STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335023	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Holly Patterson Extended Care Facility	875 Jerusalem Avenue Uniondale, NY 11553

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 - Immediate jeopardy to resident health or safety 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** Based on observations, record review, and staff interviews during an abbreviated survey (NY00380105), the facility failed to prevent and protect an incident of physical abuse for one (1) resident (Resident #1) out of three (3) residents reviewed for abuse. Specifically, on 05/04/2025 at 3:59 PM, Certified Nursing Assistant #1 was observed on facility surveillance video restraining both hands of Resident #1 and hitting them in the head two (2) times. Using the reasonable person concept, this resulted in actual psychosocial harm that was Immediate Jeopardy. The findings are: Resident #1 had a medical diagnosis including dementia, hyperlipidemia, and hypertension. Review of the Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score- 99, Resident #1 is not understood and does not understand, indicating severe impairment for decision making. Review of the facility policy entitled, Abuse with a revision date of 03/2024, documented it is the policy of the facility to ensure that every resident is free from abuse and that their rights, dignity and respect are maintained. The policy further documented all staff are responsible for reporting abuse, intervene immediately to safeguard resident if abuse, neglect, mistreatment or misappropriation of property has been observed. The policy further documents that staff are to report incidents of actual or alleged abuse, neglect or mistreatment to charge Nurse or Supervisor immediately. Review of the facility surveillance video with the Administrator, Director of Nursing, and Risk Manager on 05/19/2025 at 10:28 AM revealed that on 05/04/2025 at 3:59 PM, Resident #1 was in the hallway sitting in a wheelchair outside of a resident room. Certified Nursing Assistant #2 was observed standing at the nursing station and Certified Nursing Assistant #3 was observed in the hallway taking vital signs of another resident. Certified Nursing Assistant #1 was observed pointing their finger in the face of Resident #1. Resident #1 responded by striking the hand of Certified Nursing Assistant #1 two (2) times. Certified Nursing Assistant #1 responded by striking Resident #1 across the head and proceeded to hold both resident's hands down towards the wheelchair. Certified Nursing Assistant #2 and #3 were observed in the hallway facing the direction of the incident. (continued on next page)

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.

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

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Resident Accident/Incident Report dated 05/07/2025 at 10:30 AM documented that on 05/06/2025 an anonymous visitor reported to Unit Liaison #1, they had witnessed staff having an inappropriate encounter with Resident #1 on 05/04/2025. On 05/06/2025 between approximately 5:30 PM and 6:00 PM, the visitor notified Unit Liaison #1 that on Sunday 05/04/2025, when the visitor was present on the unit, they heard screaming and observed staff hitting Resident #1 in the head. The Accident Incident Report further documented Unit Liaison #1 did not report this information to Unit Liaison #2 until the morning of 05/07/2025. The Accident/Incident Report further documented while reviewing the camera it was observed two (2) additional staff members were in the hallway at the time of the incident looking towards the incident. The facility investigation documented Certified Nursing Assistants #2 and #3 denied seeing the occurrence. On 05/19/2025 at 10:30 AM during observation and an attempt to interview, Resident #1 was observed sitting in the wheelchair in the hallway, the resident began yelling and waving appearing fearful. During an interview on 05/19/2025 at 12:53 PM with Unit Liaison #1, they stated they received a call on 05/06/2025 at approximately 5:30PM-6:00 PM from an unidentified caller who stated that on Sunday 05/04/2025, when the caller was visiting the facility, they heard screaming and when they came out of the room they were in, they observed staff hitting Resident #1 in the head. Unit Liaison # 1 stated on the morning of 05/07/2025 they reported this to Unit Liaison #2. Unit Liaison #1 further stated that they should have notified the supervisor immediately. Multiple telephone call attempts to reach Certified Nursing Assistant #1 on 05/19/2025 at 1:30 PM and 2:00 PM, as well as on 05/20/2025 between 10:30 AM and 2:00 PM were unsuccessful. Phone call messages were not returned, and a letter was sent, with no response to the letter. Multiple telephone call attempts to reach Certified Nursing Assistant #2 on 05/20/2025 at 2:00 PM and 3:00 PM were unsuccessful. A letter was sent with no response. During an interview with Certified Nursing Assistant #3 on 05/19/2025 at 3:16 PM, they stated that on 05/04/2025 they worked 3:00 PM - 11:00 PM as their regular assignment and they stated Resident #1 was on their assignment. They stated Resident #1 is not combative and does not hit staff during care. They stated on 05/04/2025, they were taking vital signs for another Resident and did not notice Certified Nursing Assistant #1 hit Resident #1. They stated they heard Resident #1 yelling but did not look to see what was going on. When asked about the surveillance video where they were observed looking in the direction of Resident #1, Certified Nursing Assistant #3 stated they did not recall. During a telephone interview with Licensed Practical Nurse #1 on 05/19/2025 at 1:51 PM, they stated that on 05/04/2025 at approximately 4:00 PM, while at the nurse's station they heard screaming in the hallway and saw Certified Nurse Aide #1 removing a resident away from Resident #1. Licensed Practical Nurse #1 stated they did not see anyone hitting Resident #1 and this was not reported by any staff in the hallway. Licensed Practical Nurse #1 stated if the staff saw any abuse going on, such as anyone hitting a resident, they should have informed the Nursing Supervisor immediately. When asked about the video surveillance not showing another resident in the proximity at that time, Licensed Practical Nurse #1 stated they did not see the video and could not recall. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/19/2025 at 3:08 PM with the Director of Nursing, they stated the incident was reported by Unit Liaison #1 on 05/07/2025. The incident should have been reported as soon as the visitor reported what they saw. They stated during the investigation and review of the surveillance video they could see Certified Nursing Assistant #1 strike Resident #1. They further stated during the investigation, Certified Nursing Assistant #2 and Certified Nursing Assistant #3 can be seen facing the direction of Certified Nursing Assistant #1 and Resident #1 however, they denied seeing anything , and did not report any incident to the nurse or the supervisor. The investigation summary documented abuse did occur to Resident #1. During an interview on 05/20/2025 at 2:00 PM with the Medical Director, they stated Resident #1 was assessed with no visible signs of injury. They further stated Resident #1, or any other resident, should not be hit by staff. The Medical Director stated the facility has a zero tolerance for abuse. 10 NYCRR 415.4 (b)(1)(i)

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety 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 during an abbreviated survey (NY00380105), the facility failed to implement Abuse/Neglect policies to prevent, protect and report an incident of physical abuse for one (1) resident (Resident #1) out of three (3) residents reviewed for abuse. Specifically, on 05/04/2025 at 3:59 PM, the facility failed to protect Resident #1 from Certified Nursing Assistant #1 who was observed restraining both hands of Resident #1 and hitting them in the head. This incident was observed by Certified Nursing Assistants #2 and #3 who were in the hallway at the time of the incident and did not identify, correct, intervene or report the occurrence of abuse. Additionally, the incident was reported by a visitor on 05/06/2025 to Unit Liaison #1 who did not report the incident to their supervisor (Unit Liaison #2) until 05/07/2025. This allowed Certified Nursing Assistants #1, #2, and #3 to have continued access to Resident #1 and the other 436 Residents in the facility. Using the reasonable person concept, this resulted in actual psychosocial harm that was Immediate Jeopardy. The findings are: Resident #1 had a medical diagnosis including dementia, hyperlipidemia, and hypertension. Review of the Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score- 99 indicating severe impairment for decision making. The review of the facility policy entitled, Abuse, with a revision date of 03/2024, documented it is the policy of the facility to ensure that every resident is free from abuse and that their rights, dignity and respect are maintained. The policy further documented all staff are responsible for reporting abuse, intervene immediately to safeguard resident if abuse, neglect, mistreatment or misappropriation of property has been observed. Report incident of actual or alleged abuse, neglect or mistreatment to charge Nurse or Supervisor immediately. Review of the facility video surveillance with the Administrator, Director of Nursing and Risk Manager on 05/19/2025 at 10:28 AM, revealed that on 05/04/2025 at 3:59 PM Resident #1was in the hallway sitting in a wheelchair outside of a resident room. Certified Nursing Assistant #2 is observed standing at the nurse's station and Certified Nursing Assistant #3 was observed in the hallway taking vital signs of another resident. Certified Nursing Assistant #1 was observed pointing their finger in the face of Resident #1. Resident #1 responded by striking the hand of Certified Nursing Assistant #1 twice. Certified Nursing Assistant #1 responded by striking Resident #1 across the head and proceeds to hold both of the resident's hands down towards the wheelchair. Review of the Resident Accident/Incident Report dated 05/07/2025 at 10:30 AM documented that on 05/06/2025 an anonymous visitor reported to Unit Liaison #1 that they witnessed Staff had an inappropriate encounter with Resident #1 on 05/04/2025. The Accident Incident Report further documented Unit Liaison #1 did not report this information to Unit Liaison #2 until the morning of 05/07/2025. The Accident/Incident Report further documented while reviewing the camera, it was observed that Certified Nursing Assistant #1 had inappropriate contact with Resident #1. It was also noted that two (2) additional staff members were in the hallway at the time of the incident looking towards the incident. The facility investigation documented that Certified Nursing Assistants #2 and #3 denied seeing the occurrence. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/19/2025 at 12:53 PM with Unit Liaison #1, they stated they received a call on 05/06/2025 at approximately 5:30PM-6:00PM from an unidentified caller who stated that on Sunday 05/04/2025, when the caller was visiting the facility, they heard screaming and when they came out of the room they were in, they observed staff hitting Resident #1 in the head. Unit Liaison #1 stated on the morning of 05/07/2025, they reported this to Unit Liaison #2. They further stated that they should have notified the supervisor immediately about the incident. Multiple telephone call attempts to reach Certified Nursing Assistant #1 on 05/19/2025 at 1:30 PM and 2:00 PM, as well as on 05/20/2025 between 10:30 AM and 2:00 PM were unsuccessful. Phone call messages were not returned, and a letter was sent, with no response to the letter. Multiple telephone call attempts to reach Certified Nursing Assistant #2 on 05/20/2025 at 2:00 PM and 3:00 PM were unsuccessful. A letter was sent with no response. During an interview with Certified Nursing Assistant #3 on 05/19/2025 at 3:16 PM, they stated that on 05/04/2025 they worked 3:00 PM - 11:00 PM as their regular assignment and they stated Resident #1 was on their assignment. They further stated Resident #1 is not combative and does not hit staff during care. They stated on 05/04/2025 they were taking vital signs for another Resident and did not notice Certified Nursing Assistant #1 hit Resident #1. They stated they heard Resident #1 yelling but did not look to see what was going on. When asked about the video surveillance where they were observed looking in the direction of Resident #1, Certified Nursing Assistant #3 stated they did not recall. During a telephone interview with Licensed Practical Nurse #1 on 05/19/2025 at 1:51 PM, they stated that on 05/04/2025 at approximately 4:00 PM, while at the nurse's station, they heard screaming in the hallway and saw Certified Nurse Aide #1 removing a resident away from Resident #1. Licensed Practical Nurse #1 stated they did not see anyone hitting Resident #1 and this was not reported by any staff in the hallway. Licensed Practical Nurse #1 stated if the staff saw any abuse, such as anyone hitting a resident, they should have informed the Nursing Supervisor immediately. When asked about the video surveillance not showing another resident in the proximity at that time, Licensed Practical Nurse #1 stated they did not see the video and could not recall. During an interview conducted on 05/19/2025 at 3:08 PM with the Director of Nursing, they stated the incident was reported by Unit Liaison #1 on 05/07/2025. The incident should have been reported as soon as the visitor reported what they saw. They stated during the investigation and review of the video surveillance they could see Certified Nursing Assistant #1 strike Resident #1. They further stated during the investigation Certified Nursing Assistant #2 and Certified Nursing Assistant # 3 were seen facing the direction of the incident, however both denied seeing anything, and did not report any incident to the floor nurse or the supervisor. The investigation summary documented abuse did occur to Resident #1. During an interview conducted on 05/19/2025 at 4:30 PM with the Facility Administrator they stated the incident should have been reported immediately. They further stated Certified Nursing Assistant #2 and #3 denied seeing abuse however are observed facing the direction of the incident. The Administrator stated the facility has a zero-tolerance policy for abuse. They further stated the staff should have intervened and protected the resident and reported immediately. 10 NYCRR 415.4(b)(2)