Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335311	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tolstoy Foundation Rehabilitation and Nrsg Center	100 Lake Road Valley Cottage, NY 10989

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 interview during an abbreviated survey (NY00346485), the facility did not ensure residents were free from abuse for 1 of 3 residents (Resident #1) reviewed for abuse. Specifically, on 6/26/2024 a visitor to the facility reported that while walking down the hallway they witnessed Certified Nurse Assistant #1 punching Resident #1 in their head, in the resident's room. Findings include: The facility abuse policy last revised January 2024 documented all residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property. Physical abuse includes hitting, slapping, pinching, and kicking. A Quarterly 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 00/15, associated with severe cognition impairment.re impairment, 08-12 moderate impairment and 13-15 cognitively intact). The resident was dependent for eating and toileting and required maximal assistance with bed mobility and transfers. There was no documented evidence of a risk for abuse care plan in place for Resident #1. A review of resistive to care plan dated 7/27/2023 and last revised 4/22/2024 documented a behavior related to dementia. Interventions listed included to allow resident to make decisions about treatment regimen; to provide a sense of control, encourage participation by the resident as possible during care, give clear explanation of all care activities, if resist with activities of daily living, reassure the resident and leave and return within 5 minutes later and try again, praise the resident when behavior is appropriate, provide consistency with care to provide comfort in activities of daily living, provide resident with opportunities for choice during care (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 an impaired cognition care plan dated 7/29/2023 and last revised 7/22/2024 documented the resident has impaired cognitive function/dementia or impaired thought process related to Alzheimer's, Dementia long term memory loss. Interventions listed included to ask yes/no questions to determine the resident's needs, communication-use the resident preferred name, identify yourself at each interaction, face the resident when speaking clearly, reduce any distractions, provide the resident with necessary cues, keep the resident routine consistent and try to provide consistent care givers to decrease confusion, present one thought idea question or command at a time. A review of the accident/incident investigative report dated 6/26/2024 documented at approximately 3:00 PM a visitor witnessed alleged abuse involving Resident #1 and Certified Nurse Assistant #1. Certified Nurse Assistant #1 left the building at 3:05 PM and was instructed not to return to the building, pending investigation results. A certified letter was sent to the Certified Nurse Assistant #1 on 7/1/2024 terminating them. Review of the investigative summary and conclusion dated 7/1/2024 documented based on the investigation the facility was unable to substantiate the abuse allegation, although a credible witness provided statements, the alleged victim due to advanced dementia is unable to articulate any details of the alleged incident. Additionally, no other witnesses were identified, comprehensive examinations conducted by a physician and several medical professionals have revealed no evidence of abuse, therefore we cannot conclusively determine abuse occurred in this case. However, given the severity of the allegations and out of abundance of caution and concern for the safety and well-being of our residents the facility decided to terminate the employee, the decision is made to ensure the highest level of care and safety in the facility. Review of the employee statements revealed there was no documented statement from Certified Nurse Assistant #1 regarding the incident During a telephone interview on 7/3/2024 at 9:30 AM, the complainant/witness stated on 6/26/2024 they came to the facility to visit someone else. The complainant/witness stated the resident they went to see was not in their room. The complainant/witness stated there was a dayroom area near the resident room and they checked there, and they were not there either. The complainant/witness stated as they were walking back from the day room, they heard a sound to the left of them and saw a Certified Nurse Assistant #1 punching Resident #1 with a closed fist in their head. The complainant stated the Certified Nurse Assistant #1 punched Resident #1, 1 time and they then locked eyes with them. The complainant/witness stated Certified Nurse Assistant #1 and started telling them they did not see what they thought they saw. The complainant/witness stated they wanted to get the Certified Nurse Assistant #1 out of the room with Resident #1 and that they told them It is not okay, you were hitting Resident #1 in their head. (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 7/3/2024 at 12:10 PM, the Administrator stated they have been working in the facility for [AGE] years. The Administrator stated the social worker came to them shortly after 3:00 PM and stated that the complainant/witness reported they saw a Certified Nurse Assistant strike a resident. The Administrator stated they went downstairs to find the certified nurse assistant and they were gone because it was change of shift. The Administrator identified that it was Certified Nurse Assistant #1 and they went back upstairs and spoke with the complainant/witness, who was clear they had seen this. The Administrator stated the visitor recounted what they saw to them, the Director of Nursing, and the social worker. The Administrator stated the complainant/witness wrote a statement and they notified the Director of Nursing, and they came into the facility. The Administrator stated they tried to get in touch with Certified Nurse Assistant #1 by phone and they were unavailable, no response. The Administrator stated they did put in writing that Certified Nurse Assistant #1 was indefinitely suspended pending the outcome of the investigation. The Administrator stated they saw the Medical Director and they went and saw Resident #1 immediately and stated there was no indication of injury, bruising, bleeding, impaired mobility. The Administrator stated the Attending Physician came into the facility and was informed as to what occurred, and they accompanied them to assess Resident #1 and there was no injury, swelling or bleeding found. The Administrator stated Resident #1 was baseline. The Administrator stated they have regularly checked in with Resident #1 since the incident occurred. The Administrator stated that there had been no issue with Certified Nurse Assistant #1 and residents in the past. The Administrator stated Certified Nurse Assistant #1 did have an abruptness to them. The Administrator stated that the witness was very credible and that Certified Nurse Assistant #1 never came in to give a statement of what occurred. The Administrator stated a statement was not obtained from the other certified nurse assistants. The Administrator stated they feel Certified Nurse Assistant #1 did abuse Resident #1 and that they will probably lose their license over this incident. During an interview on 7/3/2024 at 2:42 PM, the Medical Director stated they have been the Medical Director in the building since last July. The Medical Director stated they were in the facility making rounds and the complainant/witness came to them and stated they witnessed Resident #1 being abused. The Medical Director stated they went and saw Resident #1, but they did not see any marks on the resident, and it is the Attending Physician's resident and not their resident. The Medical Director stated the complainant/witness told them that they saw a certified nurse assistant hitting Resident #1. The Medical Director stated complainant/witness was worked up and about to cry when they saw them and asked if they were the Administrator and they informed them they were not and to go to the second floor to find the Administrator. The Medical Director stated they gave a statement to the Administrator and then the Attending Physician came and examined Resident #1. The Medical Director stated they did not document in Resident #1's chart about their assessment, because it was not their resident, and the Attending Physician was coming in to see Resident #1 and they would chart on them. During a telephone interview on 7/30/2024 at 10:05 AM, the Director of Nursing stated when they arrived at the facility, they went downstairs and went to look in on Resident #1. The Director of Nursing stated the Attending Physician was in the facility, and they accompanied them to Resident #1's room to do an assessment. The Director of Nursing stated they assessed Resident #1 for bruising or injuries, and they did not find any. 10 NYCRR 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during an abbreviated survey (NY00346485) , the facility did not ensure allegations of abuse were thoroughly investigated for 1 out of 3 (Resident #1) residents reviewed for abuse. Specifically, a visitor in the facility reported they witnessed Certified Nurse Assistant #1 punching Resident #1 in the head on 6/26/2024, there was no written statement obtained from Certified Nurse Assistant #1. There was also no documented evidence of Resident #1 being assessed by a Medical Physician, a Nurse Practitioner, or Registered Nursing staff. In addition, the residents Certified Nurse Assistant #1 cared for were not interviewed or assessed to rule out abuse. Findings include: The facility abuse policy last updated January 2024 documented that for the investigation of actual or suspected (including alleged) cases upon notification of abuse or potential abuse, the Director of Nursing/designee shall immediately commence an investigation including interviewing, with written, signed statements of staff having knowledge or involvement in the alleged incident. Resident #1 had diagnoses including but not limited to Alzheimer's, Diabetes Mellitus, and muscle weakness. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 0 (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). The resident was dependent for eating and toileting and required maximal assistance with bed mobility and transfers. A review of the accident/incident investigative report dated 6/26/2024 documented Resident #1 was assessed by the Physician, Medical Director, nursing supervisor and Director of Nursing. The statements obtained from staff and witnesses and local police department notified and report made. Staff education/in-service completed by the Director of Social Services. Review of the employee statements revealed there was no documented statement from Certified Nurse Assistant regarding the incident. Review of the investigative summary and conclusion dated 7/1/2024 documented based on the investigation the facility was unable to substantiate the abuse allegation, although a credible witness provided statements, the alleged victim due to advanced dementia is unable to articulate any details of the alleged incident. Additionally, no other witnesses were identified, comprehensive examinations conducted by a physician and several medical professionals have revealed no evidence of abuse, therefore we cannot conclusively determine abuse occurred in this case. However, given the severity of the allegations and out of abundance of caution and concern for the safety and well-being of our residents the facility decided to terminate the employee, the decision is made to ensure the highest level of care and safety in the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the complainant/witness statement dated 6/26/2024 documented they were in the building visiting another resident, but they were not in the room. The complainant/witness stated they went to the dayroom which was close to Resident #1's room then while walking back from the dayroom they saw Certified Nurse Assistant #1 physically pushing and flipping Resident #1 onto their bed. The complainant/witness stated Certified Nurse Assistant #1 saw them and immediately started pleading with them, the Certified Nurse Assistant #1 proceeded to help Resident #1 to the bed and then walked out to the hallway where they were and stated to the visitor baby, baby, they are sorry. The complainant/witness stated they told Certified Nurse Assistant #1 it was wrong to push Resident #1 on the head, the Certified Nurse Assistant #1 stated they know but Resident #1 was biting them on their hand. The complainant/witness stated they informed Certified Nurse Assistant #1 that they are a mandated reported and they going to report what they saw. The complainant/witness stated Certified Nurse Assistant #1 then took their hand and continued to plead with them and stated, they knew that they saw what they did, and they were sorry, please. The complainant/witness stated Certified Nurse Assistant #1 stated they were on their way out. The complainant/witness stated they reported the incident to the Medical Director, Administrator, the social worker, and the nursing supervisor. During an interview on 7/3/2024 at 12:10 PM, the Administrator stated they have been working in the facility for [AGE] years. The Administrator stated the social worker came to them shortly after 3:00 PM and stated that the complainant/witness reported they saw a Certified Nurse Assistant strike a resident. The Administrator stated they went downstairs to find the certified nurse assistant and they were gone because it was change of shift. The Administrator identified that it was Certified Nurse Assistant #1 and they went back upstairs and spoke with the complainant/witness, who was clear they had seen this. The Administrator stated the visitor recounted what they saw to them, the Director of Nursing, and the social worker. The Administrator stated the complainant/witness wrote a statement and they notified the Director of Nursing, and they came into the facility. The Administrator stated they tried to get in touch with Certified Nurse Assistant #1 by phone and they were unavailable, no response. The Administrator stated they did put in writing that Certified Nurse Assistant #1 was indefinitely suspended pending the outcome of the investigation. The Administrator stated they saw the Medical Director and they went and saw Resident #1 immediately and stated there was no indication of injury, bruising, bleeding, impaired mobility. The Administrator stated the Attending Physician came into the facility and was informed as to what occurred, and they accompanied them to assess Resident #1 and there was no injury, swelling or bleeding found. The Administrator stated Resident #1 was baseline. The Administrator stated they have regularly checked in with Resident #1 since the incident occurred. The Administrator stated that there had been no issue with Certified Nurse Assistant #1 and residents in the past. The Administrator stated Certified Nurse Assistant #1 did have an abruptness to them. The Administrator stated that the witness was very credible and that Certified Nurse Assistant #1 never came in to give a statement of what occurred. The Administrator stated a statement was not obtained from the other certified nurse assistants. The Administrator stated they feel Certified Nurse Assistant #1 did abuse Resident #1 and that they will probably lose their license over this incident. The Administrator stated it would be you're their word against their word and the union would be involved. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/2024 at 4:30 PM, Licensed Practical Nurse #1 stated they were the nursing supervisor on 6/26/2024. Licensed Practical Nurse #1 stated Certified Nurse Assistant #5 provided care to Resident #1 on the shift after the incident, and that Licensed Practical Nurse #2 was the nurse for Resident #1 after the incident. Licensed Practical Nurse #1 stated the Director of Nursing called them and told them Licensed Practical Nurse #3 needed to do a full body assessment of Resident #1 at 3:00 PM and then to do another full body assessment 2 hours after. Licensed Practical Nurse #2 stated the full body assessment conducted by Licensed Practical Nurse #2 would be documented in a progress note. Licensed Practical Nurse #1 stated they asked Licensed Practical Nurse #2 if they documented the assessment and they stated they did it already and that they clarified that a before and after needed to be completed and Licensed Practical nurse #2 stated they were aware. During an interview on 7/3/2024 at 5:05 PM, Licensed Practical Nurse #2 stated when they arrived at the facility on 6/26/2024 and were receiving report, they saw the Administrator and the Attending Physician walking down the hall to Resident #1's room. Licensed Practical Nurse #2 stated after the Administrator and the Attending Physician came back from Resident #1's room, the Director of Nursing asked them to do a body check and they asked on who. Licensed Practical Nurse #2 stated the Director of Nursing stated on Resident #1, and they asked why, did they fall and they do not recall what they said. Licensed Practical Nurse #2 stated they did the body check as they got to the Resident #1's room at around 5:00 PM or 6:00 PM. Licensed Practical nurse #2 stated they found nothing alarming and did not document the skin check for Resident #1 because there were no significant findings to Resident #1's body, so there was nothing to document. Licensed Practical Nurse #2 stated there is a neuro check form that is completed with falls, but because they did not fall they did not complete it. During a telephone interview on 7/30/2024 at 9:25 AM, Registered Nurse Supervisor #1 stated they were the morning supervisor on 6/26/2024 and at around 4:00 PM the Director of Social Services called them and stated that one of the visitors saw a staff member doing something to a resident. Registered Nurse Supervisor #1 stated they went to Resident #1's room with the Director of Social Services and Certified Nurse Assistant #1. Registered Nurse Supervisor #1 stated Certified Nurse Assistant #1 stated they punched out and were ready to go home and they saw Resident #1 in the hallway sitting in the wheelchair and they were sliding down and they put the resident back in the bed. Registered Nurse Supervisor #1 stated Resident #1 was in bed and they checked the residents body and did not see any redness or injury or anything, and the resident was comfortable in bed. Registered Nurse Supervisor #1 stated they did not document the body assessment they completed because they thought the next shift would take care of it because it was the end of their shift. During a telephone interview on 7/30/2024 at 10:05 AM, the Director of Nursing stated they did not document Resident #1's skin check, because it was the Attending Physician that was doing the assessment and they were just there as a witness, but they should have. The Director of Nursing stated no other residents that Certified Nurse Assistant #1 care for were interviewed or assessed to ensure they had not been abused other than Resident #1 that was involved. The Director of Nursing stated no staff got a written statement from Certified Nurse Assistant #1 after the incident. 10 NYCRR 483.12(c)