STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335275	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Nursing at Wappingers	37 Mesier Avenue Wappingers Falls, NY 12590

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** 49372 Based on record review and interviews during an abbreviated survey (NY00342534) the facility did not ensure residents right to be free from abuse for 1 out of 3 residents (Resident #1) reviewed for abuse. Specifically, on 8/5/2024 Resident #2 who was known to be physically/verbally abusive wandered into Resident #1's room, threw their items on the floor, tried to take away their walker and punched them with a closed fist on their arm. Resident #1 reported they were punched on the right arm by Resident #2. Resident #1 was assessed with no injuries and Resident #2 was discharged to the hospital for further evaluation. Findings include: The facility abuse, neglect and exploitation of resident's policy dated 7/12/2018 and last reviewed/revised 4/2020 documented it is the policy of the facility that acts of physical, verbal, and mental abuse directed against residents are absolutely prohibited. Each resident has the right to be free from verbal, sexual, physical, and mental abuse. Residents will not be subjected to abuse by anyone, including but not limited to, staff and other residents. Comprehensive policies and procedures have been developed to aid the facility in the prevention of abuse, neglect, exploitation, mistreatment, or misappropriation of property of the residents. 1)Resident #1 was readmitted to the facility on [DATE] with diagnosis including but not limited to malignant neoplasm of endometrium, Acute Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity. An annual Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15, associated with intact cognition. No behaviors noted. The Resident was independent for eating, bed mobility and transfers, required moderate assistance for toileting and used a wheelchair or a walker for locomotion. Resident #1 was occasionally incontinent of urine and continent of bowels. (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	Review of a behavior care plan dated 8/7/2024 documented the resident was a victim of a resident-to-resident altercation and had unsolicited physical contact by another resident. The goal was the resident will be separated from the aggressor and would not be victimized by other resident, will suffer no emotional effects. Interventions included to assess for injury, keep the resident separated from other aggressor residents, provide emotional support, assess for feelings of fear or lack of safety, and provide social work counseling. Review of an accident/incident investigative form statement dated 8/7/2024 at 6:20 PM written by the Director of Nursing documented Resident #1 was sitting on their bed when another resident wandered into their room and hit them with a closed fist around the shoulder area. Review of the 5-day investigative conclusion submitted by the facility documented the findings were verified and Resident #2 was transferred to the hospital for increase agitation and later returned to the facility. The care plans for Resident #1 and Resident #2 were updated with instructions to keep the residents apart. Resident #2 to be redirected when wandering into resident's rooms and frequent visual checks to be initiated. 2) Resident #2 admitted to the facility on [DATE] diagnosis including but not limited to Neurocognitive disorder with Lewy bodies, Dementia and Personal History of Traumatic Brain Injury. A 5-day Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 99 associated with severe cognition impairment with making daily decisions. The resident exhibited verbal and physical behaviors directed towards others. Resident #2 required partial assistance with ambulation, eating and bed mobility, was dependent for toileting and required supervision for transfers. A cognitive impairment care plan dated 7/29/2024 documented Resident #2 experienced severe cognitive deficits, recent decline in cognitive status, Lewy body dementia, impaired decision-making ability, poor insight/reasoning and poor impulse control. The goal was to promote/improve alertness and awareness with interventions to anticipate the resident's needs, provide orientation and cueing as needed, provide calming environment reduce stimulus and psychiatry and psychology consult and treatment as indicated. A behaviors care plan dated 8/7/2024 documented Resident #2 exhibited combativeness, confusion, wandering, physically abusive and aggressive behaviors. The goal was episodes of aggression would be decreased by redirection. Interventions listed included educate staff, resident/representative on behavioral interventions and consequences as indicated, observe and document behaviors every shift and psychiatric evaluations as indicated. A resident-to-resident altercation (aggressor) care plan dated 8/7/2024 documented Resident #2 was physically aggressive and made unwanted physical contact with another resident. The goal was Resident #2 would be kept apart from Resident #1 and would not display any further physical aggression toward other residents. Interventions listed included keep resident apart from other residents, provide 1:1 supervision until calm, psychiatric consult as ordered, remove resident from situation utilizing calm approach and send to hospital for evaluation of increased agitation and aggressive behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	Review of an accident/incident investigative form dated 8/5/2024 documented at 6:20 PM Resident #2 was visiting with their wife and wandered into Resident #1's room. Resident #2 struck Resident #1 with a closed fist around their shoulder area. During an interview on 8/26/2024 at 10:35 AM Resident #1 stated on 8/5/2024 they were in the bathroom in their room, and they heard things being thrown to the floor. They exited the bathroom and found Resident #2 in their room, and they asked Resident #2 to stop and get out of their room. Resident #2 instead, tried to grab their walker and punched them in the arm. Resident #1 stated Resident #2's wife came and removed Resident #2 from the room. Resident #1 stated Resident #2 terrorized them and other residents for days, but after this incident the facility sent the resident out for evaluation. Resident #2 returned to the facility after a few hours, but the resident is no longer in the facility. Stated the Velcro stop sign was at the entry of their room, but Resident #2 just pulled it down and came in that day on 8/5/2024. Resident #1 pointed to a fading brownish bruised area on their right upper arm and showed a picture in their cellphone of a deep purple ecchymosis area to the right upper arm, and stated this was from the incident and is now going away. Resident #1 stated the Director of Nursing was in the building when the incident occurred on 8/5/2024 and they had Resident #2 immediately removed from the building. During an interview on 8/26/2024 at 3:45 PM the Director of Nursing stated they were in the building on 8/5/2024 when the incident occurred between Resident #1 and Resident #2. They were called by Licensed Practical Nurse #1 stating that Resident #2 went into Resident #1's room and struck them. They assessed Resident #1 and had Resident #2 sent out for evaluation. The Director of Nursing stated Resident #1 was a little shaken up after the incident, but they were not injured. The Director of Nursing stated Resident #1 did express concern with Resident #2's behaviors. Resident #2 was transferred out to another facility on 8/9/2024. The Director of Nursing stated they observed Resident #1 and there was no injury noted to Resident #1. The Director of Nursing stated on 8/5/2024 the day of the incident with Resident #1, Resident #2 was with their wife and wandered away from them and went into Resident #1's room. 10 NYCRR 415.4(b)(1)(i)