STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335265	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Rensselaer Manor	85 Bloomingrove Drive Troy, NY 12180

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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 - 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. Based on observation, record review, and staff interviews during an abbreviated survey (Case # NY00358602), the facility did not ensure the resident's right to be free of abuse for 1 (Residents #2) of 3 residents reviewed for abuse and neglect. Specifically on 10/27/2024, Certified Nurse Aide #1 threw a water bottle toward Resident #2, picked the bottle up and again threw it at the resident, striking them on their back without injury. Additionally, the second throw was witnessed by Certified Nurse Aide #2, and there was a delay in removing Certified Nurse Aide #1 from resident care. This is evidenced by: Facility policy titled, Abuse/Neglect, or Mistreatment, updated 11/04/2024, documented it was the policy of the facility that all residents had the right to be free from neglect, verbal, sexual, physical, or mental abuse, corporal punishment, exploitation, and involuntary seclusion. 1. All abuse would be reported and investigated. 2. All new hires would be educated and reviewed through background checks. 3. It was the responsibility of all staff to notify their immediate supervisor if they were exhibiting burnout. 4. Facility staff were mandated reporters if they witness abuse, neglect, exploitation and or misappropriation of funds and belongings and or a crime. 5. Facility staff must report to the facility Administrator immediately if they witnessed or suspected abuse. They may also report directly to the local police. Resident #2 was admitted to the facility with the diagnoses of Non-Alzheimer's Dementia with mild psychotic disturbances (condition where someone is experiencing symptoms of dementia, not caused by Alzheimer's disease, alongside mild hallucinations or delusions, which are considered psychotic symptoms), osteoarthritis (joint disease), and age-related debility (a gradual decline in physical and mental function that occurs with aging). The Minimum Data Set (an assessment tool) dated 10/18/2024, documented the resident could understand and was understood by others with severe cognitive impairment for daily decision making. (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	During the observation of a facility security video with no audio that was recorded on 10/27/2024 at 6:50 PM, there was an unobstructed view of the resident in a hallway. The resident was observed sitting in a wheelchair by the nurses' desk on their unit. Resident #2 attempted to open a door to a lounge area. Certified Nurse Aide #1 was seen verbally saying something to the resident. Certified Nurse Aide #1 was observed throwing a water bottle at the resident, which missed them. The Certified Nurse Aide #1 was then noted to go and pick up the bottle of water and return back behind the desk as another staff member came into the camera view. Certified Nurse Aide #1 was observed to throw the water bottle at the resident for a second time, which struck the resident on their right side. The water bottle cap separated from the bottle, and water sprayed onto the Resident #2's back. Certified Nurse Aide #1 then approached Resident #2 and pulled the lounge door closed. Certified Nurse Aide #2 is seen intervening, specifically going to Resident #2, guiding the resident wheelchair away from the situation and down the hall. The Comprehensive Care Plan for activities of daily living, initiated on 4/08/2024, documented the resident could self-propel in their wheelchair around the unit with supervision. They were not at risk of elopement but needed gentle redirection. cap flew off the bottle, and water sprayed all over the resident. During an observation on 11/04/2024 at 10:20 AM, Resident # 2 was found by the nursing station on their unit self-propelling in their wheelchair with no signs or symptoms of distress. The resident was in good spirits, talking and smiling with staff. The resident was clean and without odor and dressed appropriately. During an observation on 11/05/2024 at 5:00 PM, Resident #2 was in the main dining room on their unit having dinner with another. The resident demonstrated no signs or symptoms of distress. During an interview on 11/04/2024 at 11:07 AM, Certified Nurse Aide #2 stated they had been working on the evening shift of 10/27/2024 with Certified Nurse Aide #1. They stated they weren't aware that Certified Nurse Aide #1 had thrown the bottle at the Resident #1 more than once until the video was reviewed. They stated Certified Nurse Aide #1 was upset and angry when they reached the desk after caring for someone else; They were swearing and then threw the bottle at the resident and hit them in the back. Certified Nurse Aide #2 stated they were at first shocked and scared, but when the Certified Nurse Aide #1 went around the desk towards the resident, they went over and removed Resident #2 from the situation, 'and looked for someone to tell.' Certified Nurse Aide #2 stated they informed a Licensed Practical Nurse and went to keep an eye on Certified Nurse Aide 1. They stated that afterward, Resident #2 was not near Certified Nurse Aide #1 again; Registered Nurse Supervisor came to the unit and made Certified Nurse Aide #1 leave the facility. Certified Nurse Aide #2 stated staff reeducation was started because they should have called security immediately. During an interview on 11/04/2024 at 11:29 AM, Medical Director #1 stated they were aware of the incident but did not review the video. They stated Resident #2 had not shown any signs of injury after being assessed by the Registered Nurse and monitoring for signs of psychological abuse was continuing. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/2024 at 3:28 PM, Licensed Practical Nurse #2 stated that on 10/27/2024, Certified Nurse Aide #2 informed them that Certified Nurse Aide #1 had thrown a water bottle and swore at Resident #2. They stated they called Registered Nurse Supervisor, and there was a delay on them arriving to the unit. They stated that during that time, Licensed Practical Nurse #2 told the Certified Nurse Aide #2 to watch Certified Nurse Aide #1, and they sent another staff member to go find the Supervisor. Licensed Practical Nurse #2 stated that they 'made sure Certified Nurse Aide #1 didn't harm anyone else but couldn't make Certified Nurse Aide #1 leave. Once the supervisor arrived, they called security and Certified Nurse Aide #1 was walked out of the building by security.' During an interview on 11/04/2024 at 3:46 PM, Registered Nurse #4 stated they were called to the unit on 10/27/2024 around 6:55 PM and was informed that Certified Nurse Aide #1 had abused Resident #1. Registered Nurse #4 removed Certified Nurse Aide #1 from the floor, took them to the nurses' station and conducted an interview, notified security, and had the aide removed from the facility. Registered Nurse #4 further stated that Director of Nursing #1 and Administrator #1 were notified, both arriving to the facility around 7:15 PM that evening (10/27/2024). Registered Nurse #4 further stated Resident #1 was assessed for physical and psychosocial injury and was placed on 24-hour monitoring to ensure they had no injuries that had not been found could be addressed. Stated reeducation was given to Certified Nurse Aide #2 because there was a delay in removing the perpetrator, Certified Nurse Aide #1, and should have been removed immediately. Registered Nurse #4 further stated Certified Nurse Aide #2 expressed to them that they were afraid and removed the resident, told the Licensed Practical Nurse #2, and then followed Certified Nurse Aide #1 until the supervisor arrived. Registered Nurse #4 stated staff should have called security to the unit; when the Director of Nursing #1 arrived, they took over the investigation. Registered Nurse #4 stated local police were notified and arrived to review the video that had been retrieved by Director of Nursing #1, that is when it was discovered the gravity of the situation. The resident's family and the physician were notified of the abuse. Resident #2's Comprehensive Care Plan for abuse was implemented. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/2024 at 4:03 PM, Director of Nursing #1 stated they were notified around 7:00 PM on 10/27/2024 that a staff member had abused Resident #2. By the time Director of Nursing #1 and the Administrator #1 arrived at the building, Resident #2 had been assessed for injury and Certified Nurse Aide #1 was no longer in the facility. The physician was notified, and the video was viewed. The video demonstrated the aide had thrown the bottle at the resident twice and had struck them in the back once. Police were notified and the resident's family member was notified. Reporting to the New York State Department of Health reporting line was completed, an investigation began, and other residents that Certified Nurse Aide #1 had cared for over the last month were assessed for any signs or symptom or complaints of abuse. Director of Nursing #1 stated they reviewed video of units that Certified Nurse Aide #1 had worked on. They stated the facility investigation revealed the facility policy and procedure for reporting abuse had not been followed, and that there had been a delay in removing the perpetrator from any resident access. Director of Nursing #1 stated that as of result, all staff were immediately reeducated; facility-wide reeducation was started and by 11:00 PM on 10/27/2024, all staff in the building had completed it. They stated that after education by the staff educator and by all supervisors using a PowerPoint on abuse, a post-test with a required score of 100 percent was given to all staff from all departments prior to staff delivering care to any of the residents; calls and e-mails were completed to all staff that had not worked during the timeframe education was being given in the first 24 hours to report to education department for reeducation on abuse, neglect and reporting prior to providing resident care. They stated that it was determined no harm had occurred, but the resident had been monitored daily on every shift. They further stated that Certified Nurse Aide #1 had been suspended, and a hearing was held, and the facility were in the process of terminating them. During an interview on 11/05/2024 at 5:00 PM, Administrator #1 stated the Certified Nurse Aide #1 was suspended and in the process of being terminated for the 'obvious' abuse of Resident #2. They stated that video documenting the abuse had been viewed by the Police and it would be determined by the health care proxy whether charges would be filed against the perpetrator. They further stated that education was ongoing. During an interview on 1/31/2025 at 1:35 PM, Administrator #1 stated Director of Nursing #1--who was at the facility when the deficient practice was reported on 10/27/2024 and notified the New York State Department of Health--was no longer working at the facility. Administrator #1 stated they were involved from start to finish of education for all staff, from all departments, on the reeducation for abuse and neglect and reporting any concerns of resident abuse immediately. Administrator #1 stated Certified Nurse Aide #2 had been removed from the building by security on 10/27/2024 after being interviewed by the supervisor prior to their arrival at the facility. They further stated investigation and reporting began immediately, and everything was done to ensure the wellbeing of the resident who had been assessed for injury. Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey: 1. Beginning on 10/27/2024 at 7:00 PM, both the Director of Nursing #1 and the Administrator #1 responded to the facility when informed of Resident #2 abuse incident. Reeducation immediately began and continued until completed on 11/04/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Reeducation with Power Point on Policy and Procedure for Abuse and Neglect and Reporting with required post-test requiring 100 percent score. 3. Reeducation done on the spot for anyone unable to verbalize proper sequence on reporting abuse and neglect. 100 percent of reeducation was completed on 11/04/2024 prior to survey entrance at 9:00 AM. 4. Facility Quality Assurance reviewed for abuse/neglect and reporting education with updating of the Policy and Procedure and orientation of all staff on hire. 5. Reeducation of all staff on reporting other staff if policy and procedures are not followed by Supervisors or staff was completed by 11/04/2024 at 9:00 AM. 6. Beginning on 10/27/2024 at 7:00 PM, 100 percent facility-wide education on abuse/neglect and reporting was completed with all facility staff before beginning their shift and caring for any residents. All reeducation for staff had been completed by 11/04/2024 either in person or by phone with testing being required before the beginning of their next shift for resident care. Education was given to all facility staff which included nursing, maintenance, administration, housekeeping, security, activities department, and dietary. Anyone with any access to the residents were required to have the updated in-service on abuse and neglect and complete the post-test before beginning their shift. This was accomplished by 11/04/2024. A record of who had received the training and post-test was provided to the surveyor on 11/04/2024 by Administrator #1. 7. 100 percent of all staff had been notified by phone or email to report for reeducation and in-servicing on policy changes with abuse/neglect and reporting before beginning their shift and completing posttest required with a score of 100 percent. This was completed by 11/04/2025 by 9:00 AM. 8. Above actions of correction had been completed prior to survey enter on 11/04/2024 at 9:00 AM. 9. Facility reported within regulatory timelines to New York State Department of Health per regulation. 10. Facility investigation of the incident initiated upon notification with Resident #2 and staff failure to follow immediate reporting. 11. On 10/27/2024, Certified Nursing Aide #1 was removed from resident care and suspended pending outcome of the investigation on abuse prior to video review. 12. On 10/27/2024, Family and Physician Notification completed immediately upon review of the video demonstrating abuse had occurred. 13. Resident #2 Comprehensive Care plan for victim of abuse implemented on 10/27/2024 with interventions and person-centered plan. 14. Reporting to local police with referral to health care proxy completed on 10/27/2024 at 9:00 PM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15. Reporting to New York State and Attorney General and New York State Nurse Aide Registry detailing abuse by Certified Nurse Aide #1 against Resident #2 completed on 10/27/2024. 16. Review of video of the unit of the prior two weeks leading into event, specifically when Certified Nurse Aide #1 was working. 17. All residents reviewed for any unusual finding and incidents that had occurred if they had been cared for by Certified Nurse Aide #1. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated complaint survey (Case #NY00357407), the facility did not ensure personnels ability to provide emergency basic life support, including cardiopulmonary resuscitation (CPR), to residents requiring such care prior to the arrival of emergency medical personnel in accordance with the resident's advance directives and subject to related physician orders for one (Resident #1) of three residents reviewed. Specifically, the facility did not ensure Resident #1's advance directive status was known during a significant change in the resident's respiratory condition on [DATE]. The facility failed to initiate cardiopulmonary resuscitation in a timely manner for a resident that was a full code and was in cardiopulmonary arrest (a resident without a pulse or respiration). This resulted in Immediate Jeopardy Past Noncompliance for Resident #1 with the potential for serious harm to the health and safety of all residents in the facility and Substandard Quality of Care. This is evidenced by: The facility's policy titled, Cardiopulmonary Resuscitation, dated 5/2023 and updated on [DATE], documented the facility would provide emergency cardiopulmonary resuscitation with current standards of practice in accordance with resident end of life determination. Facility policy and procedure titled, resident identification for CPR, revised 10/2024, documented that the facility would identify all residents who had chosen cardiopulmonary resuscitation (CPR) by a resident wearing a green wristband alert bracelet. Additionally, residents who were to be given CPR would have a lime green sticker on their care plan, inside of their wardrobe, and on the spine of their chart indicating 'resuscitate.' The resident's name plate outside of their door would be printed on green paper, and the resident's electronic health record would include a lime green heart with a green box with an 'R' inside. Resident #1 could sometimes understand and was sometimes understood by others with severely impaired cognition for daily decision making. Resident #1's advance directive status was a full code. Resident #1 Medical Orders for Life Sustaining Treatment (Molst, a medical order form that allows patients to specify which treatments they want or don't want at the end of their life), dated [DATE], documented the resident wanted the facility to attempt cardiopulmonary resuscitation (CPR) when the resident was found with no pulse and or was not breathing. Resident #1's advance directive dated [DATE] documented the resident was a full cardiopulmonary resuscitation. Orders stated attempt cardiopulmonary resuscitation, check medical alert bracelet every shift, trial mechanical intubation. Review of facility Incident and Accident report initiated [DATE] and review of corresponding times on facility video that captured view of the hallway of the resident floor documented the following: - Incident: Treatment ordered but not administered. - Incident reason: Failure to identify resident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Description: Delayed care. - Measures to Prevent Recurrence: Staff education on resident code status and protocol. - Licensed Practical Nurse #1 found Resident #1 unresponsive in their room on [DATE] at 5:36 PM, and called Registered Nurse #1 to the room. - On [DATE] at 5:37 PM, Registered Nurse #1 arrived on the floor and both Licensed Practical Nurse #1 and Registered Nurse #1 went back into Resident #1's room. Registered Nurse #1 assessed the resident's vital signs for 60 seconds and made the determination that the resident had expired. - Registered Nurse #1 statement read in part, 'Upon arrival to unit on an unrelated matter regarding staffing the nurse on duty reported to me that the resident had expired. The resident was assessed via auscultating for heart and lung sounds which were noted as not present for 60 seconds. There was no palpable pulse noted to left wrist as well. Skin color was observed as mottled and skin was cool to touch. The process for discharging resident including making family, coroner, and funeral home aware was initiated. Upon completion of that process and review of resident chart, resident code status was observed as full code and cardiopulmonary resuscitation was initiated with no positive effect.' - Licensed Practical Nurse #1 statement read in part, 'Registered Nurse #1 assessed the resident and stated, the resident is gone. We both went into the office and Registered Nurse #1 stated they would take care of everything. I said OK, let me know what else I need to do. I went back to the medication cart and finished passing medications.' - On [DATE] at 5:42 PM, Registered Nurse #1 left the unit. - On [DATE] between 6:15 PM and 6:20 PM, Registered Nurse #1 went to the nurse supervisor office and stated to Registered Nurse #2 and #3 that Resident #1 had passed away. Registered Nurse #3's statement read in part, 'this writer responded by stating [to Registered Nurse #1] that the resident was a full code and needed cardiopulmonary resuscitation (CPR), I then learned CPR had not been started. At this time, [Registered Nurses] went to the unit to initiate CPR while supervisor Registered Nurse #1 went to get the Medical Director who was in house in their office. Upon entering [Resident #1's] room, upon assessment, resident was laying in bed with no pulse and absent of respirations, compressions were then started around 6:25 PM, approximately 5 rounds of CPR given. Resident was absent of all vital signs. Medical Director gave permission to stop CPR around 6:35 PM and resident was pronounced at approximately 6:40 PM. Director of Nursing #1 notified shortly after.' Review of a facility memorandum statement by Director of Nursing #1 on [DATE] at 9:32 AM documented the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At the time of the incident, Licensed Practical Nurse #1 informed Director of Nursing #1 that they knew Resident #1 was a full code. Licensed Practical Nurse #1 stated that they told Registered Nurse #1 that the resident was a full code and hold compression be stated and a Code Blue be called overhead. It was stated that Registered Nurse #1 would handle it. Registered Nurse #1 then went to nursing supervisor's office where Registered Nurses #2 and #3 questioned what was going on. Registered Nurse #1 told them a resident passed away and was a Full Code. [When questioned] why a Code Blue was not called overhead, Registered Nurse #1 stated that the resident was already dead. Registered Nurses #2 and #3 told Registered Nurse #1 that a Code Blue should have been initiated, to call the provider and they both went up to the unit and started cardiopulmonary resuscitation (CPR) compression, while Registered Nurse #1 called Medical Director #1 who came up and pronounced the resident deceased around 5:45 PM. During an interview on [DATE] at 2:14 PM, Licensed Practical Nurse #1 stated they had given Resident #1 a nebulizer treatment on [DATE] around 5:00 PM, and when they went back to discontinue the treatment, the resident was unresponsive. They then informed Registered Nurse #1, who was coming on the unit. Registered Nurse #1 went to the room and assessed the resident, then stated Resident #1 expired. Licensed Practical Nurse #1 asked Registered Nurse #1 if they needed to do anything and was told Registered Nurse #1 would take care of everything. They stated that it wasn't until Registered Nurse #1 left the unit that Licensed Practical Nurse #1 checked the chart at approximately 5:50 PM and realized Resident #1 was a full code. They stated they were getting ready to call another Registered Nurse Supervisor when Nurse Supervisors arrived on the unit, called a code, and started cardiopulmonary resuscitation (CPR) on Resident #1. Licensed Practical Nurse #1 stated the attempt was not successful. Licensed Practical Nurse #1 further stated that there was 'a considerable time lapse' between when the resident was found unresponsive and when the code was called; the code should have been called immediately when the resident was found unresponsive. They stated that both Registered Nurse #1 and Licensed Practical Nurse #1 should have done that and should have checked the resident's chart for the advanced directives, but the resident was deceased . Licensed Practical Nurse #1 stated that they had been suspended from the facility pending the outcome of an investigation because they hadn't followed the policy and procedure on Advanced Directives. During an interview on [DATE] at 4:30 PM, Registered Nurse #2 stated Registered Nurse #1 never called the code [for cardiopulmonary resuscitation] for Resident #1 when they identified the resident was unresponsive on [DATE]. They reported to both Registered Nurses #2 and #3 that they had just discovered the resident was a full code and should have initiated cardiopulmonary resuscitation (CPR). Upon hearing of the incident, Registered Nurses #2 and #3 supervisors went to the unit, found the resident unresponsive, and initiated the code. They stated that the resuscitation attempt was unsuccessful, and Director of Nursing #1 and Administrator #1 were notified; both responded to the building. They further stated that Medical Director #1 was at the facility and pronounced Resident #1 deceased at approximately 6:57 PM. They further stated that the procedure for finding a resident unresponsive was to identify whether the resident was a full code or 'do not resuscitate;' once they identify the resident is a full code, staff were to call a code on overhead pager with room number for code team to respond; 911 would be called and the physician would be notified. Registered Nurse #1 stated residents have a green band on that identify them as a full code, and Resident #1 had the band on, so Registered Nurse #1 should have identified the resident as a full code; no delay should have occurred. During an interview on [DATE] at 3:29 PM, Registered Nurse #1 stated the following: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] at around 5:50 PM, they were informed by Licensed Practical Nurse #1 that Resident #1 had expired. Registered Nurse #1 reported they had just given the resident Intravenous fluids (IV) and the resident was alert and responsive. Upon going to Resident #1's room, Registered Nurse #1 assessed the resident for 60 seconds and determined the resident was deceased . Registered Nurse #1 called the family and informed them the resident had expired and then called the funeral home and left the unit. Once they began to put in a nursing note and call the physician, they realized the resident had been a full code and should have had cardiopulmonary resuscitation (CPR). They reported this to two Registered Nurse Supervisors [Registered Nurse #2 and #3] who immediately went to the unit and called a code and initiated cardiopulmonary resuscitation. Registered Nurse #1 went to the Medical Director, who was still in the building, and informed them that the resident had been a full code, and the code had not been started because the resident was found without pulse or respiration by Licensed Practical Nurse #1. The physician then called the code. When the resuscitation attempt was unsuccessful, and the physician pronounced Resident #1 deceased , Director of Nursing #1 suspended Registered Nurse #1 for not initiating cardiopulmonary resuscitation when they became aware the resident was unresponsive because Resident #1 was a full code. Licensed Practical Nurse #1 had not called a code and told Registered Nurse #1 the resident was deceased . Registered Nurse #1 stated they followed their nursing judgement and had been trained on Basic Life Support. They further stated they hadn't realized until after being told by Licensed Practical Nurse #1 the resident was deceased that Resident #1 was a full code and by then they had left the unit. During an interview on [DATE] at 9:00 AM, Director of Nursing #1 stated the following: - Both Licensed Practical Nurse #1 and Registered Nurse #1 were suspended. - Both Licensed Practical Nurse #1 and Registered Nurse #1 were aware Resident #1 was a full code and neither initiated cardiopulmonary resuscitation upon finding Resident #1 unresponsive. - The resident was found unresponsive on [DATE] at 5:36 PM by Licensed Practical Nurse #1, who notified Registered Nurse #1 at 5:37 PM. Registered Nurse #1 then assessed the resident for 60 seconds and determined the resident was deceased . The medical provider was not notified, and no resuscitation was started. - Licensed Practical Nurse #1 disagreed with Registered Nurse #1's findings and felt cardiopulmonary resuscitation should have been started but did not take any action. -Registered Nurse #1 left the unit, went to the nursing office, and did not initially inform any other supervisor or the physician that the resident was deceased . - Re-education for all staff for resuscitation following medical orders and assessment was started facility wide. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335265	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Rensselaer Manor	85 Bloomingrove Drive Troy, NY 12180

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:01 PM, Medical Director #1 stated Registered Nurse #1 came to their office on [DATE] at approximately 6:30 PM and said Resident #1 had expired and had been a full code. Medical Director #1 stated they were still in the building doing charting and hadn't heard the code called. Registered Nurse #1 said a code wasn't called because the resident wasn't breathing when the Licensed Practical Nurse #1 came to them and said the resident was found unresponsive and they weren't aware the resident was a full code; as of result, other nurses went to the room and started cardiopulmonary resuscitation (CPR) and called 911. They further stated that Registered Nurse #1 had not followed protocol by pronouncing the resident, calling the family and the funeral home prior to advising the Medical Director of what had taken place. Medical Director #1 stated Cardiopulmonary Resuscitation (CPR) was performed for 15 minutes before it was discontinued, and Resident #1 was pronounced dead. During an interview on [DATE] at 9:15 AM, Administrator #1 stated the following: - Licensed Practical Nurse #1 and Registered Nurse #1 were being terminated for not following facility policy and procedure and physician's orders. - Staff education was ongoing. Staff that were unavailable or per diem status had been contacted by phone or email to report for in service prior to beginning their shift. Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey: 1. Beginning on [DATE] at 7:00 PM, both Director of Nursing #1 and Administrator #1 responded to the facility when informed of Resident #1 death. Cardiopulmonary Resuscitation (CPR) reeducation was begun with all facility staff. This included all departments and was completed with 100 percent of staff throughout the building on [DATE]. This included the following units: Nursing, Dietary, Maintenance, Housekeeping, Security, and Administrative Personnel. 2. Education with Power Point on Policy and Procedure for Cardiopulmonary Resuscitation with post-test requiring 100 percent score. All staff from all departments had post-test completed on [DATE]. 3. Reeducation done on the spot for anyone unable to verbalize education on cardiopulmonary resuscitation (CPR) and how to identify 'full code' or 'do not resuscitate' status for residents during mock codes until 100 percent was achieved; completed on [DATE]. 4. Two mock codes blue drills conducted beginning from [DATE] to [DATE]. 5. Mock codes were scheduled to be performed weekly for 4 weeks and monthly for 4 months. 6. Facility Quality Assurance reviewed for improving cardiopulmonary resuscitation (CPR) education with updating of the policy and procedure and orientation of all staff on hire. 7. Reeducation of all staff on how to identify residents' status on Advanced Directives was completed on [DATE] by 9:00 AM. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Reeducation of all staff on reporting other staff if policy and procedures are not followed by Supervisors or staff was completed on [DATE] by 9:00 AM. 9. Beginning on [DATE] at 7:00 PM, 100 percent facility-wide education on cardiopulmonary resuscitation was completed on all facility staff before beginning their shift; completed on [DATE] by 9:00 AM for all staff prior to providing resident care on units. 10. By [DATE] at 9:00 AM, 100 percent of all staff had been notified by phone or email to report for reeducation and in-servicing on policy changes with cardiopulmonary resuscitation before beginning their shift and completing posttest required with a score of 100 percent. 11. Reporting to New York State Department of Health completed within regulation. 12. Facility investigation of the incident with Resident #1 and staff failure to follow advanced directives and start cardiopulmonary resuscitation (CPR) began on [DATE]. Investigation was completed and ready for review on [DATE] at 9:00 AM. 13. Licensed Practical Nurse #1 removed from resident care on [DATE] and suspended pending outcome of the investigation on failure to institute cardiopulmonary resuscitation (CPR) to Resident #1. 14. Registered Nurse #1 removed from resident care on [DATE] and suspended pending outcome of the investigation on failure to institute cardiopulmonary resuscitation to Resident #1. 15. Immediate Jeopardy Template signed by Director of Nursing #1 and Administrator #1 on [DATE] at 7:00 PM. 10 New York Codes, Rules and Regulations 415.3 (e)(2)(iii)