

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Willow Point Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 Old Vestal Road Vestal, NY 13850	

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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>37385</p> <p>Based on record review and interview during the abbreviated survey (NY00339000), the facility did not promote and facilitate the resident's right to self-determination through support of resident choice, including the resident's right to choose activities and health care services consistent with their interests, assessments, and plan of care for 1 of 3 residents (Resident #1) reviewed. Specifically, Resident #1 refused care and staff continued to provide care following multiple refusals.</p> <p>Findings include:</p> <p>The undated Resident Rights policy documented each resident had the right to be treated with dignity and respect in recognition of their individual preferences; to refuse treatment and be free from abuse.</p> <p>Resident #1 had diagnoses including anxiety disorder, major depressive disorder, and mild cognitive impairment. The 3/5/2024 Minimum Data Set assessment documented the resident had intact cognitive function and did not exhibit behavioral symptoms. The resident required substantial/maximum assistance with dressing, bathing, hygiene, and required moderate assistance with transfers.</p> <p>The resident's comprehensive care plan documented:</p> <ul style="list-style-type: none"> - on 5/13/2021, the resident had an activities of daily living self-care performance deficit and could be resistive to care. Interventions included: assistance of 1 for morning/evening care, weekly shower, and dressing; offer one to one support, and if behavior continued, redirect or reapproach as needed and as the resident allowed. - On 7/23/2021, the resident had a behavior problem, was non-compliant with waiting for staff assistance, and had a history of false allegations toward others. Interventions included: explain procedures before starting; allow the resident time to adjust; approach and speak in calm manner; and divert attention. - On 1/6/2024, the resident had potential for physical aggression and had poor impulse control. Interventions included: anticipate needs; analyze triggers; engage calmly in conversation; if response was aggressive, staff to walk away calmly and approach later. <p>The 4/12/2024 facility investigation documented:</p> <p>(continued on next page)</p>

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Resident #1 refused their shower and certified nurse aide #5 asked licensed practical nurse #4 to assist in encouraging the resident to take a shower. After refusing again, certified nurse aide #5 suggested they assist the resident in washing in the bathroom and the resident agreed. - Licensed practical nurse #4 attempted to remove the resident's leg wraps (elasticized bandages wrapped around lower legs for management of swelling) and the resident became agitated and hit the nurse. - The resident was transferred from their bed to a wheelchair and then to the bathroom and on the toilet. The resident refused to stand up to remove their brief. - Licensed practical nurse #4 told the resident they must be washed and wrung out wet washcloths over the resident's head. The resident became agitated, pushed the nurse, and licensed practical nurse #4 then took approximately 4 wet washcloths and shoved them into the resident's face. The resident became angry and certified nurse aide #5 reported seeing arms flying and the call bell cord became entangled and pulled from the wall. Licensed practical nurse #4 again shoved multiple washcloths into the resident's face. - Certified nurse aide #5 asked licensed practical nurse #4 to leave the bathroom and completed care with the resident without issue. - Licensed practical nurse #4 returned and Resident #1 stated they wanted the nurse out of their room. Licensed practical nurse #4 insisted on applying the resident's leg wraps, the resident was resistive, hit the nurse, and asked the nurse to give them 5 minutes, and the nurse insisted on applying the leg wraps. <p>Statements obtained by the facility and included in the 4/12/2024 investigation documented:</p> <ul style="list-style-type: none"> - Resident #1's statement, written by registered nurse Manager #9, included they did not want to take a shower and said they would take one the following day. The nurse told the resident they would take one this day, the resident said no. In the bathroom, the nurse started scrubbing their head and the resident said no, and the nurse continued. The resident said they will take a shower the next day, the nurse was insistent and continued to wash the resident. The resident bit the aide who came near them (certified nurse aide #6) and they were doing everything I didn't want. The nurse threw the washcloth in the resident's face. The nurse also hit the top of their head, but it did not hurt. - Certified nurse aide #5's statement documented the incident as noted in the facility investigation. Additionally, certified nurse aide #5 documented they held hands with the resident when licensed practical nurse was removing their leg wraps. The resident asked them to let go, and the aide said they would if they stopped hitting the nurse. Certified nurse aide #6 entered the bathroom and held Resident #1's hands to stop them from hitting licensed practical nurse #4 when they were re-applying the leg wraps. - Licensed practical nurse #4's statement stated the tried to assist the certified nurse aide in getting the resident into the shower chair and the resident refused. The nurse attempted to wash the resident's head or hair and took a defensive approach after the resident grabbed at them and threw a washcloth. The resident hit the nurse when they were reapplying their leg wraps. <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident #1 on 4/18/2024 at 1:40 PM, they stated on 4/12/2024 they did not want to take a shower and told the staff they would take one the next day. The resident got irritated and wanted to be left alone. Licensed practical nurse #4 took off their leg wraps when they told them no, they did not want the nurse near them. The nurse took the wraps off anyway. In the bathroom, the nurse pushed washcloths in my face. The resident stated when certified nurse aides #5 and 6 held their hands, it was like a restraint and they did not want the nurse near them.</p> <p>During an interview with certified nurse aide #6 on 4/18/2024 at 2:46 PM, they stated they heard screaming and yelling from Resident #1's room and responded. Certified nurse aide #5 was heard telling the resident to stop hitting licensed practical nurse #4. The resident was heard saying stop and that they did not want a shower. Licensed practical nurse #4 told the resident they had to take a shower. The shower chair was outside the bathroom, and they kept telling the resident they had to take a shower. When certified nurse aide #6 approached, they held onto one of the resident's arms and the resident turned and bit the aide, and the aide left the room. They stated it seemed as if the resident was getting more agitated by the nurse and aide trying to get them into the shower chair. Certified nurse aide #6 returned approximately 15 to 20 minutes later in response to more yelling in the bathroom. Licensed practical nurse #4 was putting leg wraps on the resident and the resident was yelling at the nurse to get away. The nurse said they had to do it and the resident continued to tell them to get away from them. Certified nurse aide #6 stated they did not hold the resident's hands while the nurse reapplied the leg wraps. The aide was unaware of a specific care plan and stated when a resident refused care, staff should honor that request and reapproach later.</p> <p>During an interview with certified nurse aide #5 on 4/19/2024 at 8:32 AM, they stated on 4/12/2024, the resident was found awake and sitting on their bed at approximately 4:00-4:15 AM. The aide brought the shower chair into the room. The resident said they did not want to take a shower and the aide continued to encourage them to take a shower. Licensed practical nurse #4 entered the room told the resident they did not take a shower last week and needed to take one that day. The resident refused again, and the nurse said they would remove their leg wraps. The resident said no, and the nurse proceeded to remove the wraps. The resident began hitting the nurse and certified nurse aide #5 held their hand and talked to the resident asking them not to hit the nurse. They held the resident's hand like a friend and did not restrain them. The resident agreed to go into the bathroom in their wheelchair. Certified nurse aide #5 stated they thought they could place the shower chair under the resident when they stood in the bathroom. When the resident stood up, they brought the shower chair closer to try to put it under them, and the resident said they were not getting in that chair and sat down on the toilet. The nurse started washing the resident, who became agitated and combative with the nurse. The aide asked the nurse to leave but the nurse returned shortly after. The resident said they did not want the nurse in there and did not want the nurse touching them, and the nurse insisted on applying their leg wraps. The resident asked for a few minutes, and the nurse insisted on doing it at that time. Certified nurse aide #6 returned, the resident was hitting licensed practical nurse #4 as they continued to wrap the resident's legs. Certified nurse aide #6 held the resident's hands so the nurse could finish wrapping their legs. Certified nurse aide #5 was unaware of a specific care plan and stated when a resident refused care, staff should listen to them, leave them as long as they were safe, and reapproach later.</p> <p>During an interview with licensed practical nurse #4 on 4/19/2024 at 10:00 AM, they stated on 4/12/2024, the resident refused their shower, and they assisted in washing the resident in the bathroom. The nurse stated they could not recall removing the resident's leg wraps or any refusals of care until the resident hit them when they were nearly done wrapping their legs.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on 4/19/2024 at 10:30 AM, they stated if a resident was resistive to care or refusing, staff should ensure their safety and leave them alone. Staff should report to a nurse and try to reapproach later or ask another staff member who may have a different approach. Staff should not have tried to get the resident to sit in the shower chair by swapping it out with the wheelchair, as the resident had already refused the shower. When certified nurse aide #5 said certified nurse aide #6 held the resident's hands, that was not an appropriate intervention. That could be considered restraining the resident and they should have stopped what they were doing.</p> <p>10 NYCRR 415.5(b)(1,3)</p>		

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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37385</p> <p>Based on record review and interview during the abbreviated survey (NY00339000), the facility did not ensure residents were free from abuse, including but not limited to corporal punishment and any physical restraint not required to treat the resident's medical symptoms, for 1 of 3 residents reviewed (Resident #1). Specifically, licensed practical nurse #4 pushed multiple wet washcloths into the resident's face when the resident declined to receive care and certified nurse aides #5 and 6 held the resident's hands while licensed practical nurse #4 provided care that the resident declined.</p> <p>Findings include:</p> <p>The Abuse Prevention Policy, modified 3/20/2019, documented the facility will not permit residents to be subjected to abuse by anyone, including staff members and residents will be provided with appropriate clinical care and treatment and will be cared for according to the individualized care plan.</p> <p>Resident #1 had diagnoses including anxiety disorder, major depressive disorder, and mild cognitive impairment. The 3/5/2024 Minimum Data Set assessment documented the resident had intact cognition, did not exhibit behavioral symptoms, and did not resist care. The resident required substantial/maximum assistance with dressing, bathing, hygiene, and moderate assistance with transfers.</p> <p>The resident's comprehensive care plan documented:</p> <ul style="list-style-type: none"> - on 5/13/2021, the resident had an activities of living self-care performance deficit and could be resistive to care. Interventions included: assistance of 1 for morning/evening care, weekly shower, and dressing; offer one to one support, if behavior continued, redirect or reapproach as needed and as the resident allowed. - On 1/6/2024, the resident had potential for physical aggression and had poor impulse control. Interventions included: anticipate needs; analyze triggers; engage calmly in conversation; if response is aggressive, staff to walk away calmly and approach later. <p>The 4/12/2024 facility investigation documented:</p> <ul style="list-style-type: none"> - Resident #1 refused their shower and certified nurse aide #5 asked licensed practical nurse #4 to assist in encouraging the resident to take a shower. - Licensed practical nurse #4 attempted to remove the resident's leg wraps (elasticized bandages for the management of swelling) and the resident became agitated and hit the nurse. - Licensed practical nurse #4 told the resident they must be washed and wrung out wet washcloths over the resident's head. - The resident became agitated, pushed licensed practical nurse #4 and licensed practical nurse #4 took approximately 4 wet washcloths and shoved them into the resident's face. <p>(continued on next page)</p>		

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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>	<ul style="list-style-type: none"> - The resident became angry and certified nurse aide #5 reported seeing arms flying and the call bell cord became entangled and pulled from the wall. - Licensed practical nurse #4 again shoved multiple washcloths directly into the resident's face. - Certified nurse aide #5 asked licensed practical nurse #4 to leave the bathroom and completed care with the resident without issue. - Licensed practical nurse #4 returned and insisted on applying the resident's leg wraps. The resident was resistive, hit the nurse, and the nurse insisted on applying the leg wraps. - The resident was assessed with no injury noted after the incident and social services interviewed the resident who had recall of the event and was not fearful of staff or peers. <p>Statements obtained by the facility and included with the 4/12/2024 investigation included:</p> <ul style="list-style-type: none"> - Resident #1's statement, documented by registered nurse Manager #9, included they did not want to take a shower and said they would take one the following day. Licensed practical nurse #4 told the resident they would take a shower that day and the resident said no. In the bathroom, licensed practical nurse #4 started scrubbing the resident's head and the resident said no, and the nurse continued. Licensed practical nurse #4 threw the washcloth in the resident's face. The nurse also hit the top of their head, but it did not hurt. - Certified nurse aide #5's statement documented the incident as noted in the investigation and additionally noted they held hands with the resident when licensed practical nurse #4 was removing their leg wraps. The resident asked them to let go, and the aide said they would if they stopped hitting the nurse. Certified nurse aide #6 entered the bathroom and held Resident #1's hands to stop them from hitting licensed practical nurse #4 when they were applying the leg wraps. - Licensed practical nurse #4's statement documented they tried to assist with getting the resident into the shower chair and the resident refused. Licensed practical nurse #4 attempted to wash the resident's head or hair and took a defensive approach after the resident grabbed at them and threw a washcloth. The resident hit the nurse when they were applying the leg wraps. <p>The 4/12/2024 at 11:37 AM Director of Social Services' progress note documented they followed up with the resident regarding the incident. The resident reported they were doing fine and added it will be forgotten. They did not present with any signs of distress.</p> <p>During an interview with Resident #1 on 4/18/2024 at 1:40 PM, they stated on 4/12/2024 they did not want to take a shower and licensed practical nurse #4 pushed washcloths in my face. The resident stated when certified nurse aides #5 and 6 held their hands, it was like a restraint and they did not want the nurse near them. The resident stated they were angry when it happened, but not fearful of staff. They stated they had no current concerns with staff and just wanted to get past it.</p> <p>(continued on next page)</p>		

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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>During an interview with certified nurse aide #6 on 4/18/2024 at 2:46 PM, they stated on 4/12/2024, they heard screaming and yelling from Resident #1's room and went to assist. When certified nurse aide #6 approached the resident, certified nurse aide #6 held onto one of the resident's arms and the resident turned and bit them. Certified nurse aide #6 left the room and returned approximately 15 to 20 minutes later in response to more yelling in the bathroom. Licensed practical nurse #4 was putting leg wraps on the resident and the resident was yelling at the nurse to get away. The nurse said they had to do it and the resident continued to tell them to get away from them. Certified nurse aide #6 stated they did not hold the resident's hands while the nurse applied the leg wraps.</p> <p>During an interview with certified nurse aide #5 on 4/19/2024 at 8:32 AM, they stated on 4/12/2024, the resident refused a shower and licensed practical nurse #4 said they would remove their leg wraps. The resident said no, and the nurse proceeded to remove the wraps. The resident began hitting the nurse and certified nurse aide #5 held their hand telling the resident they could not hit the nurse. The resident told the aide to let go; the aide told them only if they agreed to stop hitting. They stated they held the resident's hand like a friend and not in a restraining manner. In the bathroom, licensed practical nurse #4 wrung out water from the washcloths over the resident's head. The resident became upset and pushed the nurse. Licensed practical nurse #4 then took several wet washcloths and mushed them into the resident's face. The resident's and nurse's arms were flying around, washcloths were being thrown, and the call bell came out of the wall. Certified nurse aide #5 asked licensed practical nurse #4 to leave and by then the nurse had again shoved multiple wet washcloths into the resident's face. Licensed practical nurse #4 returned shortly after and insisted on applying the resident's leg wraps. Certified nurse aide #6 returned, the resident was hitting licensed practical nurse #4 as they continued to wrap their legs. Certified nurse aide #6 held the resident's hands so the nurse could finish wrapping their legs.</p> <p>During an interview with licensed practical nurse #4 on 4/19/2024 at 10:00 AM, they stated on 4/12/2024, the resident refused their shower, and they assisted in washing the resident in the bathroom. The nurse stated they could not recall removing the resident's leg wraps or any refusals of care until the resident hit them when they were nearly done wrapping their legs.</p> <p>During an interview with the Director of Nursing on 4/19/2024 at 10:30 AM, they stated when they investigated they found that licensed practical nurse #4 abused Resident #1. Their findings were based on Resident #1's report and certified nurse aide #5's statement. The Director of Nursing stated when certified nurse aide #5 noted they held the resident's hands, it was explained that was in a friend-like manner and not perceived as restraining the resident. They did not notice certified nurse aide #5 included that certified nurse aide #6 held the resident's while the nurse continued to wrap their legs and the resident was resisting and hitting the nurse. The Director of Nursing stated that could be a means of restraint.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>37385</p> <p>Based on record review and interview during the abbreviated survey (NY00339000), the facility did not ensure all allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated and did not ensure further potential abuse was prevented for 1 of 3 residents (Resident #1) reviewed. Specifically,</p> <ul style="list-style-type: none"> - certified nurse aide #5 witnessed alleged abuse by licensed practical nurse #4 towards Resident #1 and did not report the alleged abuse immediately resulting in licensed practical nurse #4 continuing to have access to residents for the remainder of the shift while the investigation was pending. - Statements from staff, given the facility, documented additional potential abuse and those allegations were not investigated. - The resident was not assessed by a qualified professional timely following allegation of abuse. <p>Findings include:</p> <p>The Abuse Prevention Policy, modified 3/20/2019, documented the facility must ensure that all alleged violations involving mistreatment, neglect, exploitation, or abuse are reported immediately to the Administrator. The facility shall document that all alleged violations were thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.</p> <p>The Abuse Reporting and Investigation policy, modified 2/5/2019, documented:</p> <ul style="list-style-type: none"> - any employee who suspected or witnessed abuse, neglect, or mistreatment or has reasonable cause to believe abuse occurred must immediately report to the supervisor. - The Supervisor will notify the designated registered nurse and Administrator on call. - The Supervisor or designated registered nurse will immediately assess the resident for injury or harm. - Written statements from staff who cared for and/or were responsible for the management of the resident's care before and after the incident will be obtained. - Interviews will be conducted by nursing supervisors of the resident(s) involved, all witnesses, and all others as indicated. <p>Resident #1 had diagnoses including anxiety disorder, major depressive disorder, and mild cognitive impairment. The 3/5/2024 Minimum Data Set assessment documented the resident had intact cognitive function and did not exhibit behavioral symptoms. The resident required substantial/maximum assistance with dressing, bathing, hygiene, and required moderate assistance with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 4/12/2024 at 4:48 AM, licensed practical nurse #4's progress note documented the resident refused a shower and was washed up in bathroom. In the process, the resident bit certified nurse aide #6 and broke their skin and then was hitting licensed practical nurse #4 while wrapping their legs.</p> <p>The 4/12/2024 facility investigation documented:</p> <ul style="list-style-type: none"> - Licensed practical nurse #4 told the resident if they refused to take a shower they had to be washed and wrung out wet washcloths over the resident's head. The resident became agitated, pushed the nurse, and licensed practical nurse #4 then took approximately 4 wet washcloths and shoved them into the resident's face. - The resident became angry and certified nurse aide #5 reported seeing arms flying and the call bell cord became entangled and pulled from the wall. - Licensed practical nurse #4 again shoved multiple washcloths into the resident's face. - Certified nurse aide #5 asked licensed practical nurse #4 to leave the bathroom and completed care with the resident without issue. - Licensed practical nurse #4 returned and Resident #1 stated they wanted the nurse out of their room. - Licensed practical nurse #4 insisted on applying the resident's leg wraps, the resident was resistive, hit the nurse and asked the nurse to give them 5 minutes, and the nurse insisted on applying the leg wraps. - Certified nurse aide #5 reported this occurred between 4:00 AM and 4:45 AM on 4/12/2024. - Certified nurse aide #5's statement documented the incident as noted in the investigation and additionally noted that certified nurse aide #6 entered the bathroom and held Resident #1's hands to stop them from hitting licensed practical nurse #4 when they were re-applying the leg wraps. - Licensed practical nurse Supervisor #7's statement documented at 7:00 AM on 4/12/2024, certified nurse aide #5 reported alleged abuse by licensed practical nurse #4 towards Resident #1. Licensed practical nurse Supervisor #7 updated the Director of Nursing and the protocol for abuse and neglect prevention was initiated. <p>There was no documented evidence the allegation that certified nurse aide #6 held the resident's hands was investigated.</p> <p>Licensed practical nurse #4's timecard documented they clocked in on 4/11/2024 at 6:40 PM and clocked out on 4/12/2024 at 7:30 AM.</p> <p>There was no documented evidence licensed practical nurse #4 was prevented from having access to Resident #1 or other residents following the incident (4:00 AM- 4:45 AM) until they left the facility at 7:30 AM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 4/12/2024 Director of Nursing's progress note at 8:00 AM, documented it was a late entry and at approximately 7:00 AM, staff reported inappropriate physical contact between staff and the resident during care. The immediate intervention was a registered nurse assessment, and no injuries were noted. The staff member was removed from care and an investigation was initiated.</p> <p>The 4/12/2024 Quality Assurance Accident/Incident Report completed by registered nurse #8 at 10:30 AM, documented they were called to the unit to assess the resident. The resident denied pain and had no bumps or bruising on their head. Staff reported to licensed practical nurse Supervisor #7 that a staff member had put washcloths in the resident's face 2 times while the resident was refusing care and became combative.</p> <p>The 4/12/2024 registered nurse #8's progress note at 11:05 AM, documented the were called to the unit to assess the resident.</p> <p>During an interview with registered nurse #8 on 4/18/2024 at 12:23 PM, they stated they were called to the unit to assess the Resident #1 on 4/2/2024 at approximately 10:30 AM. Registered nurse Manager # 9 called them to complete the assessment. They were unaware of any delays in doing the assessment and began the assessment shortly after being asked.</p> <p>During an interview with certified nurse aide #6 on 4/18/2024 at 2:46 PM, they stated on 4/12/2024 when they entered the resident's room, they held onto one of the resident's arms and the resident turned and bit the aide, and the aide left the room. Certified nurse aide #6 returned approximately 15 to 20 minutes later in response to yelling in the bathroom. Licensed practical nurse #4 was putting leg wraps on the resident and the resident was yelling at the nurse to get away. Certified nurse aide #6 stated they did not hold the resident's hands while the nurse applied the leg wraps. Certified nurse aide #6 reported they were not questioned by anyone at the facility about the incident and was not asked to provide a written statement.</p> <p>During an interview with certified nurse aide #5 on 4/19/2024 at 8:32 AM, they stated on 4/12/2024, the resident woke up around 4:00 AM. They attempted to have the resident take a shower and the resident refused. Certified nurse aide #5 witnessed licensed practical nurse #4 commit suspected abuse during the time they attempted to provided care. Certified nurse aide #5 also witnessed certified nurse aide #6 hold the resident's arms when the resident was hitting licensed practical nurse #4. The incident took place from approximately 4:15 AM to 4:45 AM. Certified nurse aide #5 was not able to call for a Supervisor while the incident was occurring as they wanted to stay with the resident. After the incident, certified nurse aide #5 did not report it as they did not want to be obvious in leaving the unit. Certified nurse aide #5 stated they also did not feel comfortable calling for a Supervisor or notifying someone to report the incident. When their shift ended at 7:00 AM, they went to see licensed practical nurse Supervisor #7 and reported what happened with Resident #1. The aide stated they thought what they witnessed was abuse and knew they had to report it, and they were not aware of any policy about when it had to be reported.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Willow Point Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 Old Vestal Road Vestal, NY 13850	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with licensed practical nurse #4 on 4/19/2024 at 10:00 AM, they stated on 4/12/2024, the resident refused their shower, and they assisted in washing the resident in the bathroom. The nurse stated they could not recall removing the resident's leg wraps or any refusals of care until the resident hit them when they were nearly done wrapping their legs. They could not recall certified nurse aide #6 being in the resident's bathroom as they applied the leg wraps. Licensed practical nurse #4 continued to work until the end of their shift. They were not notified to leave the floor prior to the end of the shift and continued to provide resident care.</p> <p>During an interview with the Director of Nursing on 4/19/2024 at 10:30 AM, they stated the protocol for incidents of suspected abuse was to report immediately to a Supervisor. The purpose of immediate reporting was to ensure resident safety and removal of the accused staff pending investigation. Once the resident was safe and certified nurse aide #5 was able, they should have reported it immediately, not 2 hours later. The Director of Nursing did not address the delayed reporting with certified nurse aide #5. Once and incident of suspected abuse was reported, the resident should be assessed immediately by a registered nurse. Immediate assessment was important in order to observe for any injuries or redness. The Director of Nursing was unaware of the reason the resident was not assessed until approximately 10:30 AM, as they were in receipt of the allegation at approximately 7:00 AM. The Director of Nursing did not notice certified nurse aide #5's statement that certified nurse aide #6 held the resident's while the nurse continued to wrap their legs and the resident was resisting and hitting the nurse. The Director of Nursing stated that could be a means of restraint and they did not ask certified nurse aide #6 about the incident or obtain a statement.</p> <p>During an interview with registered nurse #9 on 4/30/2024 at 10:25 AM, they stated they were covering the resident's unit on 4/12/2024 and learned about the incident that morning. They were delayed in going to see the resident due to the resident being in an activity. They were hesitant to interrupt the resident and eventually did have them leave in order to obtain their statement. Registered nurse #8 was also present and completed the assessment after registered nurse #9 obtained the resident's statement. The registered nurse stated assessments should be done immediately following an incident or allegation and they should not have delayed doing so. The resident was not injured and reported no emotional distress.</p> <p>10NYCRR 415.4(b)</p>		