STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fordham Nursing and Rehabilitation Center	2678 Kingsbridge Terrace Bronx, NY 10463

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285 Based on observation, record review and interviews during an abbreviated and Partial Extended Survey (NY00294473), the facility failed to protect resident's rights to be free from sexual abuse and psychosocial harm using the reasonable person concept. The facility did not ensure each resident was free from abuse for 1 out of 6 residents (Resident # 1). Specifically, on 4/18/22 at approximately 11:30 PM, CNA #1 observed LPN #1 in the room of Resident #1 who was diagnosed with dementia and severely impaired cognition. CNA #1 observed LPN #1 naked from the waist down, with pants at the ankles and Resident #1 was observed lying across the bed naked from the waist down, not wearing disposable brief or underwear. Resident #1's buttocks were rested on the edge of the bed and legs elevated in the air. CNA#1 informed the RNS supervisor of the incident. The RNS immediately went to assess Resident #1 who refused physical assessment and denied (through Spanish interpreter) that a man was ever in their room or was assaulted. Resident #1 was transferred to the to the ER (emergency room). This resulted in Substandard Quality of Care that was Immediate Jeopardy with the likelihood for serious injury and harm using the reasonable person concept for Resident #1. The findings are: The facility's Policy and Procedure entitled Reporting and Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation/Exploitation dated 11/2021, documented: All personnel have the responsibility to report any incident or suspected incident of resident abuse, including injuries of an unknown source. The facility shall conduct a thorough investigation of all alleged violations involving exploitation, mistreatment, neglect or abuse, and misappropriation of resident property and comply with State reporting regulations. Sexual Abuse was defined as non-consensual sexual contact of any type with a resident. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility investigation dated 04/18/2022, documented on 04/18/2022 at approximately 11:30PM, CNA #1 observed Resident #1 lying in bed on their back with their legs up in the air without a disposable brief. LPN #1 was standing in front of Resident #1, 1-2 feet away from Resident #1 with their pants down. LPN #1 immediately pulled up their pants and followed CNA #1 into the hallway as CNA # 1 tried to use the elevator. CNA #1 stated that LPN #1 tried to hinder CNA #1 from reporting what was seen. CNA #1 reported what was witnessed to the Registered Nurse Supervisor (RNS #1). RNS #1 attempted to assess Resident #1, but Resident #1 refused the assessment. Resident #1 was interviewed with an interpreter, and Resident #1 denied seeing a man in their room. The Director of Nursing (DON) was notified and 911 was called. Police Officers arrived at the facility at 12:56 AM, obtained statements from the staff and directed LPN #1 not to leave the facility. Resident #1 with diagnoses that included Dementia, Peripheral Vascular Disease and Hypertension. Resident #1 resided on the Dementia Unit. The Quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 05 out of 15, indicating Resident #1 had severely impaired cognition. A Comprehensive Care Plan (CCP), dated 5/26/2021, identified that Resident #1 is at risk to be a victim of abuse, neglect and or mistreatment and documented interventions that are necessary to ensure the safety of Resident #1. A Physician's order dated 05/26/2021, ordered Donepezil HCI tablet 5 milligrams (mg), give 1 tablet orally at bedtime for Dementia; Memantine HCI tablet 5 mg, give 1 tablet orally every 12 hours for Dementia. A nursing note, by Registered Nurse Supervisor (RNS) #1, dated 04/19/2022 at 12:02PM, documented they received a call from CNA #1 regarding inappropriate behavior by a nurse LPN #1 with Resident #1 that was witnessed by CNA #1, while doing rounds on the unit. During an interview on 04/20/2022 at 10:15 AM, CNA #1 stated that he/she was employed at the facility for 2 years and worked with LPN #1 for six months on the Dementia unit on the 11-7 shift. CNA #1 arrived at the facility at 11:19 PM on 04/18/2022, to begin the 11-7 shift and went to the second dementia unit to start making their rounds on the unit. CNA #1 stated, upon arrival at Resident # 1's room, the door was closed, and they opened the door. Upon opening the door, CNA #1 stated they observed LPN #1 standing at the side of Resident #1's bed. Resident #1 was lying across the bed with their nude buttock at the edge of the bed and both legs elevated in the air. CNA # 1 stated that he/she observed LPN #1's pants were down around their ankles. CNA #1 stated that Resident #1 was not making any sounds when they opened the door to the resident's room and LPN #1 bent down to pull up their pants. CNA #1 stated that LPN #1 exited Resident #1's room and spoke to CNA #1, telling CNA #1 not to report what was witnessed. CNA #1 stated they reported what was seen to the RNS #1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Fordham Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2678 Kingsbridge Terrace Bronx, NY 10463	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/19/2022 at 2:00 PM, RNS #1 stated that he/she received a call from the security guard at approximately 12:10 AM on 4/19/2022 stating that CNA #1 would like to speak with them. RNS #1 stated that he/she went to Resident #1's unit at 12:30 AM. RNS #1 stated that CNA #1 reported that he/she observed LPN #1 standing in Resident #1's room with their pants down. Resident #1 was observed lying on their back without a disposable brief on with both legs elevated in the air. RNS #1 stated that Resident #1 refused physical assessment. RNS #1 stated the Director of Nursing (DON) was called at 12:37 AM and informed of the incident. The DON advised RNS #1 to call the Police. Police Officers arrived and took LPN #1 into custody. During a follow up interview on 04/20/2022 at 6:00PM, RNS #1 stated that observational rounds were performed on each unit 2-3 times during all tours. RNS #1 reported that spot checks are performed on the unit to ensure that staff members are providing care to the residents. An observational round was performed on the dementia unit at 11:00 PM on 04/18/2022. During an interview on 04/20/2022 at 5:04 PM, the DON stated a call was received from RNS #1 on 04/19/2022 at 12:37 AM to report the allegation involving Resident #1. The DON stated that RNS #1 was instructed to remove LPN #1 from the unit and to call the Police. The DON stated that RNS #1 followed the facility's protocol and protected Resident #1. The DON stated that Resident #1 refused a body assessment and was transferred to the hospital for a rape kit per the Medical Doctor's order. The DON stated that Resident #1's family was notified. The DON stated that RNS #1 is responsible for monitoring resident's care and supervising the staff by conducting rounds on the units three times while on tour and as needed. The RNS #1 did rounds on the Demented Unit at 11:00 PM. On 4/18/2022 there were 2 RNs, 4 LPNs and 13 CNA on duty for the 11:00 PM to 07:00 AM shift. Immediate Jeopardy (IJ) was identified and declared. The facility Administrator and Director of Nursing were notified on 04/21/2022 at 7:33 PM. The facility submitted a removal plan that was reviewed and accepted by NYSDOH on 04/21/2022 at 10:10 PM. On 04/22/2022 at 5:40 PM, the survey team determined IJ was removed based on the following corrective actions taken by the facility: 911 was called on 04/19/2022 at 12:42 AM to report the incident from 04/18/2022 and Police Officers arrived at about 12:56 AM. The staff was interviewed. The resident was cognitively impaired and was not able to provide pertinent information. LPN #1 was arrested by the Police Officers on 04/19/2022. The facility terminated the LPN from his/her employment on 04/19/2022. The Facility reported the LPN to the Office of the Professions on 04/20/2022. The Social Services staff interviewed 39 out of 40 residents on Unit 2. There were no findings that would indicate that there are any other residents who had similar concerns or issues. All employee files were reviewed for appropriate background checks, license verifications and other regulatory requirements for employment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The comprehensive care plans of all residents were checked to ensure there is a plan in place to prevent abuse. Nightly audits on the Dementia Unit will be conducted by the RN Supervisor for proper resident monitoring. On 04/22/2022 the facility provided re-in-service on Abuse Prevention and Resident's Rights. The Surveyors reviewed in-service attendance sheet dated 04/22/2022. Listed as follows: Administration/Admission 3/3 = 100%; Maintenance 3/4 = 75%; Directors 8/8 = 100%; Fiscals 2/2 = 100%; MDS 2/2 = 100%; Recreation 4/4 = 100%; Housekeeping 19/20 = 95%; Dietary 23/23 = 100%; Nursing LPN 15/15 = 100%; RNS 28/28 = 100%, CNA 90/90 = 100%, and Security 10/10 = 100%. The Surveyors conducted interviews with the following staff regarding Abuse Prevention and Resident's Rights: 19 CNAs, 4 LPNs, 6 RNs, 4 Housekeepers, 3 Occupational Therapists, 6 Physical Therapists, 1 Speech Therapist, 1 Social Worker, 8 dietary Aides, 1 maintenance workers, 3 Recreation staff, 2 Security Guards, 1 ADON, 1 DON, 1 Administration, 1 IT/Central Supply, and 1 Nursing Liaison. All staff stated they were in-serviced, and staff were knowledgeable on the policy and procedures regarding Abuse Prevention and Resident's Rights. The new policy for resident monitoring will be part of new hires' mandatory in-service for nursing staff. 415.4(b)(1)(i)