STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335239	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clove Lakes Health Care and Rehab Center, Inc	25 Fanning Street Staten Island, NY 10314

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48711 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00330767), the facility failed to protect the resident's right to be free from physical abuse by a nursing home staff. This was evident for one out of seven residents (Resident #4) sampled for abuse. Specifically, on 12/30/2023 at 2:44 AM, the facility's surveillance video recording showed Certified Nursing Assistant #2 roughly pulling some incontinent briefs away from Resident #4 who was sitting in their wheelchair in the hallway. Nurse Supervisor #2 assessed Resident #4 who did not sustain any visible injuries nor complained of pain. The findings are: The facility Policy and Procedure for Prevention/Identification and Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident's Property was last updated on 11/11/2022. The policy states that residents must not be subjected to abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property by anyone, including, but not limited to facility staff. Resident #4 was admitted to the facility with diagnoses that include Hypertensive Heart Disease, Chronic Kidney Disease and Depression. The Minimum Data Set assessment dated [DATE] documented Resident #4 had intact cognition. An Abuse Care Plan for Resident #4 was implemented on 05/26/2022. The interventions include to assess Resident #4 for signs/symptoms of abuse, neglect, bruises, and behavior, and to report to appropriate resources. The care plan was updated post incident of 12/30/2023 with additional interventions. The facility surveillance video camera recording dated 12/30/2023 at 2:44 AM was reviewed with the Director of Nursing on 10/08/2024. The video recording is blurry. The surveillance recording showed the following: At 2:43:49 AM, Resident #4 wheeled themself down the hallway to a linen cart stationed in the hallway. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:44: AM, Resident #4 removed items (identified as incontinent briefs) from the linen cart. Resident #4 was in the process of wheeling themself away from the linen cart but was stopped by Certified Nursing Assistant #2. Certified Nursing Assistant #2 could be seen on the camera roughly trying to pull the incontinent briefs away from Resident #4 and Resident #4 was pulling back/while holding on to the incontinent briefs. At 2:44:19 AM, Resident #4 was wheeling themself up the hallway. Certified Nursing Assistant #2, who was holding multiple brown incontinent briefs in their hand, caught up/stopped Resident #4. At 2:45:01 AM, Certified Nursing Assistant #2 attempted to hand Resident #4 the brown incontinent briefs which Resident #4 was refusing. Certified Nursing Assistant #2 observed struggling to pull the blue incontinent briefs away from Resident #4. Certified Nursing Assistant #2 was also holding onto Resident 4's arm with their (Certified Nursing Assistant #2) left hand while using their right hand to roughly pull the incontinent briefs away from Resident #4. At 2:45:44 AM, Certified Nursing Assistant #2 was able to pull the incontinent brief away from Resident #4 and walked away leaving two incontinent briefs on the floor. At 2:45:52 AM, Certified Nursing Assistant #3 appeared in front of Resident #4 and was talking to Resident #4. Certified Nursing Assistant #3 picked up the incontinent briefs off the floor and wheeled Resident #4 away from the area and out of camera's view. The facility Incident Investigation report dated 12/30/2023 documented that Resident #4 reported that Certified Nursing Assistant #2 took an incontinent brief away from them. Resident #4 also reported wanting to push Certified Nursing Assistant #2 to the floor but did not. Resident #4 also reported feeling upset. Resident #4 was assessed with no visible injuries and no complaints of pain or discomfort. Certified Nursing Assistant #2 was removed from the unit. Several residents were interviewed, and all stated they had no issues with Certified Nursing Assistant #2. The Director of Nursing and the Administrator were immediately notified. The facility's investigation concluded that Certified Nursing Assistant #2's hands, had physical contact with Resident #4's arm. The investigation also concluded that the outcome of the investigation is inconclusive. The police were contacted, and two Police Officers reported to the facility on [DATE] (badge numbers are documented in the incident report). A Nursing progress note dated 12/30/2023 at 8:25 AM, written by Licensed Practical Nurse #1, documented at around 3:10 AM, Certified Nurse Assistant #2 reported that Resident #4 was upset because the incontinent brief was taken away. There were no visible injury or openings observed on Resident #4. Resident #4 was upset upon entry into Resident #4's room. Resident #4 was assessed at their bedside by the Nursing Supervisor who was called. Multiple attempts were made to contact Certified Nursing Assistant #2 but was unsuccessful. Certified Nursing Assistant #2 resigned from the facility. A certified letter was mailed out to Certified Nursing Assistant #2. Awaiting response. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nurse Assistant #2 submitted a written statement to the facility dated 12/30/2023. The statement documented that they are not allowed to leave briefs into the rooms, so when Resident #4 took all the briefs from the cart, they told Resident #4 to take two and Resident #4 said no. the statement documents that Certified Nursing Assistant #2 told Resident #4 that they will need the briefs back and Resident #4 said no. It is documented that Certified Nursing Assistant #2 tried to take the briefs away from Resident #4 and Resident #4 refused to give back the briefs. Certified Nursing Assistant #2 left Resident #4 with the briefs and Resident #4 took the briefs back to their room. Resident #4 was not on Certified Nursing Assistant #2's assignment. Certified Nursing Assistant #3 provided an undated written statement to the facility. The statement documents that on 12/30/2023 at around 3:10 AM, they heard someone screaming for help. The statement documents that they observed Certified Nursing Assistant #2 and Resident #4 in the hallway and Resident #4 was crying. Resident #4 reported that they went to the cart to get a brief and Certified Nursing Assistant #2 took the briefs away from them. Certified Nursing Assistant #3 took Resident #4 to their room and reported to the nurse (Licensed Practical Nurse #1). During a telephone interview on 10/10/2024 at 10:41 AM, Licensed Practical Nurse # 1, stated that they do not recall Resident #4 and ended the interview. Licensed Practical Nurse #1 provided the facility with a written statement dated 12/30/2023. The statement documents that when Licensed Practical Nurse #1 returned to the unit, Resident #4 reported to Licensed Practical Nurse #1 that they are mad because Certified Nursing Assistant #2 took the brief away from them. Resident #4 was anxious and stated that they needed something, maybe Tramadol (a pain medication). Nursing Supervisor #1 was notified. Resident #4 continued to verbalize that Certified Nursing Assistant #2 snatched the brief away from them. Multiple attempts were made to contact Nursing Supervisor #1 but was unsuccessful. Nursing Supervisor #1 provided a written statement to the facility dated 12/30/2023. The statement documented that Resident #4 was observed lying in bed alert and oriented times three. Resident #4 reported that they went to take a brief from the cart and Certified Nursing Assistant #2 hold my forearm and took the brief away from them. Resident #4 also stated that they wanted to push Certified Nursing Assistant #4 to the floor. Resident #4 was assessed with no visible injury and had no complaints of pain or discomfort. During a face-to-face interview on 10/09/2024 at 11:40 AM, the Director of Nursing, stated the incident occurred at around 2:44 AM on 12/30/2023. The Director of Nursing stated Resident #4 wheeled themself down the hallway to the linen cart and took multiple brown and green incontinent briefs from the linen cart and proceeding to go back to their room. The Director of Nursing stated that Certified Nurse Assistant #2 came up from behind and started to grab the incontinent briefs from Resident #4. The Director of Nursing stated that while Certified Nursing Assistant #2 was grabbing the incontinent briefs out of Resident #4's hands, Certified Nurse Assistant #2 also grabbed Resident #4's right forearm. The Director of Nursing stated that they reviewed the video surveillance recording and investigated the incident. The Director of Nursing stated Certified Nursing Assistant #2 was called back to view the video recording and after Certified Nurse Assistant #2 was shown the video, Certified Nursing Assistant #2 immediately resigned. The Director of Nursing stated the investigation was inconclusive for abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 - 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** 48711 Based on observation, interviews, and record review during an abbreviated survey (NY00333881), the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. In addition, the facility did not ensure that violations involving sexual abuse was 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 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 for 2 out of 10 residents sampled (Resident #2 and Resident #3). Specifically, On 02/18/2024 at 1:15 PM, a visitor reported to Certified Nursing Assistant #1 that they observed Resident #2 putting their hand in Resident #3's pajamas pants. The facility did not have a policy for reporting to local law enforcement and the did not report the sexual allegation to local law enforcement. The finding is: The facility Policy and Procedure titled, Prevention/Identification and Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident' Property, states Residents must not be subjected to abuse, neglect, exploitation, mistreatment and misappropriation of resident's property by anyone, including, but not limited to facility, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals. It is the policy of this facility to report any suspected patient verbal/and/or physical abuse, neglect, exploitation, mistreatment and misappropriation of resident's property occurring with the facility. It is the policy of the facility to report the suspicion of suspected crime resulting in serious bodily injury to the injury to the resident no later than 2 hours after forming the suspicion. If there is no bodily injury the facility will report the suspicion no later than 24 hours after forming the suspicion. The facility policy did not mention reporting suspicion of a crime to local law enforcement. Resident #2 was admitted to the facility on [DATE] with diagnoses including Dementia and Type 2 Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented Resident # 2 had intact cognition. Resident #3 was admitted to the facility on [DATE] with diagnoses including Dementia and Depressive disorder. The Minimum Data Set assessment dated [DATE] documented Resident #3 had moderately impaired cognition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Incident Report of the investigation dated 02/18/2024 documented that it was reported at 1:15 PM that Resident #2 was observed with their hand under Resident #3's pajama (pants). Resident #3 was assessed with no acute distress. The Social Worker conducted an interview with Resident #3 whose cognition was identified as moderately impaired. A full body assessment was conducted on Resident #3 had no bruising, redness, or acute skin impairment. Resident #2 was interviewed and denied the allegation stating that they were talking to Resident #3 in the hallway and helped fixed Resident #3's clothes. The facility concluded there was no reasonable suspicion. During an interview on 10/11/2024 at 1:40 PM, Certified Nursing Assistant #1 stated that another resident's family member reported to them that they observed Resident #2 with their hand into Resident #3's pants. Certified Nursing Assistant #1 stated that they immediately went into the hallway and observed Resident #2 with their hand into Resident #3's pants. Certified Nursing Assistant #1 stated that they screamed don't do that and Resident #2 immediately pulled their hand out of Resident #3's pants stating, I did not do anything. Certified Nursing Assistant #1 stated that Resident #2 and Resident #3 were sitting in the hallway next to each other. Certified Nursing Assistant #1 stated that they scream for the nurse as there were no other staff members in view. The nurse was administering medication in another resident's room. Certified Nursing Assistant #1 stated that they stayed with both residents until the nurse arrived and separated the residents. Certified Nursing Assistant #1 stated that Resident #2 had a surprised look on their face. Certified Nursing Assistant #1 stated that Resident #3 was fully dressed and there was no skin exposed. During an interview on 10/11/2024 at 4:30 PM, the Director of Nursing stated Resident #3 has a baseline of being confused. The Director of Nursing stated at the time of the incident, Resident #2 and Resident #3 were interviewed. The Director of Nursing stated there were no evidence to support that sexual abuse had occurred and that Resident #3 could not recall the incident. Resident #2 stated they were trying to help Resident #3 pull up their pants because Resident #3 was undressing in the hallway. The Director of Nursing stated that Resident #2 is the President of the Resident Council. The Director of Nursing stated that Resident #2 was immediately taken off the unit and was placed on another unit away from Resident #1. The Director of Nursing stated that local law enforcement was not contacted because the investigation concluded there was no suspicion of a crime. The Director of Nursing stated the facility does not have a policy and procedure for reporting to law enforcement. 10 NYCRR 415.4(b)(2)