STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335377	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collar City Nursing and Rehabilitation Center	100 New Turnpike Road Troy, NY 12182

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. 33538 Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint NY00334205), the facility did not ensure residents were free from physical abuse for two (Residents #8 and 9) of three residents reviewed. Specifically, the facility did not implement interventions following resident-to-resident abuse (Resident #8, 9) incidents on 12/18/2023 and 2/06/2024 resulting in third incident on 2/23/2024. Findings include: The policy and procedure titled Abuse, Neglect and Mistreatment Prevention dated 9/2021 documented that Department Managers and Administration will identify residents whose personal histories and diagnoses render them at risk for abusing other residents. Develop strategies to prevent occurrences and monitor for changes that would trigger abusive behavior. Systemically reassess these interventions to monitor their effectiveness. Ensure adequate assessment, care planning, and monitoring of residents. In particular, focus on residents with history of aggressive, wandering, or self-injurious behaviors. Resident #8 Resident #8 was admitted to the facility with diagnoses of dementia, insomnia, and cervical disc disorder. The Minimum Data Set (an assessment tool) dated 2/1/2024, documented the resident could sometimes be understood, could usually understand others, and had severe cognitive impairment. A Progress Note dated 12/18/2023 documented the resident wandered into a resident's room and struck them causing a bloody nose. A Progress Note dated 2/6/2024 documented the resident wandered into Resident #9's room and struck them in the face. A Progress Note dated 2/23/2024 documented the resident wandered into Resident #9's room and struck them in the chest. A Comprehensive Care Plan titled behavioral problem with wandering into other resident's rooms was created on 11/10/2023 and last revised on 12/18/2023 with the intervention for 30-minute safety checks when out of bed was added. (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	A Comprehensive Care Plan titled resident has potential to become physically aggressive related to dementia was created on 5/17/2021 and last revised on 2/12/2024 when the following interventions were added: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. The Care Card, printed on 3/05/2024 documented 30-minute safety checks when out of bed. During an interview on 3/06/2024 at 12:00 PM, Registered Nurse #2 stated they put the 30-minute checks in the care plan and the documentation should be completed by the nurses and scanned into the medical record. They were unable to provide any documented 30-minute checks for this resident. During an interview on 3/06/2024 at 12:10 PM, Licensed Practical Nurse #3 stated they were not aware of the need for 30-minute checks on this resident. Typically, that information would be relayed by the outgoing nurse and the document would be in the folder on the med cart. There was no folder on the cart today. During an interview on 3/6/2024 at 12:15 PM, Licensed Practical Nurse #4 stated 30-minute checks were documented on the Medication or Treatment Administration Record. There was no documentation found on the Administration Records. During an interview on 3/06/2024 at 12:50 PM, the Director of Nursing stated they did not do 30-minute checks and they stopped doing them some time last year. They stated they put the stop sign on victim's door after this incident, but the resident did not want it because it impeded entrance to the room. There were no other interventions after the first incident and the intervention in place was not consistently utilized. The stop sign remained on the care plan, it should have been removed and 30-minute checks should not have been put in the care plan at all. Resident #9 Resident #9 was admitted to the facility with diagnoses of dementia, insomnia, and cervical disc disorder. The Minimum Data Set (an assessment tool) dated 2/1/2024, documented the resident could be understood, could understand others, and had moderate cognitive impairment. A Progress Note dated 2/6/2024 documented resident was struck in the face by another resident (Resident #8) that wandered into their room. A Progress Note dated 2/23/2024 documented the resident was hit in the chest by another resident (Resident #8) A Comprehensive Care Plan titled At Risk to be a Victim of Abuse Related to Dementia and Immobility was initiated on 2/16/2024 and last revised on 2/23/2024. The only intervention documented was, stop sign on door when in room. The Care Card, printed on 3/5/2024 documented stop sign on door when in room. An Interdisciplinary Team review note dated 2/26/2024 documented the resident chose not to use stop sign at times secondary to restriction of movement in and out of room. No new interventions at this time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 3/5/2024 at 2:15 PM and 3/6/2024 at 10:15 AM the resident was in the room and the stop sign was hanging down the left side if the entry doorway. During an interview on 3/6/2024 at 10:15 AM, Resident #9 stated the stop sign was usually down and it did not matter because the resident that punched them last week still comes in even if the stop sign was up. Resident #9 stated they understood the resident did not know what they were doing was wrong, but they should not have to deal with it. During an interview on 3/6/2024 at 10:25 AM, Licensed Practical Nurse #2 stated the stop sign should be across the door. They stated they would re-direct the resident from wandering in there if they saw them but could not watch constantly. All staff knew to re-direct and did not know what else they could do 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 43805 Based on observations, interviews, and record reviews conducted during the abbreviated survey (Case #NY00333272), the facility did not ensure each resident was free from misappropriation of resident property and exploitation for 1 (Resident #7) of 9 residents reviewed. Specifically, the facility did not ensure that Resident #7's property was secured in a locked drawer. This is evidenced by: Resident #7 Resident #7 was admitted to the facility with the diagnoses of Guillain-Barre syndrome (a rare disorder of the immune system), chronic kidney disease and type 2 diabetes. The Minimum Data Set (an assessment tool) dated 2/9/2024 documented the resident was able to be understood and was able to understand others. The Brief Interview for Mental Status documented a score of 12/15, significant for a moderate cognitive impairment. The Policy and Procedure titled Abuse, Neglect, and Mistreatment - Definitions and Examples dated 9/2022 was reviewed and defined misappropriation as the theft, unauthorized use or removal, embezzlement, or intention destruction of the resident's personal property. The policy documented the facility would not use nor permit verbal, sexual, or physical abuse, neglect, or mistreatment of residents. The Policy and Procedure titled Abuse, Neglect, and Mistreatment - Identification dated 9/2022 was reviewed and documented appropriate corrective actions should be taken after the identification and investigation into abuse, neglect, and mistreatment. An Incident and Accident report dated 2/09/2024 was reviewed and documented Resident #7 claimed $75 dollars was missing from their drawer. The incident report documented Resident #7 had been given a locked drawer after the alleged event. During an interview on 3/5/2024 at 11:43 AM, Resident #7 stated they had money in their drawer for the eye doctor. Resident #7 stated they were given a drawer with a lock on it but did not have a key to lock the drawer. When Resident #7 was observed to go get the money, they noticed the money was not in their drawer. Resident #7 reported the missing money to the nurse. They stated that nothing else of theirs was missing. During an interview on 3/5/2024 at 11:48 AM, Registered Nurse #2 stated the resident should have been provided a key with the locked drawer. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/2024 at 11:52 AM, Director of Nursing #1 stated Resident #7 had reported their eye doctor money missing. After a search of the resident's belongings, an investigation was started and reported to the Department of Health. Director of Nursing #1 stated the resident was provided with a locked drawer after the 2/09/2024 incident, but the facility was unable to locate a key for the drawer. They stated an order for a replacement key had been completed. They stated a new administration team had come into the facility around 2 weeks ago and they mentioned it to them as well. They were unaware that the order had not been completed. They stated an audit for locked drawers was done after the incident and locked drawers were offered to all residents that did not have a locked drawer. They could not say why Resident #7 did not have a way to secure their valuables from the time of the reported incident until the abbreviated survey. During an interview on 3/5/2024 at 12:01 PM, Administrator #1 stated they had requested a new lock from corporate and they have been waiting for it to be fulfilled. They stated they would provide the resident with a portable safe in the meantime. They could not state why a portable safe was not provided before. 10 New York Codes, Rules and Regulation 415.4(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43805 Based on observation, record review and interviews during the abbreviated survey (NY00332433), the facility did not ensure care plans were reviewed and revised in a timely manner for 1 (Resident #6) of 9 residents reviewed for Comprehensive Care Plans. Specifically, for Resident #6's Comprehensive Care Plan for at risk for falls was not reviewed and revised after a fall in which the intervention of a floor mat was added on the Accident and Incident report. This is evidenced by: Resident #6 Resident #6 was admitted with the diagnoses of aftercare following joint replacement surgery, muscle weakness, and dysphagia (difficulty swallowing). The Minimum Data Set (an assessment tool) dated 1/17/2024 documented the resident was able to be understood and was able to understand others. The Brief Interview for Mental Status documented the resident scored 13/15, indicating the resident was cognitively intact. The facility's policy and procedure titled Resident Assessment and Care Planning dated 2/19/2022 was reviewed and indicated an individualized comprehensive plan of care would be developed and kept current to meet each resident's needs. The Comprehensive Care Plan titled Resident is at risk for Falls was reviewed and indicated did not include the intervention of or a floor mat was not initiated until 3/5/2024. One listed intervention, fall risk precautions, did not provide any explanation or clarification. During observations on 3/5/202024 at 11:35 AM and 3/6/2024 at 11:18 AM, a folded-up floor mat was noted in Resident #6's room. During Resident #6's record review, a document titled Un-witnessed Fall dated 1/23/2024 was reviewed and documented after interdisciplinary team review, a door-side fall mat was added to the care plan. The Certified Nurse Aide Kardex (Certified Nurse Aide Care Card) for Resident #6, dated 1/31/2024, was reviewed and did not include floor mats as an intervention for resident safety. During an interview on 3/24/2024 at 11:45 AM, Certified Nurse Aide #1 stated that the Kardex (Certified Nurse Aide Care Card) should be checked at the start of each shift, so each Certified Nurse Aide knows what kind of care to provide to each resident. They stated that if a safety measure like floor mats was not on the Kardex (Certified Nurse Aide Care Card) they might not realize a resident needs them, even if they were in the room. During an interview on 3/24/2024 at 11:48 AM, Registered Nurse #2 stated they were the covering unit manager for the unit and was not very familiar with the residents. Registered Nurse #2 stated that if an intervention was added to an incident/accident report, that intervention should have been carried over to the care plan and Kardex (Certified Nurse Aide Care Card). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/2024 at 11:52 AM, Director of Nursing #1 reviewed the interdisciplinary meeting related to Resident #6's fall that occurred on 1/23/2024. They stated that the floor mat should have been added to the comprehensive care plan and the Kardex (Certified Nurse Aide care card) and did not know why it was not. Director of Nursing #1 stated they did not know what fall risk precautions (listed as an intervention on the comprehensive care plan) meant. They stated someone should have questioned this during Resident #6's care conference. They stated it is the facility expectation that the entire care plan should be reviewed and updated as appropriate prior to the care conference and should again be reviewed by the interdisciplinary team during the care conference. 10 New York Codes, Rules and Regulation 415.11(c)(2)(i-iii)