STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335339	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountainside Residential Care Center	42158 State Highway 28 Margaretville, NY 12455

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** 35228 Based on record review and interviews during an abbreviated survey (Case #s NY00347949 and NY00347739), the facility did not ensure the resident had the right to be free from abuse for 2 (Resident #s 1 and 2) of 4 residents reviewed for abuse. Specifically, on 7/08/2024, Resident #2 was observed in Resident #1's room with their hand down the front of Resident #1's gown holding their left breast and attempting to kiss the resident. Both residents had severe cognitive impairment and could not consent. This is evidenced by: The Policy and Procedure titled, Nursing Services: Resident Abuse, Neglect, Mistreatment, Exploitation, Misappropriation, Reporting and Elder Justice Act dated August 2001, documented the resident would be free from all sexual abuse. It documented sexual abuse in the case of resident-to-resident was defined as any form of sexual contact without the other resident's consent when the other resident was incapable of giving informed consent, when the perpetrator was incapable of giving consent, or of understanding the implications of their actions. Resident #1 was admitted to the facility with diagnoses of dementia, high blood pressure, and pain. The Minimum Data Set (an assessment tool) dated 5/23/2024, documented the resident was cognitively intact; however, the incident report provided to New York State Department of Health documented the resident had severe cognitive impairment which aligned with the surveyor's observation of the resident, could usually be understood, and could usually understand others. The Comprehensive Care Plan for The Potential to Present with Sad, Pained, Anxious Facial Expressions related to Fluctuations in Mood updated 7/08/2024, documented Resident #1 was kissed and their breast was exposed and fondled by Resident #2. It documented to be aware of residual effects from Resident #2's sexual touching, the resident did remember the event, and to assure their comfort. The Comprehensive Care Plan for At Risk for Abuse by Other Residents updated on 7/08/2024, documented the resident was kissed and their breast was exposed and fondled by Resident #2. It documented if accosted, to monitor for adverse reactions. A stop alarm banner was placed across Resident #1's door. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Mountainside Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 42158 State Highway 28 Margaretville, NY 12455	

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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	The Certified Nurse Aide Kardex as of 7/25/2024 (a document that provided the Certified Nurse Aides with the directions for the care a resident needed) documented a stop alarm banner was to up at all times when the resident was in their room. A Resident and Family Services Note dated 7/09/2024 at 5:08 PM, documented Director of Resident and Family Services #1 interviewed Resident #1 regarding the incident with Resident #2 who inappropriately kissed and sexually touched Resident #1. The staff who witnessed the incident intervened immediately and removed Resident #2 from the room. Resident #1 had no memory of the event. During an interview on 7/23/2024 at 11:32 AM, Certified Nurse Aide #4 stated Resident #1 had difficulty communicating and had not said anything to them about the incident that occurred with Resident #2. During an interview on 7/23/2024 at 12:31 PM, Resident Care Coordinator #1 stated Resident #1 did not recall the incident when they spoke with them. Resident Care Coordinator #1 stated they notified the family who agreed to a stop sign banner across the resident's door to discourage others from entering their room. During an interview on 7/23/2024 at 1:56 PM, Resident #1 was unable to answer any questions and repeated their name numerous times. Resident #2 was admitted to the facility with diagnoses of a stroke, dementia, and depression. The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood, and could understand others. The Comprehensive Care Plan for Mood/Affect/Behavior revised on 7/09/2024, documented the resident inappropriately sexually touched and kissed a non-consenting resident (Resident #1) on 7/08/2024. An intervention was added on 7/08/2024 to remind Resident #2 to stay away from residents who could not defend themselves. It documented on 7/09/2024 1-to-1 supervision was started and on 7/10/2024, a beam alarm was placed on Resident #2's door (an alarm to alert staff when the resident was leaving their room). The Certified Nurse Aide Kardex as of 7/25/2024 (a document that provided the Certified Nurse Aides with the directions for the care a resident needed) documented the resident was on 1-to-1 supervision and on 07/10/2024, a beam alarm was placed on the resident's doorway. A Resident and Family Services Note dated 7/09/2024 at 8:51 PM, documented Director of Resident and Family Services #1 received report Resident #2 was found by Certified Nurse Aide #1 to be kissing Resident #1 on the mouth, exposing their left breast and touching it. Swift intervention was taken, and Resident #2 quickly left the scene and returned to their room. Resident #1 was unable to consent to the activity and had limited ability to defend themselves. Discussions with Resident #2 to set boundaries and expectations were to no avail due to moderate cognitive impairment, poor insight/judgement, and dementia diagnosis. The resident was started on 1-to-1 supervision due to acting in an opportunistic manner and crossing the line to predatory behavior. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A Medical Provider Note dated 7/09/2024 at 6:58 PM, documented Physician Assistant #1 was aware of the 07/08/2024 incident between Resident #s 1 and 2. The facility was working on a discharge plan for Resident #2 to return to their country and in the meantime, the resident was on 1-to-1 supervision. Physician Assistant #1 documented they did not feel medication for Resident #1's sexual desire was indicated. Such medical interventions typically take a relatively long time to become effective. In summary, Physician Assistant #1 documented that safe discharge home would be the most logical and ethical plan considering all options.

During an interview on 7/23/2024 at 11:32 AM, Certified Nurse Aide #4 stated Resident #2 tired to kiss 2 residents when in the common area and staff needed to keep an eye on them to redirect them. The stated Resident #2 was now on 1-to-1 supervision. It was on their assignment sheet, so they knew who was assigned for the shift. They had been updated in report regarding the incident between Resident #s 1 and 2 so they could keep them and the other residents safe.

During an interview on 7/23/2024 at 12:31 PM, Resident Care Coordinator #1 stated Resident #2 had cognitive impairment and was forgetful. They stated they started 1-to-1 supervision for Resident #1 on 7/09/2024 due to the 7/08/2024. They stated they were off from work on 7/10/2024 and when they returned to work on 7/11/2024, Resident #2 had been put back on 15-minute checks. Resident Care Coordinator stated they reimplemented 1-to-1 supervision for Resident #2 and put the intervention in their care plan.

During an interview on 07/23/2024 at 12:58 PM, Certified Nurse Aide #1 stated (on 7/08/2024) Resident #1's call light was on and when they entered their room, they saw Resident #2's hand in Resident #1's gown holding their breast. Resident #2 was trying to kiss Resident #1. Certified Nurse Aide #1 stated they yelled at Resident #2 that was not okay and told them to get out of the room. Certified Nurse Aide #1 stated they yelled for help and Certified Nurse Aide #3 came to the room. They stated they told Certified Nurse Aide #3 to keep an eye on Resident #2 and not let them out of their sight. Certified Nurse Aide #1 stated they reported the incident to Licensed Practical Nurse #1. They stated Resident #1 looked afraid. Resident #1 was unable to verbally respond.

During an interview on 7/23/2024 at 1:16 PM, Licensed Practical Nurse #1 stated immediately upon report of the 07/08/2024 incident between Resident #s 1 and 2, Certified Nurse Aide #3 was assigned to provide 1-to-1 supervision for Resident #2. They stated both residents had dementia and could not consent to a sexual relationship.

During an interview on 07/23/2024 at 3:11 PM, Director of Resident and Family Services #1 stated at some point in time, Resident #2 turned a corner and became predatory. Director of Resident and Family Services #1 stated the incident with between Resident #s 1 and 2 occurred on 7/08/2024. Resident #1 was unable to recall the incident when the Social Worker talked with them after the incident. Director of Resident and Family Services #1 stated if people were able to give consent, had capacity, insight, and judgement for a sexual relationship, they could decide if they wanted one. If a person could not say yes or no or be able to defend themselves, they should not have a sexual relationship. Dementia was progressive and a resident who may have consented to a sexual relationship prior to their dementia, may no longer be able to do so, so that needed to be watched to protect the resident. The Social Worker stated everyone was aware eyes had to be on Resident #1 and they were on 1-to-1 supervision. Staff were to have an awareness of the where about of the vulnerable residents.

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NAME OF PROVIDER OR SUPPLIER: Mountainside Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 42158 State Highway 28 Margaretville, NY 12455	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2024 at 8:54 AM, Director of Nursing #1 stated on 7/08/2024 at 1:45 PM Certified Nurse Aide #1 witnessed the inappropriate touching of Resident #1 by Resident #2. They saw Resident #2's hand down Resident #1's gown fondling their breast and trying to kiss them. Certified Nurse Aide #1 reported it to the nurse immediately and the nurse reported it to them. Director of Nursing #1 stated an investigation was started right away and the Administrator was made aware. They stated they had a Spanish interpreter to interview Resident #2. They stated neither Residents #1 nor #2 could recall the incident. Director of Nursing #1 stated Resident #1 would not have been able to tell Resident #2 they did not want to be touched. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35228 Based on record review and interviews during an abbreviated survey (Case #s NY00347949 NY00347739), the facility did not ensure in response to allegations of abuse that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse for 3 (Resident #s 1, 2, and 3) of 4 residents reviewed for abuse. Specifically, the facility did not report witnessed resident-to-resident sexual abuse between Resident #s 1 and 2, neither of whom were cognitively intact within 2 hours. Additionally, the facility did not report suspected sexual abuse within 2 hours for an alleged resident-to-resident incident that involved Resident #s 2 and 3. Resident #2 was not cognitively intact. This is evidence by: The Policy and Procedure titled, 483.35 Nursing Services: Resident Abuse, Neglect, Mistreatment, Exploitation, Misappropriation, Reporting & Elder Justice Act effective 08/2001, documented if an incident or allegation was considered reportable, the Administrator or designee would make an initial (immediately or within 24 hours) report to New York State Department of Health via the Health Commerce System. Resident #1 was admitted to the facility with diagnoses of dementia, high blood pressure, and pain. The Minimum Data Set (an assessment tool) dated 5/23/2024, documented the resident was cognitively intact; however, the incident report provided to New York State Department of Health documented the resident had severe cognitive impairment which aligned with the surveyor's observation of the resident, could usually be understood, and could usually understand others. Resident #2 was admitted to the facility with diagnoses of a stroke, dementia, and depression. The Minimum Data Set (an assessment tool) dated 4/18/2024, documented the resident had severe cognitive impairment, could be understood, and could understand others. Resident #3 was admitted to the facility with diagnoses of spinal cord injury in the neck, seizures, and chronic yeast infection of the vagina. The Minimum Data Set (an assessment tool) dated, documented the resident was cognitively intact, could be understood, and could understand others. The New York State Department of Health Intake Information form documented an incident of alleged resident-to-resident sexual abuse that occurred on 7/07/2024 at 7:30 PM was submitted incorrectly to New York State Department of Health on 7/10/2024 at 11:13 AM. It was submitted via an attachment to an email rather than via the required form through the Health Commerce System. The New York State Department of Health Intake Information form documented an incident of alleged resident-to-resident sexual abuse that occurred on 7/08/2024 at 12:24 PM was reported to Department of Health on 7/11/2024 at 9:02 AM. During an interview on 7/24/2024 at 8:54 AM, Director of Nursing #1 stated the Administrator was the person who reported incidents to New York State Department of Health. Director of Nursing #1 stated abuse had to be reported to Department of Health within 24 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2024 at 10:41 PM, Interim Administrator #1 stated they thought they had 24 hours to report abuse/suspected abuse to New York State Department of Health. The Interim Administrator stated they were not aware of the first alleged incident (that occurred on 7/07/2024) until after they were made aware of the second incident (that occurred 7/08/2024). 10 New York Codes, Rules, and Regulations 415.4(b)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35228 Based on record review and interview during an abbreviated survey (Case #s NY00347949 and NY00347739), the facility did not ensure a resident who displayed or was diagnosed with a mental disorder received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for 2 (Resident #s 1 and 2) of 4 residents reviewed. Specifically, Resident #1's care plan documented to notify a mental health provider if they had signs of post-traumatic stress disorder following a witnessed incident of sexual abuse by Resident #2. Additionally, it was documented Resident #2 had a diagnosis of depression, had become predatory and staff were concerned about their escalating sexual activity accompanied by opportunistic behavior/lack of judgement, insight, and impulsivity. There was no documented evidence that Resident #2 received psychiatry services. This is evidenced by: The Policy and Procedure titled, Psychotropic Drug (medications used to treat mental health disorders) Usage Review revised on 2/25/2022, documented the facility recognized the significance of depression and anxiety among nursing home residents and strove to meet the needs of any resident who may be suffering. It documented Nursing, Social Work, and medical staff would attempt the following as appropriate or applicable; counseling, referral for Psychiatric evaluation and/o referral to a Licensed Clinical Social Work or Licensed Mental Health Clinician for evaluation. Resident #1 was admitted to the facility with diagnoses of dementia, high blood pressure, and pain. The Minimum Data Set (an assessment tool) dated 5/23/2024, documented the resident was cognitively intact; however, the incident report provided to New York State Department of Health documented the resident had severe cognitive impairment which aligned with the surveyor's observation of the resident, could usually be understood, and could usually understand others. The Comprehensive Care Plan for At Risk for Abuse by Other Residents updated on 7/08/2024, documented the resident was kissed and their breast was exposed and fondled by Resident #2. It documented if accosted, to monitor for adverse reactions and make a mental health referral if they had symptoms of post-traumatic stress syndrome. Resident #2 was admitted to the facility with diagnoses of a stroke, dementia, and depression. The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood, and could understand others. The July 2024 Medication Administration Record documented the resident was prescribed Lexapro (a drug to treat depression) 20 milligrams by mouth one time a day. A Late Entry Note written by Director of Resident and Family Services #1 dated 7/08/2024 at 5:21 PM, Resident #2's cognitive deficits were evident. The Interdisciplinary Team and staff were concerned regarding escalating sexual activity accompanied by opportunistic behavior/lack of judgement, insight, and impulsivity. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's medical records revealed no documented evidence that the resident received psychiatry services. During an interview on 7/23/2024 at 11:29 AM, Director of Nursing #1 stated the facility did not have psychiatric services or a psychologist to see the residents. They stated they were advocating for tele-psych services to have someone that their Physician Assistant and Medical Doctors could consult with for medication management. They stated the Medical Doctors (internists and family practitioners) did not feel comfortable managing psychotropic medications for residents with psychiatric diagnoses and prescribed the medications in low doses. They stated the staff provided alternative interventions to manage resident behaviors. 10 New York Codes, Rules, Regulations 415.12(f)(1)