STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335780	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA PROMESA	**308 EAST 175 STREET 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)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the second Focused Infection Control Survey (FICS) and Complaint Investigation Survey (Complaint #NY 434), the facility did not ensure alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to the administrator and State Survey Agency. Specifically, a resident-to-resident physical altercation that occurred on 07/10/2020 was identified as abuse, but it was not reported to the State Survey Agency until 07/15/2020. This was evident for 1 of 2 residents reviewed for abuse (Resident #2). The finding is: The facility policy and procedure titled, Abuse, Neglect, and Mistreatment of [REDACTED]. It also documented the following, .investigating abuse .an investigation report form is filed with the administrator within 24 hours of the receipt of the report of abuse .all suspected cases of abuse will be promptly reported to the New York State Department of Health .the facility should not conduct a complete investigation before reporting to the NYSDOH. In order to gather the best evidence relevant to the allegation, it is necessary that the NYSDOH be told that there is reasonable cause to believe that abuse has occurred. Timing is therefore important and there should be no delay .the administrator or his/her designee will provide the appropriate agencies/individuals listed above with a written report of the findings of the investigation, within 5 days of the occurrence of the incident. Should the findings reveal that abuse did occur, the written report will include the corrective actions taken by the facility to prevent abuse from recurring . The facility's investigation summary for the physical altercation between resident #1 and #2 documented the altercation ocurred on 7/11/2020 and was reported to the New York State Department of Health (NYSDOH) on 07/14/2020. The NYSDOH Intake Information form documented the complaint intake was received on 07/15/2020. Resident #1 was admitted with [DIAGNOSES REDACTED]. Resident #1 was identified as the aggressor. Resident #1 Minimum Data Set (MDS) 3.0 Significant Change assessment dated [DATE] documented the resident with moderately impaired cognitive status. The resident did not exhibit behaviors during this assessment period. The Activities of Daily Living (ADL) indicated resident required extensive with one assist for transfers. Active [DIAGNOSES REDACTED]. The resident received 7 days of Antipsychotic medication. Resident #1 MDS 3.0 Quarterly assessment dated [DATE] documented the resident with moderately impaired cognitive status. The resident had episodes of inattention and disorganized thinking. There were no behaviors exhibited during this assessment period. The resident required extensive with one assist for transfers. Active [DIAGNOSES REDACTED]. The resident received 7 days of Antipsychotic medication. Resident #2 was admitted with [DIAGNOSES REDACTED]. Resident #2 was identified as the victim. Resident #2 MDS 3.0 Quarterly assessment dated [DATE] documented the resident with intact cognition scoring a 15 on the Brief Interview for Mental Status (BIMS). The resident did not have mood symptoms. The resident did not exhibit behaviors during the assessment period. The ADL's documented resident was independent for transfers. Active [DIAGNOSES REDACTED]. Progress notes were reviewed from 07/01/2020 to 07/15/2020 for resident #1 and #2 which revealed the following. The resident to resident altercation occurred on 07/10/2020 and not on 07/11/2020 as per nursing progress note dated 07/10/2020. On 08/13/2020 at 02:24 PM, the Social Work Director (SWD) was interviewed and stated the Director of Nursing (DON) is responsible for completing the investigation and reporting abuse allegations to NYSDOH. He further stated that this incident is reportable abuse because the resident was hit. On 08/13/2020 at 03:00 PM, the Administrator was interviewed and stated the DON who is currently on family medical leave was the one who completed the investigation and reported the incident to the NYSDOH. The administrator stated if there is an allegation of abuse, it should be reported within 24 hours of the occurrence. The Administrator could not explain why this incident was not reported timely. On 08/13/2020 at 04:00 PM, the MDS Director was interviewed and stated that she has been taking on some responsibilities of the DON since he is currently out on leave. The MDS director stated she is the alternate person to report abuse to the NYSDOH in the Health Emergency Response System (HERDS). She stated any abuse allegation should be reported within 24 hours and could not explain why this incident was not reported timely. 415.4(b)(2)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the second Focused Infection Control Survey (FICS) and Complaint Investigation Survey (Complaint #NY 434), the facility did not ensure corrective actions were implemented to help prevent further potential abuse while the investigation was in progress. Specifically, the facility did not implement the corrective action of every (Q) 30-minute checks following and incident of resident-to-resident abuse. This was evident for 2 residents reviewed for abuse (Resident #1 and #2). The findings are: The facility policy and procedure titled, Abuse, Neglect, and Mistreatment of [REDACTED].the IDT completes an assessment of appropriate intervention strategies once risk is identified, to prevent occurrences. Such strategies might include, but are not limited to psychiatric evaluation, individual or group psychotherapy, specialized activity programs, increased supervision, diversional task activities, etc .Develops a plan of care that reflects individualized interventions, including monitoring the resident/client for any changes in behavior, identifying potential triggers to specific behavior, and communicating specific strategies to all involved caregivers .Should the findings reveal that abuse did occur, the written report will include the corrective actions taken by the facility to prevent abuse from recurring . The facility policy and procedure titled, Resident to Resident Abuse (Dated 11/2001) was reviewed. The policy documented the following, .all incidents of resident to resident abuse will be investigated, and appropriate interventions will be initiated without delay to prevent recurrence . In the event of resident to resident abuse, the staff will (a) immediately separate the residents during the incident (b) notify the nursing supervisor immediately of the incident (c) assess both residents for any signs of injury, with appropriate first aid (d) notify the medical provider of the incident (e) notify the psychiatrist of the incident (f) notify administrator .IDT initiate immediate interventions to prevent any further incidents .the interdisciplinary team will be informed of the incident and will review both resident's care plans and revise as needed, including possible room change, psychological services, increased recreational activities, etc. IDT closely monitor any future interactions between the two residents and intervene as needed. Closely monitor the interactions of the resident who committed the abuse with other residents and intervene as needed .Reporting procedures will be followed, and records of the incident will be maintained. The investigation summary for a physical altercation between Resident #1 and Resident #2 documented the following: Resident #2 was sitting in his wheelchair about 07:15 PM, when his roommate, Resident #1, asked him for a cigarette. He told him he did not have one, so resident #1 hit him with a urinal on the forehead. No one was injured. The facility concluded the incident was resident-to-resident abuse, but the aggressor is confused. Interventions included separation of residents, encouraging residents to go to staff first when having disagreements, Q 30-minute checks for both residents, and a room change for Resident #1. 1) Resident #1, the Aggressor, has [DIAGNOSES REDACTED]. The Minimum Data Set 3.0 (MDS) assessment

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.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dated [DATE] documented the resident had moderately impaired cogniton. There were no behaviors exhibited. The CCP titled, Physical Altercation (Initiated 07/10/2020 and Last Updated 07/11/2020) documented the resident was involved in a physical altercation with a peer where he was the aggressor. Interventions included monitoring for changes in mood and encourage verbalization of feelings while encouraging anger management groups participation during the next 90 days. There was no documented evidence the resident's CCP reflected the intervention of Q30-minute checks after the altercation, as specified in the investigation summary, to prevent further potential abuse. The Progress notes were reviewed from 07/01/2020 to 07/15/2020. The notes documented the resident was monitored every 60 minutes for falls. A nursing progress note dated 07/10/2020, documented the resident was observed in an altercation with his roommate where staff intervenente and taken out of the room. The facility monitoring form dated from 07/01/2020 to 07/15/2020 documented resident was monited for every 60-minutes for falls/elopement and there was no documentation that the resident was monitored every 30 minutes for behaviors. There was no documented evidence that the resident was placed on every 30-minute monitoring for behaviors following the physical altercation on 07/10/2020 to prevent further potential abuse. 2) Resident #2, the Victim, had [DIAGNOSES REDACTED]. Resident #2 was identified as the victim in this facility reported incident. The MDS 3.0 Quarterly assessment dated [DATE] documented the resident with intact cognition. The resident did not have mood symptoms. The resident did not exhibit behaviors during the assessment period. On 08/13/2020 at 09:50 AM, Resident #2 stated he was lying in bed when Resident #1 approached him, asking him for a cigarette. When he said he did not have any cigarettes because he does not smoke, Resident #1 came at him with the plastic urinal hitting him on the forehead. Resident #2 stated he was not injured and pushed Resident #1's hand away. Resident #2 denied using any item to hit Resident #1 back. Resident #2 stated the staff intervened right away and separated them. He further stated that the staff changed his room. Resident #2 stated he feels safe where he is currently residing. The Comprehensive Care Plan (CCP) titled, Behavior Symptoms: Physical Abuse (Initiated 03/03/2020 and Last Updated 07/11/2020) included the following interventions: (1) Remove resident from situation triggering behavior (2) Allow resident time to de-escalate when agitated (3) Notify and report behavioral changes to MD. (4) Document in the medical record the intensity, duration or frequency of behavior. (5) Social service evaluation and follow-up. (6) Redirect negative behaviors. (7) Refer for Psychiatric consult. (8) Administer medications as ordered by physician. (9) Assess/evaluate comfort level and medicate as necessary. Updates on both 07/10/2020 and 07/11/2020 documented the resident was involved in a physical altercation with Resident #1. There was no documented evidence the resident's CCP was revised to reflect the new intervention of Q 30-minute checks to prevent further potential abuse after the altercation on 7/10/20. The Progress notes were reviewed from 07/01/2020 to 07/14/2020 and there was no documented evidence that the resident was on a every 30-minute monitoring for behaviors following the physical altercation on 07/10/2020 to prevent further potential abuse. There was no documented evidence that a facility monitoring form for every 30 minute checks was completed following the physical altercation on 07/10/2020 to prevent further abuse. The facility in-services on Abuse was reviewed. The staff received in-service on 05/21/2020 titled, Types of Nursing Home Abuse and Casa Promesa Abuse Prevention Plan and Understanding and Helping Patients who Self Harm. The in-services included information on different types of abuse, an abuse prevention plan, understanding self-injury, and behavioral interventions. On 08/13/2020 at 01:50 PM, the Certified Nursing Assistant (CNA) #1 was interviewed. CNA #1 stated she did not witness incident but was working on the unit at the time. She stated that she heard of the incident and was told the residents were separated immediately, and Resident #2 had a room change. There were no further issues between the residents. CNA #1 stated when there is a resident to resident altercation, the protocol is to separate them immediately and to notify the nurse in charge. Interventions applied usually include Q30-minute monitoring and room changes. She further stated the head nurse is responsible for implementing monitoring and documenting in the monitoring book. CNA #1 stated Resident #1 was on every 60-minute monitoring because he is at risk for falls. She was not sure if Resident #1 was on every 30-minute monitoring. On 08/13/2020 at 01:55 PM, CNA #2 was interviewed and stated she did not witness the incident, but she was working on the unit at the time. She stated she heard of the incident and was told Resident #1 and #2 were separated immediately and Resident #2 had a room change. CNA #2 stated when there is a resident-to-resident altercation, the protocol is to separate them immediately to protect them and to calm them down. Interventions applied are normally to have a room change and have a counselor come to talk with them. CNA #2 was not aware if the residents were placed on every 30-minute monitoring. On 08/13/2020 at 02:15 PM, the Licensed Practical Nurse (LPN) was interviewed and stated she was on break when the incident occurred. She was told of what had happened. LPN stated when there is a resident-to-resident altercation, the protocol is to separate them immediately, do a room change, assess the residents, and implement a 30- or 60-minute check, which the CNA's complete during their rounds. On 08/13/2020 at 02:24 PM, the Social Work Director (SWD) was interviewed and stated he was not on duty when the incident occurred. He further stated when there is a resident to resident altercation, the first thing to do is to assess to see who the aggressor and victim was by looking at their history. Resident #1 is a [MEDICAL CONDITION] (TBI) and cognitively impaired resident. Resident #2 is alert and oriented with no past behaviors. Residents are separated immediately during an altercation and the aggressor is usually moved to another floor or unit. In this case, the victim was moved instead due to Resident #1 being confused. Nursing usually completes a Q 30-minute monitoring form after resident altercations. On 08/13/2020 at 03:00 PM, the Administrator was interviewed and stated the DON was the one who completed the investigation and reported the incident to the NYSDOH. The administrator stated if there was any abuse incident, it is reported to the interdisciplinary team to discuss and review interventions of both the aggressor and victim. Psychiatry is also usually involved to help assess for any emotional trauma. The interdisciplinary team would meet to discuss interventions and update the CCP. Interventions after a resident to resident altercation usually include Q 30-minute checks, separation, and a room change to a different floor. She further stated she was not sure why the 30-minute checks were not completed. On 08/13/2020 at 04:00 PM, the MDS Director was interviewed and stated that she has been taking on some responsibilities of the DON since he is currently out on leave. The MDS director stated nursing is responsible for implementing every 30-minute checks and communicating the assignment to the CNA. She further stated the 30-minute checks for both residents were not completed, with the exception of the 60-minute check for falls for Resident #2. 415.4(b)(3-4)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the second Focused Infection Control Survey (FICS) and Complaints Investigation Survey (Complaint #NY 434), the facility did not ensure the Comprehensive Care Plan (CCP) was revised, specifically, resident #1 and #2 CCP were not revised to reflect the interventions and corrective action implemented following a resident to resident physical altercation to prevent further potential abuse. This was evident for 2 residents investigated for abuse (Resident #1 and #2). The finding is. The facility policy and procedure titled, Abuse, Neglect, and Mistreatment of [REDACTED].Develops a plan of care that reflects individualized interventions, including monitoring the resident/client for any changes in behavior, identifying potential triggers to specific behavior, and communicating specific strategies to all involved caregivers .Evaluates and revises the care plan monthly or as needed .assess and monitor residents/clients with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues . The facility policy and procedure titled, Resident to Resident Abuse (Dated 11/2001) was reviewed. The policy documentedthe following, .the interdisciplinary team will also initiate a specific and individualized plan of care for the resident at risk for being abused by other residents .the Interdisciplinary Team (IDT) will initiate immediate interventions to prevent any further incidents, review both residents' care plans, and revise as needed The facility's investigation summary for the physical altercation between Resident #1 and Resident #2 documented the incident ocurred on 7/11/20. Resident #2 was sitting in his wheelchair about 07:15 PM, when their roommate, Resident #1, asked for a cigarette. Resident #2 told Resident #1 they did not have one, so Resident #1 hit Resident #2 with a urinal on the forehead. No one was injured. The investigation concluded, the incident was considered resident-to-resident abuse, but the aggressor was confused. Interventions includeded: Separate residents; Encourage residents to go to staff first when having disagreements; Q30 minute checks for both residents; and a Room Change for Resident #1. (1) Resident #1 has [DIAGNOSES REDACTED]. Resident #1 was identified as the aggressor in this facility reported incident. The Minimum Data Set 3.0 (MDS) Significant Change assessment dated [DATE] documented the resident had moderately impaired cognition. The resident did not exhibit behaviors during the assessment period. The MDS Quarterly assessment dated [DATE] documented the resident had moderately impaired cognition with episodes of inattention and disorganized thinking. There were no behaviors

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) exhibited during the assessment period. The CCP titled, Physical Altercation (Initiated 07/10/2020 and Last Updated 07/11/2020) documented the resident was the aggressor in a physical altercation with a peer. Interventions included monitor for changes in mood and encourage verbalization of feeling while encouraging anger management groups participation. The Progress notes were reviewed from 07/01/2020 to 07/15/2020. A nursing progress note dated 07/10/2020, documented the resident was observed in an altercation with his roommate where staff intervened and took him out of the room. There was no documented evidence the resident's CCP was revised with the recommended intervention of Q 30-minute checks following the physical altercation on 07/10/2020 to prevent further potential abuse. (2) Resident #2 has [DIAGNOSES REDACTED]. Resident #2 was identified as the victim in this facility reported incident. The MDS 3.0 Quarterly assessment dated [DATE] documented the resident had intact cognition. The resident did not have mood symptoms or behaviors during the assessment period. The CCP titeld, Behavior Symptoms: Physical Abuse (Initiated 03/03/2020 and Last Updated 07/11/2020) documented the following interventions: (1) Remove resident from situation triggering behavior (2) Allow resident time to de-escalate when agitated (3) Notify and report behavioral changes to MD. (4) Document in the medical record the intensity, duration or frequency of behavior. (5) Social service evaluation and follow-up. (6) Redirect negative behaviors. (7) Refer for Psychiatric consult. (8) Administer medications as ordered by physician. (9) Assess/evaluate comfort level and medicate as necessary. Updates on both 07/10/2020 and 07/11/2020 documented the resident was involved in a physical altercation with Resident #1. The Progress notes were reviewed from 07/01/2020 to 07/15/2020. A social work progress note dated 07/10/2020, documented the resident was involved in a physical altercation and was attacked by Resident #1. There was no documented evidence the resident's CCP was revised with the recommended intervention of Q 30-minute checks after the altercation on 7/10/20 to prevent further potential abuse. On 08/13/2020 at 04:00 PM, the MDS Director was interviewed and stated that she has been taking on some responsibilities of the DON since he is currently out on leave. The MDS director stated nursing is responsible for implementing every 30-minute check and communicate to the CNA. She further stated the 30-minute checks for both residents were not completed with the exception of the 60-minute check for falls for resident #2. The MDS director also stated the CCP should have been updated to reflect the new interventions. She was not able to explain why it was not done. 415.11(c)(2)(i)-(iii)