

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2025
NAME OF PROVIDER OR SUPPLIER New Paltz Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Jansen Road New Paltz, NY 12561	

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 - Minimal harm or potential for 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the Abbreviated Survey (NY00376400) the facility did not ensure that 1 of 3 residents (Resident #1) investigated for abuse remained free from abuse. Specifically, on 3/27/2025, Resident #1, who was severely cognitively impaired with a history of wandering and entering other residents' rooms, was found in Resident #2's bed. Resident #2, who was cognitively intact, stated that they did touch Resident #1 on their breasts per their request. Resident #1 lacked the capacity to make sound decisions at the time of the incident. The facility investigative conclusion found that no abuse had occurred. The findings include: The Facility Policy titled Abuse revised 6/1/2024 documented that the facility has designed and implemented processes which strive to ensure the prevention, and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment and /or misappropriation of property. The Facility incident report dated 3/27/2025 documented that Resident #1 was found in Resident #2's bed. Resident #2 admitted to touching Resident #1's breasts when Resident #1 asked. Resident #1 had diagnoses that included unspecified dementia, cerebral infarction, and unspecified psychosis. The Quarterly Minimum Data Set, dated [DATE], documented that the resident had severely impaired cognition, no behaviors, self-propels wheelchair independently, and a wander guard in use daily. The Annual Minimum Data Set, dated [DATE], documented that the resident had severely impaired cognition, no behaviors, self-propels wheelchair after set up assistance, and a wander guard in use daily. Resident #1's care plan initiated 4/4/2022, Resident at risk for misappropriation, neglect, abuse, and/or exploitation related to impaired cognition, documented a goal that resident will not experience any form of abuse, neglect, misappropriation, or exploitation. Interventions initiated 4/4/2022 included assessment of resident for any signs of abuse and investigate all allegations of abuse promptly Resident #1's care plan initiated 3/3/2022, Resident exhibits risk for elopement, cognitive impairment/decline, and wandering, documented a goal that resident safety will be maintained. Interventions initiated 3/3/2022 documented distract resident from wandering, identify patterns and triggers for wandering, and use of wander guard management device. Resident #1's care plan initiated 2/6/2023, Resident exhibits behavior symptoms including trying to feed and care for other residents and wanders into other residents' rooms, documented a goal that resident will exhibit less behaviors, safety will be maintained, and resident will not harm self. Interventions initiated 2/6/2023 included distracting resident with activities of interest, resident to sit at nurses' station as tolerated, and distract resident with activities. During an observation and interview on 7/9/25 at 2:06PM, Resident #1 was observed sitting in a wheelchair in the Unit A hallway. They were pleasant, denied any complaints, did not appear fearful or distressed, and were dressed appropriately. Resident #1 was interactive and engaging but had limited comprehension and unable to carry on effective conversation. Resident #2 had diagnoses that included, but not limited to, cerebral infarction, hemiplegia affecting the left side, and depression. The Quarterly Minimum Data Set, dated [DATE] documented intact cognition, no behaviors, antidepressant use, no antipsychotic medication use. The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition, no behaviors, no antidepressant or antipsychotic medication use. There was no documented evidence, including a care plan, of Resident #2 exhibiting any type of behavior, including sexually inappropriate behavior prior to 3/27/2025. During an observation and interview on 7/9/2025 at 10:55AM, Resident #2 was observed in their bed, dressed, awake, and engaging. They denied any complaints. Resident did not exhibit any inappropriate comments or actions. During an interview on 7/10/25 at 3:10PM, Resident #2 stated that they remember the incident involving Resident #1 on 3/27/2025. They stated that they were both at an activity, after which Resident #1 asked them to keep them company. Resident #1 asked to use their bathroom which they allowed. Then Resident #1 asked them to touch and have oral contact with their breasts, which they stated they did. Resident #2 stated that Resident #1 then asked to lay down and invited them in the bed with them, but they stated there was not enough room, so they stayed in their wheelchair while Resident #1 rested. An aide arrived shortly after that, and many more people came including the police. They stated they thought Resident #1 was just hard of hearing, not cognitively impaired. During an interview on 7/9/2025 at 3:05PM, Certified Nurse Aide #1 stated that Resident #1 does wander. On 3/27/2025 they were looking for Resident #1 at dinner time and located them in Resident #2's room in their bed. They stated they monitor Resident #1 very closely now, hourly rounding was implemented after the incident. During an interview on 7/9/2025 at 3:36PM Registered Nurse Supervisor #2 stated that they were the Supervisor on duty at the time of the</p>