STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335146	A. BUILDING _____ B. WING _____	**08/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRVIEW NURSING CARE CENTER INC	**69 70 GRAND CENTRAL PARKWAY FOREST HILLS, NY 11375**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview conducted during the Infection Control Focus and Abbreviated Survey (NY 266), the facility did not ensure that abuse policies and procedures were implemented. Specifically, there was no documented evidence that a Certified Nursing Assistant (CNA) reported an altercation with a resident to facility staff in order to facilitate a thorough investigation. This was evident for 1 of 1 resident reviewed for Abuse/Neglect. (Resident # 1). The findings are: The undated facility policy and procedure for titled Abuse Prevention documented that the facility will protect its residents from abuse and neglect in accordance with State and Federal Regulations. The facility policy further documented that all employees will be trained and be knowledgeable about the facility's abuse and prevention policy. Training will be provided as follows: how to report allegation or suspected abuse cases, appropriate behavior interventions. Resident # 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had moderately impaired cognition and the resident required extensive assistance with bed mobility and transfer. On 08/03/20 at 11:00 AM, the resident was observed in bed, alert and awake. The resident stated an incident happened a while back which was reported to the resident's designated representative and the resident declined to talk further about it. On 08/03/20 at 12:00 PM, an interview was conducted with the resident's designated representative in response to a complaint called into the Department of Health (NY 266). The resident's representative stated the resident contacted him and reported a staff member had been throwing water on the resident. The resident representative stated that he had not been able to contact any one at the facility to report the incident so reported the incident to the police department. On 08/03/20, at 10:30 AM, the Director of Nursing (DON) was asked to provide all investigation allegations completed for Resident # 1. The DON stated that there was no incident investigation completed for the resident. On 08/03/20 at 3:00 PM, an interview was conducted with the CNA #1. CNA #1 stated he had been working for the past 4 months as a concierge and job duties included visiting different units to offer facility cell phones to residents who want to contact their relatives. CNA # 1 also stated that about a week ago he pushed Resident #1 in a wheelchair to the bedroom and the resident punched him in his face. CNA # 1 further stated he did not report the incident to anyone at the facility and instead called the police. The officers came to the facility and took a statement from him. The CNA also stated that he received training on abuse and was fully aware that incidents such as these needed to be reported to his supervisor, but he felt issues were not addressed at the facility and so he called the police. Inservice record for CNA #1 dated 4/7/20 titled Reporting Patient Abuse documented that every residential healthcare facility employee must report occurrences of patient physical abuse. The record did not document procedures to be followed if a staff person is assaulted by a resident. On 08/3/20 at 3:25 PM, an interview was conducted with the Charge Nurse (RN #1) for the unit. RN #1 stated that he was not informed of any incident that occurred between the resident and CNA#1. RN #1 also stated that the protocol is for staff to report such incident to the RN who would then report it to the DON. On 08/03/20 at 3:45 PM, an interview was conducted with the DON. The DON stated when incidents occur, they should be reported to the Charge Nurse, who would then report it to the DON. All staff have been in-serviced on abuse policies and this is done upon hire and annually as part of the job training protocol. The DON further stated that she had not been informed about any incidents involving an altercation between the CNA and a resident so an investigation was not initiated. 415.4 (b)

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

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.