STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335100	A. BUILDING _____ B. WING _____	**08/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ISABELLA GERIATRIC CENTER INC	**515 AUDUBON AVENUE NEW YORK, NY 10040**

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 observation, interview, and record review conducted during an abbreviated survey (NY 008), the facility did not ensure that all alleged violations involving abuse are reported immediately. This was evident in 1 of 3 residents sampled (Resident #1), Specifically, on 07/21/2020, three (3) nursing staff members reported to Registered Nurse #1 (RN #1) an allegation of staff to resident abuse. The allegation was not reported to the facility's Administrator or Director of Nursing within 2 hours. In addition, no interventions were implemented on 07/21/2020 to protect Resident #1. The findings are: A facility policy and procedure related to Abuse Prohibition - Prevention and reporting, updated November 2018, documented all staff/volunteers are to intervene to stop suspected abuse, report the incident immediately to the departmental supervisor for further investigation. All alleged violations involving abuse are reported immediately but not later than 2 hours after the allegation is made or no later than 24 hours if the events did not involve abuse. If the health care professional licensed by the State Education Department fails to report, the licensing board will be notified and may take disciplinary action. Following a report, the Administrator on Call and Risk manager are to be notified. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 05/01/2020 documented that Resident #1 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15 associated with intact cognition. Resident #1 required total assistance of two (2) people for bathing and toileting. A Nursing Note dated 07/22/2020 documented that Resident #1 was observed at approximately 2:15AM with scratch marks to the right arm. Resident #1 denied pain, the Medical Doctor (MD) was made aware, and an incident report was initiated. Review of the facility's Accident/Incident Report dated 07/23/2020, revealed that on 07/21/2020, Resident #1 reported to Licensed Practical Nurse #1 (LPN #1) that Certified Nursing Assistant #1 (CNA #1), who was assigned to Resident #1, was aggressive and LPN #1 reported the allegation to RN #1. The report further revealed that on 07/21/2020, CNA #2 assisted CNA #1 twice in providing care to Resident #1 on the evening shift. CNA #2 reported that at approximately 5:45 PM on 07/21/2020, she went to Resident #1's room to assist CNA #1 with the resident's care. CNA #2 stated that CNA #1 and Resident #1 appeared to be arguing. CNA #2 observed CNA #1 forcefully turned Resident #1 to the side. CNA #1 also picked up Resident #1's head and dropped it onto the pillow without any caution. On 07/21/2020 at approximately 9:00PM, LPN #2 observed that CNA #1 was being rough with Resident #1. LPN #2 documented that she instructed CNA #1 to calm down and get control of herself. LPN #2 also instructed Resident #1 to cooperate with CNA #1 so care could be completed. LPN #2 documented that RN #1 was notified. On 07/21/2020, CNA #2 documented that later on in the evening, she assisted CNA #1 with a second change. LPN #2 was in Resident #1's room assisting CNA #1, but left the room when CNA #2 arrived. CNA #2 observed CNA #1 talking angrily to Resident #1 and forcefully turned the resident onto the side causing the ventilator tube to come out. CNA #2 told CNA #1 several times to stop and put the ventilator tube back in. CNA #1 ignored CNA #2. CNA #2 observed CNA #1 pulled up Resident #1's head to adjust the pillow and drop the resident's head down harshly. CNA #2 reported that she became scared and left the room to call the Respiratory Therapist. CNA #2 reported the incident immediately to RN #1. Review of the Accident/Incident Report revealed that three staff members reported an allegation of staff to resident abuse to RN #1. Record review revealed that Resident #1 was not assessed. Neither the Administrator nor Director of Nursing (DON) was not notified within 2 hours of the allegations. The Medical Doctor (MD) was not notified and no interventions were implemented on 07/21/2020. CNA #1 continued caring for Resident #1 until her 3-11 shift ended. The DON and the Administrator became aware of the abuse allegation on 07/22/2020 and an investigation was initiated. The DON was interviewed on 08/03/2020 at 12:25PM and stated that the incident was reported in the morning meeting on 07/22/2020, an investigation was initiated. The staff members thought that RN #1 would have addressed the issues identified with CNA #1 and Resident #1. If the staff members witness abuse, they should stop the abuse, remove the abuser immediately and call someone in Administration. The DON stated that if the charge nurse or RN #1 did not respond to the abuse allegation or rough handling, the LPN should have called the nursing supervisor or someone in Administration. The Administrator was interviewed on 08/03/2020 at 4:38PM and stated that the abuse allegation that involved Resident #1 and CNA #1 was reported to him late evening on 07/22/2020. The Administrator verbalized that an investigation was launched immediately. RN #1 did not report the staff members concerns regarding the rough handling of Resident #1. Both RN #1 and CNA #1 were taken off the schedule. Upon inquiry, the Administrator stated that all staff members are expected to report abuse to their department head or the nursing supervisor immediately. Licensed and certified staff members are aware that they are mandated to report and can make a direct report to New York State Department of Health. 415.4(b)(1)(i)

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.