STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335011	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patricks Home	66 Van Cortlandt Park South 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 - Actual harm 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** 48907 Based on observation, record review, and interviews conducted during an abbreviated survey (NY 00338277), the facility failed to protect residents from sexual abuse by nursing home staff. This was evident in two out of ten residents (Resident #1 and Resident #2) sampled for sexual abuse. Specifically, 1. On 04/06/24 at approximately 1:00 pm Resident #1 reported to Certified Nursing Assistant #1 that an Asian man (alleged perpetrator) entered their room and asked Resident #1 to see their hernia; the alleged perpetrator grabbed and fondled Resident #1's penis. Resident #1 reported the sexual abuse occurred on 04/06/24 at 10:00 am. Subsequently during an interview with Resident #1 on 04/16/24 at 12:19 pm, they stated at the time of the incident they were scared. 2. On 04/06/24 at 8:00 pm Resident #2 reported to Licensed Practical Nurse #1 that an Asian man (alleged perpetrator) entered their room and sexually assaulted them on 04/06/24 between 10:30am and 11:00am. Resident #2 was transferred to the emergency roiagnom on [DATE] and did not return to the facility. Subsequently during an interview with Resident #2 on 05/01/24 at 12:27 pm, Resident #2 stated they felt helpless and sick to their stomach because they could not move when they were being sexually assaulted. This resulted in actual harm to Resident #1 and Resident #2 that was not Immediate Jeopardy. The findings are: The Facility's Policy and Procedure on Abuse, revised date of 12/2023, documented the facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends, and residents of the facility. The facility strives to ensure the prevention and reporting of suspected or alleged resident/patient abuse. Any time an allegation is made involving abuse, which names a specific employee, the employee is suspended until the completion of the investigation. Resident #1 was admitted to the facility with diagnoses including Schizophrenia, (a disorder that affected the ability to think, feel and behave clearly), Post Traumatic Stress Disorder, and right groin pain and mass. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Minimum Data Set (an assessment tool), dated 03/04/24, documented that Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 15 associated with intact cognition. The Comprehensive Care Plan dated 10/20/23, documented Resident #1 was at risk for neglect and abuse. The interventions documented to contact police authorities as needed and to monitor Resident #1 for signs of abuse and neglect. An Initial Event Documentation written by the Director of Nursing on 04/10/24, which indicated Date/Time of Event as 04/06/24 at 10:00 am, documented Resident #1 reported to staff that earlier during the morning a Chinese person (alleged perpetrator) came into their room and asked them to see their hernia, located on Resident #1's lower abdomen. The alleged perpetrator held onto and played with their penis and then left the room. Resident #1 did not tell anyone but reported the incident later in the day. Resident #1 refused to be assessed. On 04/06/24, the police from the 50 th precinct was contacted and responded. The facility's Investigation Summary dated 04/06/24 documented Resident #1 reported to staff the alleged perpetrator came into their room (early morning) and asked to see their hernia and then the alleged perpetrator held and played with their penis and then left the room. Resident #1 refused to be assessed. Resident #1 described the alleged perpetrator as being Chinese, tall, and bald. Resident #1 stated the alleged perpetrator had worn gray scrubs and black eyeglasses. The investigation documented that a female staff was assigned to Resident #1. The investigation also documented Resident #1 was inconsistent with their statement and reiterated different stories and different descriptions of the alleged perpetrator and gave different timeframes of when the alleged incident occurred. The investigation concluded there is no evidence to support that any alleged resident abuse, neglect, exploitation, or mistreatment occurred. Resident #1's Primary Physician's Progress Note dated 04/10/24 at 1:33 pm, documented Resident #1 reported an Asian man (alleged perpetrator) wearing ordinary clothes came into their room wearing a badge (did not see the name clearly as the badge was inverted) and identified themselves as an employee at the facility. The man asked Resident #1 about their right inguinal hernia and began touching the hernia, touched Resident #1's penis for 5 minutes, kissed and hugged Resident #1, and then left the room. Resident #1 said do not have same gender identity for sexual relationship. They were in shock and wanted to go to the Emergency Department to be examined. Resident #1 also voiced not wanting to return to the facility. Resident #1 was not transferred to the hospital for an evaluation. There was no documentation to support that Resident #1 refused to be transferred to the hospital. Resident #2 was admitted to the facility with diagnoses including chronic kidney disease, difficulty swallowing, and penile implant. The Minimum Data Set, dated dated dated [DATE] documented Resident #2 had a Brief Interview of Mental Status score of 14 indicating intact cognition. Resident #2 also had frequent incontinence of bladder/bowel and required maximum assistance of one person. (continued on next page)

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(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 - Actual harm Residents Affected - Few	A Comprehensive Care Plan for abuse dated 03/15/24 documented Resident #2 was at risk for neglect and abuse. The interventions documented to monitor for signs and symptoms of abuse, neglect, and report to facility staff. An Initial Event Documentation written by the Director of Nursing on 04/08/24, which indicated Date/Time When Nursing Became Aware of Event as 04/06/24 at 8:00 pm, documented Resident #2 reported that earlier today (04/06/24) between 9:30 am and 10:00 am, an Asian man (identified as Physical Therapist Assistant #1) came into their room and performed an oral sexual act while they were asleep. Resident #2 reported that they were startled, and the man pulled up their pants and left the room after telling Resident #2 not to tell anyone. Resident #2 was immediately placed on 1:1 monitoring. Resident #2 was assessed with no evidence of injury. The police and family member were notified. Resident #2 was transferred to the hospital for further evaluation. The facility's Investigation Summary dated 04/06/24, documented Resident #2 reported to staff, earlier in the day between 9:30 am and 10:00 am, the alleged perpetrator came into their room and performed an oral sexual act while they were asleep. Resident #2 stated the alleged perpetrator then took Resident #2's penis and put it into the alleged perpetrator's anus. It is documented staff reported that Resident #2 had a penile implant and had a large penis that was always erect. The investigation concluded there is no evidence to support that any alleged resident abuse, neglect, exploitation, or mistreatment occurred. Record review revealed that Resident #1 and Resident #2 resided on different units. Interviews conducted on 04/16/24, indicated that Resident #1 and Resident #2 have never visited each other and are not familiar with each other. An Emergency Department Provider Note dated 04/07/24 at 5:02 am documented Resident #2 reported around 12:00 pm on 04/06/24, Resident #2 thought they were waiting for someone to come and change them, but a young Asian male (alleged perpetrator) came into their room and placed their (the alleged perpetrator's) mouth on Resident #2's penis. Resident #2 reported that the alleged perpetrator then placed Resident #2's penis into the alleged perpetrator's rectum. Resident #2 stated they did not report the incident to the nursing manager for several hours because they did not feel comfortable telling a young female nurse. Assessment and Plan: New York Police City Department, Resident #2's adult child, and Domestic and Other Violence Emergence program representatives present at bedside. Resident #2 consented to a sexual assault forensic exam (SAFE) and evidence collected and released to New York City Police Department. Emergency Department Course: sexual assault forensic exam done; prophylactic treatment given. Resident #2 does not want to return to the facility. Physical Exam documented dried substance present on Resident #2's penis. During an interview on 04/16/24 at 12:19 pm, Resident #1 stated they told the alleged perpetrator that their hernia hurts. Resident #1 pulled their pants down and pulled up their shirt showing the alleged perpetrator their hernia. Resident #1 stated the alleged perpetrator touch and rub their sexual body part and said that it will make Resident #1 feel better. Resident #1 stated they did not call for help because they were afraid, and the alleged perpetrator was about 6 feet tall. Resident #1 stated they called for help between 1:00 pm and 4:00 pm. Resident #1 stated they are willing to testify against the alleged perpetrator. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a follow up interview via telephone on 05/02/24 at 12:10 pm, Resident #1 stated they told staff they wanted to go to the emergency room to be examined but did not want to return to the facility. Resident #1 stated they had never refused going to the hospital. During a telephone interview on 05/01/24 at 12:27 pm, Resident #2 stated on the day of the incident someone came to change their brief and they did not open their eyes as it was standard procedure. Resident #2 stated they felt something warm on their penis area and thought it was water but then they opened their eyes, and they saw the alleged perpetrator on their knees performing a sexual act. Resident #2 stated they pushed the alleged perpetrator off them. Resident #2 stated the alleged perpetrator turned them onto their left side, pulled their (alleged perpetrator's) pants down and inserted Resident #2's penis into the alleged perpetrator's rectum. Resident #2 stated they pushed the alleged perpetrator off them. Resident #2 stated the alleged perpetrator did not say anything to them, pulled their pants up and walked out of the room. They felt helpless and sick to their stomach because they could not move when they were being sexually assaulted. Resident #2 stated the alleged perpetrator was young, mixed Caucasian, Chinese Oriental look with no beard. Almost six feet tall, and well built. Resident #2 also stated the alleged perpetrator was not wearing any eyeglasses or mask, had on short sleeve T-shirt (regular clothes) and no lab coat. During an interview on 04/16/24 at 1:50 pm, the Physical Therapist Assistant #1 (alleged perpetrator) stated they were assigned on 04/06/24 to performed physical therapy activity for Resident #1 and Resident #2 who resided on different units. The Physical Therapist Assistant #1 stated they were wearing a facial mask (like other staff), had on eyeglasses, and lab coat. Physical Therapist Assistant #1 stated they went to Resident #1's room between 9:30 am and 10:00 am (not sure of the time) and asked Resident #1 if they would like to go to the gym and Resident #1 said no. The Physical Therapist Assistant #1 stated Resident #1 stated their hernia hurt and pulled up their shirt and pulled down their pants exposing their hernia located on the right side of Resident #1's penis. Physical Therapist Assistant #1 affirmed they could see the hernia bulging to the right of Resident #1's penis, but they did not touch Resident #1's penis. They instructed Resident #1 to pull up their pants because they were not the right person to show the hernia to and they would notify the nurse. The nurse was not informed. Physical Therapist Assistant #1 stated Resident #1 instructed them to close the room door which they did and started physical therapy that lasted about 30 to 40 minutes. Physical Therapist Assistant #1 stated they only touched Resident #1 on the shoulder during turning and ambulation activities. Physical Therapist Assistant #1 stated after the session was completed Resident #1 went back to bed and they both said bye. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The interview of the Physical Therapist Assistant #1 continued: The Physical Therapist Assistant #1 (alleged perpetrator) stated they did not touch Resident #2's penis or performed any sex acts on Resident #2. Physical Therapist Assistant #1 stated went to Resident #2 'room (on another unit, don't remember time) and Resident #2 was lying in bed. Physical Therapist Asssitant #1 stated they instructed Resident #2 to stand up and when Resident #2 stood up their incontinent brief fell . Physical Therapist Asssitant #1 stated they assisted Resident #2 in pulling up their brief and proceeded with the exercises. Physical Therapist Asssitant #1 stated after therapy was completed Resident #2 requested to go to the bathroom. Physical Therapist Asssitant #1 stated they escorted Resident #2 to the toilet and supported Resident #2 from behind as Resident #2 pulled their incontinent brief down. Physical Therapist Asssitant #1 stated they assisted in pulling up Resident #2's brief and felt resistance (Resident #2 had an erection). Physical Therapist Asssitant #1 stated that Resident #2 pulled their brief up and they escorted Resident #2 out of the bathroom and Resident #2 transferred themselves back in bed and they left the room. Physical Therapist Asssitant #1 stated they never saw Resident #2's penis. During an interview on 04/17/24 at 9:58 am, Resident #2's significant other stated Resident #2 told them the alleged perpetrator performed fell atio on them but Resident #2 did not mention that they were penetrated. During an interview on 04/17/24 with Certified Nursing Assistant #1 and the Ombudsman, they both stated Resident #1 reported the alleged perpetrator asked to see their hernia and masturbated Resident #1's penis on 04/06/24. During an interview on 04/17/24 at 2:39 pm, the Director of Nursing stated Resident #1 provided conflicting statements about the time of the incident and the description of the alleged perpetrator to the supervisor at approximately 2:00pm-2:30 pm. Resident #1 refused assessment and transfer to the hospital. The Director of Nursing stated they spoke to Resident #2 via the telephone and Resident #2 informed them that at around 10:00 am, the alleged perpetrator performed an oral sexual act on them, and the alleged perpetrator turned them on their side and inserted Resident #2's penis in the alleged perpetrator's anus for a short time and then the alleged perpetrator ran off. The Director of Nursing stated Resident #2 also reported they fell back asleep after the alleged perpetrator left the room. The Director of Nursing stated abuse was ruled out because Resident #2 provided different versions of the incident. Resident #2 was transferred to the hospital and did not return to the facility. The Director of Nursing stated Resident #1 was placed on two-person approach for all services. The Physical Therapist Assistant #1 (alleged perpetrator) was terminated. During an interview on 04/18/24 at 11:43 am, Registered Nurse Supervisor #1 stated Licensed Practical Nurse #3 notified them Resident #2 reported an Asian American man came into their room and sexually assaulted them. Registered Nurse Supervisor #1 stated they assessed Resident #2's penis and there was no wetness, unusual stains, or drainage and Resident #2 did not complain of pain or discomfort to their penis. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 04/19/24 at 3:57 pm Police Officer #1 stated they spoke to Resident #1 and Resident #2 on 04/07/24. Police Officer #1 stated Resident #1 reported to them an Asian person (alleged perpetrator) whom Resident #1 had never seen before entered Resident #1's room. Police Office #1 stated Resident #1 reported the alleged perpetrator asked Resident #1 a few questions about pain and Resident #1 told the alleged perpetrator they had a hernia. Police Officer #1 stated Resident #1 also reported they pulled their pants down and showed the alleged perpetrator their hernia and the alleged perpetrator grabbed their penis (Resident #1's penis) and attempted to masturbate it. Police Officer #1 stated on 04/10/24 they provided Resident #1 with 6 pictures, including a picture of the alleged perpetrator, and Resident #1 could not identify any as the perpetrator. Police Officer #1 stated Resident #1 told them they could not identify the alleged perpetrator because the alleged perpetrator had worn a mask. Police Officer #1 stated they interviewed Resident #2 who reported that an Asian person entered their room to change their (Resident #2) brief and they went back to sleep. Police Officer #1 stated Resident #2 stated they woke up to a great sensation and found the alleged perpetrator performing fell atio. Police Officer #1 stated Resident #2 stated the alleged perpetrator propped them on their side and inserted Resident #2's penis deep into the alleged perpetrator's anus, removed it, and exited the room. Police Officer #1 stated Resident #2 stated they did not report the incident earlier because Resident #2 did not trust the female staff. Police Officer #1 stated they provided Resident #2 with 6 pictures, including a picture of the alleged perpetrator, and Resident #2 could not identify any as the perpetrator. Police Officer #1 stated the investigation will continue because there are two residents involved. During a telephone interview on 05/02/24 at 11:14 am, the Medical Doctor stated on 04/08/24 (don't recall the time), they assessed Resident #1 after the allegation of sexual abuse and there were no injuries. The Medical Doctor stated Resident #1 requested to go the hospital to be examined and Resident #1 voiced they did not want to return to the nursing home. The Medical Doctor stated they gave a verbal order to the nurse (did not recall name of nurse) on the unit to transfer Resident #1 to the hospital. The Medical Doctor stated they do not know why Resident #1 was not transferred to the hospital and they did not follow up as to the reason why Resident #1 was not transferred. The Medical Doctor stated they did not examine Resident #2 as Resident #2 was transferred to the hospital. 10 NYCRR 415.4(b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48907 F609 S/S=E Based on observation, record review, and interviews conducted during an abbreviated survey (NY00338277), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, and mistreatment, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident in two out of four residents sampled (Residents #1 and #2). Specifically, 1. On 04/06/24 at approximately 1:00 pm Resident #1 reported to Certified Nursing Assistant #1 that an Asian man (alleged perpetrator) entered their room and asked Resident #1 to see their hernia and then the alleged perpetrator grabbed and fondled Resident #1's penis. Resident #1 reported that the sexual abuse occurred on 04/06/24 at 10:00 am. During an interview with Resident #1 on 04/16/24 at 12:19 pm, Resident #1 stated that at the time of the incident they were scared. The facility did not report the allegations of abuse within 2 hours to New York State Department of Health. The facility reported Resident #1's allegation of abuse on 04/07/24 at 1:08 am. 2. On 04/06/24 at 8:00 pm Resident #2 reported to Licensed Practical Nurse #1 that an Asian man (alleged perpetrator) entered their room and sexually assaulted them on 04/06/24 between 10:30 am and 11:00 am. Resident #2 was transferred to the emergency roiagnom on [DATE] and did not return to the facility. During an interview with Resident #2 on 05/01/24 at 12:27 pm, Resident #2 stated that they felt helpless and sick to their stomach because they could not move when they were being sexually assaulted. The facility did not report the allegations of abuse within 2 hours to New York State Department of Health. The facility reported Resident #2's allegation of abuse on 04/07/24 at 12:39 am. The findings include: The Facility's Policy and Procedure on Abuse and Neglect, revised 12/23, states on page 7 should the investigation reveal that abuse occurred the Administrator shall report such finds to local police department, the ombudsman and the state licensing certification agency within 2 hours of the results of the completion of the investigation. Resident #1 was admitted to the facility with diagnoses including Anxiety disorder, Schizophrenia, Post Traumatic Stress Disorder, and right groin pain/mass inguinal hernia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Investigation Summary dated 04/06/24 documented Resident #1 reported to staff that the alleged perpetrator came into their room (early morning) and asked them to see their hernia and then the alleged perpetrator held and played with their penis and then left the room. Resident #1 refused to be assessed. Resident #1 described the alleged perpetrator as being Chinese, tall, and bald. Resident #1 stated that the alleged perpetrator had worn gray scrubs and black eyeglasses. The investigation documented that a female staff was assigned to Resident #1. The investigation also documented Resident #1 was inconsistent with their statement and reiterated different stories and different descriptions of the alleged perpetrator and gave different timeframes of when the alleged incident occurred. The investigation concluded there is no evidence to support that any alleged resident abuse, neglect, exploitation, or mistreatment occurred. Resident #2 was admitted to the facility with diagnoses including Chronic Kidney Disease, Dysphagia, and penile implant. The facility's Investigation Summary dated 04/06/24 documented Resident #2 reported to staff earlier today that between 9:30 am and 10:00 am the alleged perpetrator came into their room and performed fell atio while they were asleep. Resident #2 stated that the alleged perpetrator then took Resident #2's penis and put it into the alleged perpetrator's anus. It is documented that staff reported that Resident #2 had a penile implant and had a large penis that was always erect. The investigation documented Resident #2's significant other reported that Resident #2 told them that they (Resident #2) heard staff on the unit talking about an Asian man on the loose on another floor giving fell atio and that they (Resident #2) had received fell atio, but there was no penetration. The investigation concluded there is no evidence to support that any alleged resident abuse, neglect, exploitation, or mistreatment occurred. During an interview on 04/22/24 at 12:24 pm, the Director of Nursing stated if there was reasonable cause for abuse, incident should be reported within 2 hours. The Director of Nursing stated that this allegation was not reported immediately because the Administrator and the Assistant Director of Nursing was not available, and they (Director of Nursing) did not have access to a computer. During an interview on 04/22/24 at 1:20 pm, the Administrator stated that all abuse allegations should be reported within 2 hours to New York State Department of Health. The Administrator stated that the incident was not reported within the timeframe because the Director of Nursing did not have access to a computer. 10 NYCRR 415.4(b)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907 Based on observation, record review, and interviews conducted during an abbreviated survey (NY00338277) the facility did not report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident in two out of four residents sampled (Residents #1 and #2). Specifically, 1. On 04/06/24 at approximately 1:00 pm Resident #1 reported to Certified Nursing Assistant #1 that an Asian man (alleged perpetrator) entered their room and asked Resident #1 to see their hernia and then the alleged perpetrator grabbed and fondled Resident #1's penis. Resident #1 reported that the sexual abuse occurred on 04/06/24 at 10:00 am. During an interview with Resident #1 on 04/16/24 at 12:19 pm, Resident #1 stated that at the time of the incident they were scared. The facility became aware of the abuse allegations on 04/06/24 and completed their investigation on 04/15/24. The facility submitted their 5 days report on 04/15/24 at 12:39 pm to New York State Department of Health. 2. On 04/06/24 at 8:00 pm Resident #2 reported to Licensed Practical Nurse #1 that an Asian man (alleged perpetrator) entered their room and sexually assaulted them on 04/06/24 between 10:30 am and 11:00 am. Resident #2 was transferred to the emergency roiagnom on [DATE] and did not return to the facility. During an interview with Resident #2 on 05/01/24 at 12:27 pm, Resident #2 stated that they felt helpless and sick to their stomach because they could not move when they were being sexually assaulted. The facility became aware of the abuse allegations on 04/06/24 and completed their investigation on 04/15/24. The facility submitted their 5 days report on 04/15/24 at 3:21 pm to New York State Department of Health. The findings include: The Facility's Policy and Procedure on Abuse and Neglect, revised 12/23, states on page 7 should the investigation reveal that abuse occurred the Administrator shall report such finds to local police department, the ombudsman and the state licensing certification agency within 2 hours of the results of the completion of the investigation, as indicated, and to the state survey and certification agency within five (5) days of the completion of the investigation. Resident #1 was admitted to the facility with diagnoses including Anxiety disorder, Schizophrenia, Post Traumatic Stress Disorder, and right groin pain/mass inguinal hernia. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Investigation Summary dated 04/06/24 (completed 04/15/24 at 12:39 pm) documented Resident #1 reported to staff that the alleged perpetrator came into their room (early morning) and asked them to see their hernia and then the alleged perpetrator held and played with their penis and then left the room. Resident #1 refused to be assessed. Resident #1 described the alleged perpetrator as being Chinese, tall, and bald. Resident #1 stated that the alleged perpetrator had worn gray scrubs and black eyeglasses. The investigation documented that a female staff was assigned to Resident #1. The investigation also documented Resident #1 was inconsistent with their statement and reiterated different stories and different descriptions of the alleged perpetrator and gave different timeframes of when the alleged incident occurred. The investigation concluded there is no evidence to support that any alleged resident abuse, neglect, exploitation, or mistreatment occurred. Resident #2 was admitted to the facility with diagnoses including Chronic Kidney Disease, Dysphagia, and penile implant. The facility's Investigation Summary dated 04/06/24 (completed 04/15/24 at 3:21 pm) documented Resident #2 reported to staff earlier today that between 9:30am and 10:00am the alleged perpetrator came into their room and performed fell atio while they were asleep. Resident #2 stated that the alleged perpetrator then took Resident #2's penis and put it into the alleged perpetrator's anus. It is documented that staff reported that Resident #2 had a penile implant and had a large penis that was always erect. The investigation documented Resident #2's significant other reported that Resident #2 told them that they (Resident #2) heard staff on the unit talking about an Asian man on the loose on another floor giving fell atio and that they (Resident #2) had received fell atio, but there was no penetration. The investigation concluded there is no evidence to support that any alleged resident abuse, neglect, exploitation, or mistreatment occurred. During an interview on 04/22/24 at 12:24 pm, the Director of Nursing stated that they submitted the summary within 5 working days. During an interview on 04/22/24 at 1:20 pm, the Administrator stated that the summary of investigation should have been reported within 5 working business days. 10 NYCRR 415.4 (b)(1)(ii)