. Findings include:The Terminal Room Cleaning Policy dated 12/2012 documented when a room comes off isolation or when a resident is discharged , terminal cleaning will occur. The purpose is to provide residents, staff, and visitors with a sanitary and comfortable environment and endeavor to prevent the development and transmission of infection. It further documented in the procedures to make sure to wear personal protective equipment (gowns, gloves and masks), remove all privacy/cubicle curtains and send to laundry for washing. Resident #72 was admitted to facility with diagnoses including thyroid disorder, diabetes insipidus, and unspecified lack of expected normal physiological development in childhood. The 7/22/25 Annual Minimum Data Set assessment documented the resident had severe cognitive deficits. Resident #72 was able to eat with substantial to maximal assist and was dependent on staff for all other areas of activities of daily living. The 7/24/25 Physician Order documented Resident #72 was put on contact precautions which was discontinued on 8/1/25.During an observation on 7/31/25 at 10:12 AM Resident #72 was in their room with a contact precaution sign on the door. During an interview on 8/1/25 at 10:25 AM Registered Nurse #4 stated the resident was taken off contact precautions today at 7:22 AM. They stated the resident had been on contact precautions for positive Rhino-Entero virus.During an observation on 8/1/25 at 10:33 AM, Housekeeper #3 was doing a terminal cleaning of Resident #72's room and was removing privacy/cubicle curtain. Housekeeper #3 was wearing only gloves and a mask. During an interview on 8/1/25 at 10:35 AM, Housekeeper #3 stated when they do a terminal cleaning after contact precaution was discontinued, they were only instructed to use gloves and a mask. During an interview on 8/01/2025 at 11:05 AM, the Infection Preventionist stated Resident #72 was on contact precautions for 7 days that ended on 8/1/25. The Infection Preventionist stated during a terminal cleaning staff clean all surfaces, including privacy/cubicle curtains. The Infection Preventionist stated when removing a privacy curtain, staff should wear the proper personal protective equipment including a gown. During an interview on 8/07/2025 at 11:15 AM, the Director of Environmental Services and Security stated when they did a terminal cleaning after contact precautions were discontinued, the staff was required to wear personal protective equipment including a gown, gloves, and a mask. Privacy/cubicle curtains were removed, washed and returned to the room the same day. The Director of Environmental Services and Security stated Housekeeper #3 was trained by them or the environmental supervisor for use of personal protective equipment, terminal cleaning and infection control. The Director of Environmental Services and Security stated Housekeeper #3 was last trained on terminal cleaning and infection control in March of 2025. 10NYCRR 415.19(a)(1-3)(b)(2)