

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>335214</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/15/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>EASTCHESTER REHAB AND HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2700 EASTCHESTER ROAD</b> <b>BRONX, NY 10469</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223 SS=G	<p>483.13(b), 483.13(b)(1)(i) ABUSE</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, observation and record review the facility did not protect a resident with a history of wandering into other residents' rooms with a history of peer victimization from potential resident to resident abuse as evidenced by not taking preventative measures to prevent abuse by others.</p> <p>This was evidenced in 1 of 4 sampled residents (Resident is #1).</p> <p>This resulted in actual harm that is not Immediate Jeopardy.</p> <p>Complaint # NY00036317</p> <p>The findings are:</p> <p>Resident #1 is an 88 year old female admitted to the facility on 8/16/02. Her diagnoses include Senile Dementia and Hypertension. According to the Minimum Data Set 2.0 (MDS) dated 7/16/06 the resident demonstrates short and long term memory impairments with moderately impaired decision making. She triggers for wandering and repetitive physical movements.</p>	F 223			

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 223	<p>Continued From page 1</p> <p>The Certified Nursing Assistant Accountability Records (CNAAR) for August and September 2006 contained special instructions regarding "Monitor whereabouts every 1/2 hour". No documentation of the 1/2 hour visual observation checks could be found.</p> <p>The 1/11/06 Comprehensive Care Plan (CCP) for Abuse Risk deemed the resident at the risk of abuse in the environment related to her history of wandering. Interventions selected for implementation included: observing the resident's whereabouts and redirecting the resident away from other residents who are not welcoming him/her; trying to redirect the resident's attention to be occupied with something other than the behavior putting the resident at risk and redirecting the resident to a more soothing environment to decrease current pattern behavior.</p> <p>Following a 5/12/06 Resident to Resident altercation when Resident #1 had been hit by another resident, Resident #1 was transferred to another unit and the abuse risk CCP was updated stating "will continue to monitor resident whereabouts".</p> <p>On 7/11/06 the abuse risk CCP was updated and indicated the resident remained at risk for abuse because she continued to wander into other resident's rooms. No new interventions were added.</p> <p>A facility incident report dated 9/27/06 at 9:45AM, revealed that resident #1 was observed entering the room of another resident and "seconds later she was flying out of the room onto the floor".</p>	F 223			

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F 223	<p>Continued From page 2</p> <p>On 9/27/06 an x-ray was performed of the right forearm which revealed a "fracture of the mid shaft of the radius". The resident was transferred to the hospital and returned with a cast from the right upper arm extending through the forearm.</p> <p>The Psychiatrist Progress note dated 9/28/06 reads "incurred fracture-likely entered room and handled roughly...recommend close supervision; consider change of floor".</p> <p>The resident's 9/28/06 Falls CCP evaluation following the events of 9/27/06 indicated "no visible injury noted. Staff encouraged to continue to keep resident out of other residents rooms".</p> <p>Review of the 10/5/06 quarterly Activity Program notes revealed that resident #1 "continues to walk around her unit aimlessly constantly during this recording period. Resident sat during an activity for 3 minutes ...". Resident #1's updated short-term Activity goals included to "sit in the activity area for a 4- minute interval by the next review period".</p> <p>The 11/16/06 Psychiatry notes observe "Restlessness persists, in and out of rooms, many resident angered".</p> <p>The Social Work Room Change log reveals the resident moved from the 5th floor to the 3rd floor on 6/15/07-approximately nine months after the incident and the Psychiatrist's recommendation.</p> <p>The Unit Clerk who witnessed the event on 9/27/06 was interviewed at 1:10PM on 12/27/07 and related that she "looked up and saw Resident #1 at the door to Resident #2's private room and started to tell her not to go in. When she looked</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>up again she saw the door partially closed. She stated she went toward the door and Resident #1 was backing into the hall. The Unit Clerk thought that the person on the other side of the door was pushing Resident #1 out and she ended up on the floor in the hallway on her buttocks.</p> <p>The Registered Nurse Supervisor (RNS#1) who responded to the 9/27/06 incident was interviewed on 12/27/07 at 1:40PM. She indicated she questioned resident #2 about the 9/27/06 incident. Resident #2 said "I don't want her in my room" but did not provide an account of what had happened. The RNS further explained they "have tried so many things with Resident #1 but we will always find her in someone else's room". When questioned regarding interventions employed to ensure the resident's safety and manage her behavior, RNS#1 indicated that they "monitored and redirected the resident as needed". She was not able to recall what other interventions the team would have placed, but that any suggestion would have been implemented. She later noted that the resident was placed on documented 30 minute visual observations for a "day or two" following the event. However, staff was not able to locate forms validating the visual observations for September 2006.</p> <p>Review of the facility December 2007 Accident and Incident reports revealed the resident was found with ecchymosis and a 0.5 cm cut on Left orbital area and a scratch on her Left upper chest on 12/6/07. The report revealed the resident was unable to state how it occurred. The investigation concluded that there was "no fall/injury", that there was no reasonable cause to believe any alleged abuse, neglect or mistreatment occurred</p>	F 223			

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F 223	<p>Continued From page 4</p> <p>and that the resident had long fingernails. The facility corrective actions included "cut resident's fingernails and monitor patient closely".</p> <p>Another incident report dated 12/26/07 indicated that resident #1 was found at 7:00AM that day with left eye ecchymosis and bruising. The investigation summary indicated that preceding shifts were interviewed and staff had no knowledge of the injury or event, "but patient has injury on Left eye. Something happened before 7:00AM on 12/26/07. Unknown." The corrective measures taken were, "Continue to monitor resident and make rounds and do proper assessment".</p> <p>On 12/27/07, resident #1 was observed by the surveyor in her room at 11:05AM with prominent ecchymosis of the left eye. She was resting in bed, clean, well-groomed, Spanish speaking and pleasantly confused, unable to provide any concrete information.</p> <p>The day shift Third floor Registered Nurse Supervisor (RNS) was interviewed at 11:10AM on 12/27/07 and stated Resident #1 was placed on ½ hourly Visual Observation as of 12/27/07. The RNS stated they do not know how the latest injury occurred.</p> <p>The Third floor Licensed Practical Nurse (LPN) was interviewed at 11:15AM on 12/27/07 and stated that Resident #1 wanders into other residents' rooms which makes them "upset". She further stated that the staff redirects and monitors the resident as needed. The LPN indicated when she saw the resident's eye on 12/26/07 she was not sure if it was related to the 12/6/07 incident, since they did not "ever figure out how or why it</p>	F 223			

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F 223	Continued From page 5 happened."  The primary Social Worker was interviewed at 2:15PM on 12/27/07 and stated that Resident #1 demonstrated pacing behaviors, and violated other residents' personal spaces by opening closed doors and sleeping in their beds and that peers would often yell at the resident. She could not recall any specific care plan meeting when interventions regarding resident #1's wandering behavior were discussed.  During an interview with the facility Ombudsman at 2:45PM on 12/27/07, she stated that in the past she has received complaints from other residents regarding resident #1 wandering into their rooms.  Based on her continued wandering into other residents' rooms, her history of resident to resident altercation, a history of a fracture due to an unknown cause and two recent instances of ecchymoses of the left eye, there is no evidence of the implementation of any additional or effective interventions to protect resident #1 from potential resident to resident abuse.	F 223			
F 225 SS=D	415.4 (b) (1) (ii) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225			

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F 225	<p>Continued From page 6</p> <p>other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility did not thoroughly investigate injuries of unknown origin as evidenced by not thoroughly investigating four injuries acquired by a Demented resident to determine causation and rule out abuse.</p> <p>This was evidenced in 1 of 4 sampled residents. (Resident #1)</p>	F 225			

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F 225	<p>Continued From page 7</p> <p>This resulted in no actual harm that is not Immediate Jeopardy.</p> <p>Complaint ID# NY00036317</p> <p>The findings are:</p> <p>Resident #1 is an 88 year old female admitted to the facility on 8/16/02. Her diagnoses include Senile Dementia and Hypertension. According to the Minimum Data Set 2.0 (MDS) dated 7/16/06 the resident demonstrates short and long term memory impairments with moderately impaired decision making. She triggers for wandering and repetitive physical movements. The resident requires supervision with walking.</p> <p>According to a facility investigation dated 9/26/06, Resident #1 was found at 8:10AM with pain and edema to the right forearm. The resident was not able to give an account. The x-ray of the right hand reported on 9/26/06 was negative for fracture. The investigation conducted by Registered Nurse Supervisor (RNS) #1 concluded that the probable cause of the incident was that the resident "may have bumped into something" and the summary indicated that "staff was reminded to monitor resident whereabouts. Investigation has revealed that there is a need for investigation. Resident wanders about unit".</p> <p>According to the 5th floor Unit Clerk's statement included in an additional incident report on 9/27/06 at 9:45AM, Resident #1 was observed entering the room of another resident and "seconds later she was flying out of the room onto the floor where she was observed sitting".</p> <p>The Unit Clerk who witnessed the event on</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>9/27/06 was interviewed at 1:10PM on 12/27/07 and related that she "looked up and saw Resident #1 at the door to Resident #2's private room and started to tell her not to go in". When she looked up again she saw the door partially closed. She stated she went towards the door and Resident #1 was backing into the hall. The Unit Clerk thought that the person on the other side of the door was pushing Resident #1 out of the room and she ended up on the floor in the hallway on her buttocks.</p> <p>On 9/27/06 a x-ray of the right forearm was performed and revealed a "comminuted fracture of the mid-shaft of the radius". The resident was transferred to the hospital and returned with a cast from the right upper arm extending through the forearm.</p> <p>The Psychiatrist Progress note dated 9/28/06 reads "incurred fracture-likely entered room and handled roughly ...recommend close supervision; consider change of floor".</p> <p>The Registered Nurse Supervisor (RNS) #1 who responded to both the 9/26/06 and 9/27/06 incidents and conducted the preliminary facility investigations was interviewed on 12/27/07 at 1:40PM. She indicated the facility was not able to determine how the resident sustained the injury to her arm. She further stated she questioned resident #2 about the 9/27/06 incident but could not state why she did not include that statement in the investigation. RNS #1 indicated that resident #2 said "I don't want her in my room" but did not provide an account of what had happened. She further explained they "have tried so many things with Resident #1 but we will always find her in someone else's room". She also indicated that</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>she "would possibly do a different investigation today" considering the possibility that the 9/27/06 resident to resident altercation might have exacerbated Resident #1's existing forearm condition.</p> <p>A review of the facility December 2007 Accident and Incident reports revealed the resident was found with ecchymosis and a 0.5 cm cut on Left orbital area and a scratch on her Left upper chest on 12/6/07. The report revealed the resident was unable to state how it occurred and the investigation concluded that there was "no fall/injury"; that there was no reasonable cause to believe any alleged abuse, neglect or mistreatment occurred and that the resident had long fingernails.</p> <p>Another incident report initiated 12/26/07 was received on 12/28/07 and indicated that resident #1 was found at 7:00AM on 12/26/07 with Left eye ecchymosis and bruising. The investigation summary indicated the preceding shifts were interviewed and staff had no knowledge of the injury or event, "but patient has injury on Left eye. Something happened before 7:00AM on 12/26/07. Unknown."</p> <p>The day shift Third floor Registered Nurse Supervisor (RNS#2) who was conducting the 12/26/07 investigation was interviewed at 11:10AM on 12/27/07 and stated Resident #1 was placed on ½ hourly Visual Observation as of 12/27/07. RNS#2 stated they do not know how the injury occurred.</p> <p>The Third floor Licensed Practical Nurse was interviewed at 11:15AM on 12/27/07. She indicated when she saw the resident's eye on</p>	F 225			

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F 225	Continued From page 10 12/26/07 she was not sure if was related to the 12/6/07 incident, since they did not "ever figure out how or why it happened."  The facility did not thoroughly investigate four incidents of injury of unknown origin to rule out abuse.  415.4 (b)(1)(ii)	F 225			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 335214	<b>(Y2) Multiple Construction</b> A. Building _____ B. Wing _____	<b>(Y3) Date of Revisit</b> 2/28/2008
<b>Name of Facility</b> EASTCHESTER REHAB AND HEALTH CARE CENTER		<b>Street Address, City, State, Zip Code</b> 2700 EASTCHESTER ROAD BRONX, NY 10469

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <b>F0223</b>	Correction Completed 02/15/2008	ID Prefix <b>F0225</b>	Correction Completed 02/15/2008	ID Prefix _____	Correction Completed
Reg. # <b>483.13(b), 483.13(b)(1)(i)</b>		Reg. # <b>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</b>		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 1/15/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		