STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335371	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Endicott L L C	301 Nantucket Drive Endicott, NY 13760

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 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. Based on record review and interviews (2989447), the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation was made for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Certified Nurse Aide #3 alleged on the evening of 04/18/2026, they witnessed Certified Nurse Aide #4 holding the resident's wrists firmly, banging the resident's fists into their face and bending the resident's fingers backwards. Certified Nurse Aide #3 did not report the abuse immediately and Certified Nurse Aide #4 continued to work with residents. Furthermore, Certified Nurse Aide #3 reported the incident to Certified Nurse Aide #7 and Certified Nurse Aide #7 did not report the abuse allegation timely.Findings include:The facility policy Abuse Policy and Prevention, revised 11/2023 documented employees must always report any abuse or suspicion of abuse immediately to the Administrator. The alleged employee accused of alleged abuse would immediately be removed from the facility and would remain removed pending the results of the investigation. Resident #1 had diagnoses including dementia and psychotic disorder (severe mental illness). The 03/19/2026 Minimum Data Set assessment documented the resident's cognition was severely impaired. The 01/08/2026 Comprehensive Care Plan documented Resident #1 had behaviors of physical aggression and resistance to care. The resident was incontinent of bowel/bladder and they had potential to abuse others. Interventions included: reapproach as needed; avoid overstimulation; provide care out of room (i.e.: shower room); check and change every two hours and as needed; and if the resident was agitated, cease interaction/activity and return after the agitation had diffused. The 04/20/2026 Incident Report completed by Registered Nurse Manager #5 documented Certified Nurse Aide #3 reported that during the evening shift on 04/18/2026, Certified Nurse Aide #4 was being rough with care with Resident #1. There were no injuries, no signs of pain or verbal complaints. The medical provider and family were notified. Staff statements included:- Certified Nurse Aide #3 documented during incontinence care, they witnessed Certified Nurse #4 grab the resident by the wrists and hit the resident in the face with the resident's own hands every time the resident moved. Certified Nurse Aide #4 bent the resident's fingers backwards and made the resident say uncle before they would let go. They asked Certified Nurse Aide #4 what they were doing and the aide stated they got this. The resident yelled ouch and stop during the incident. They did not know what to do as they had never dealt with a situation like that and they did not report the incident to anyone that night.- Certified Nurse Aide #4 documented they were asked by Certified Nurse Aide #3 to help with a combative resident. While attempting to change Resident #1, the resident became more combative and started swinging (their arms). Certified Nurse Aide #4 held on the resident's wrists to avoid both staff getting hit. While holding the resident's wrist, the resident was jerking themselves back and forth hitting their face into their fists. They denied pushing the resident's hands into their face and denied bending the resident's fingers backward.- Certified Nurse Aide #7 reported to the facility (in a telephone interview), they were not aware of the incident, and nothing was reported to them. The facility's Investigative Summary documented:- The Administrator and Director of Nursing were notified of the incident on 04/20/2026 at 3:41 PM.- Certified Nurse Aide #4 was on duty at the time the incident was reported, and they were (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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(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	suspended.- Certified Nurse Aide #3 was interviewed about why they did not report the incident on 04/18/2026 and stated they were afraid Certified Nurse Aide #4 would confront them.- On 04/23/2026, Certified Nurse Aide #7 was interviewed and stated Certified Nurse Aide #3 told them about the incident when they worked together on 04/19/2026. This was different than what Certified Nurse Aide #7 documented in their statement obtained on 04/20/2026. When questioned why Certified Nurse Aide #7 did not immediately report the incident to a supervisor, they stated they told Certified Nurse Aide #3 to report it to the nurse manager.- Certified Nurse Aide #3 was re-interviewed and questioned why, during their initial interview, they did not report they had spoken to Certified Nurse Aide #7 about the incident. They stated they were upset about the incident and told Certified Nurse Aide #7 because they were not sure what to do. Certified Nurse Aide #3 was educated about the importance of the investigative process and if they reported to any other staff, they needed to know immediately. Certified Nurse Aide #3 denied reporting the incident to anyone else. Certified Nurse Aide #4's time sheet documented on 04/18/2026, they clocked in at 3:12 PM and clocked out on 04/19/2026 at 3:03 AM. During an interview on 04/27/2026, Certified Nurse Aide #3 stated on 04/18/2026, the resident was not agitated during care and was fidgety. Certified Nurse Aide #4 grabbed the resident's wrists and hit the resident in the face with the resident's own hands. They also bent the resident's fingers backwards until the resident said uncle. They questioned Certified Nurse Aide #4 on what they were doing and the aide stated to them they got this. They did not report to anyone that night because they were worried about Certified Nurse Aide #4 retaliating against them as the aide had yelled at them and others in the past. They believed they could report to their unit manager who was not going to be on duty until 04/20/2026. They reported to the manager on 04/20/2026, was suspended for not reporting timely, and was retrained on the facility's Abuse Policy and timely reporting of abuse. During an interview on 04/28/2026, the Administrator stated the investigation was inconclusive because it was one aide's word against the other's, the resident had no injuries and was at their baseline. They terminated Certified Nurse Aide #4 because interviews with staff revealed Certified Nurse Aide #4 was a bully (to other staff) and they felt the aide had the potential to abuse others. Certified Nurse Aides #3 and #7 were suspended for not reporting the incident timely. A full house re-education on their Abuse Policy, Corporate Compliance, with a focus on timely reporting was currently in process. Certified Nurse Aide #4 was not reached for an interview on 04/28/2026 at 8:34 AM and on 05/21/2026 at 9:00 AM. During an interview on 05/27/26 at 9:17 AM, the Medical Director stated they expected staff to report abuse immediately because it was serious, the facility was responsible for taking care of residents, and it needed to be addressed right away. They discussed the incident with the facility and heard the aide delayed reporting the incident because they questioned what they had witnessed. The witnessing staff should have reported it immediately. During an interview with Certified Nurse Aide #7 on 05/27/2026 at 10:40 AM, they stated on 04/19/2026, Certified Nurse Aide #3 reported to them they witnessed another aide holding Resident #1's hands tightly, bending their fingers, and making the resident say uncle. They told Certified Nurse Aide #3 to report the incident on Monday (05/20/2026) morning. Certified Nurse Aide #7 stated they should have reported the allegation immediately and have since been retrained. 10 New York Codes, Rules and Regulations 415.4(b)(3)