

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Sodus Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6884 Maple Ave Sodus, NY 14551	

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>Respond appropriately to all alleged violations.</p> <p>41591</p> <p>Based on observation, interviews, and record review completed during an Abbreviated Survey (#NY00337643), for one (Resident #1) of three residents reviewed, the facility did not ensure that an allegation of abuse was thoroughly investigated. Specifically, a staff member reported on 3/25/24 that they witnessed a potential abuse incident on 3/20/24 between another staff member and Resident #1. The facility's investigation to rule out any abuse, neglect or mistreatment concluded no abuse occurred but did not include any interviews with staff members who were working at the time of the alleged incident and witnessed the incident. Additionally, the facility did not report the alleged abuse until 13 days after it occurred. This was evidenced by the following:</p> <p>Resident #1 had diagnoses including dementia, depression, and diabetes. The Minimum Data Set Resident Assessment, dated 1/10/24, documented the resident was severely impaired cognitively.</p> <p>Review of a facility's Investigation Summary dated 3/25/24 and completed by the Director of Nursing, revealed that an incident occurred on 3/20/24 between Licensed Practical Nurse #1 and Resident #1. Resident #1 was sitting at the nurse's station, appeared upset and threw food at Licensed Practical Nurse #1 and the nurse swatted it away. The report included that the food went back towards the resident but did not hit them. The summary included that interviews were conducted by the Director of Nursing with Licensed Practical Nurse #1, Licensed Practical Nurse Manager #1 and two additional witnesses who were not identified in the report and did not include any statements. The Director of Nursing concluded there was no abuse and no action taken. The Investigation Summary later added that updated interviews (4/4/24 after surveyor intervention) that were conducted with staff members were inconclusive, but that two staff members reported Resident #1 was hit with the food that was thrown back by Licensed Practical Nurse #1.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/24 at 11:49 AM and again at 1:11 PM Licensed Practical Nurse Manager #1 stated the incident was reported to them on 3/20/24 via a text from Licensed Practical Nurse #1 that included that Resident #1 threw food at them which they swatted away. The text included that a Staff Member who was present was upset about the incident. Licensed Practical Nurse Manager #1 stated that on 3/25/24 (five days after the incident) they overheard a staff member telling a nurse about the incident that occurred 3/20/24. When questioned at the time, the staff member informed Licensed Practical Nurse Manager #1 that when Resident #1 threw the food, Licensed Practical Nurse #1 threw it back at the resident hitting them in the face causing a red spot. Licensed Practical Nurse Manager #1 stated they obtained written statements from staff regarding the incident at that time but were unable to find any of them. Licensed Practical Nurse Manager #1 said they reported the incident to the Administrator, Director of Nursing and Assistant Administrator but did not complete an Incident/Accident Report.</p> <p>During interviews on 4/4/24, between 2:00 PM to 2:30 PM, Certified Nursing Assistants #1, #2 and #3 each stated they had not been asked to provide a statement regarding their account of the incident that they witnessed on 3/20/24 until that morning (4/4/24).</p> <p>During an interview on 4/4/24 at approximately 1:30 PM the Director of Nursing stated they were unaware Licensed Practical Nurse Manager #1 was unable to find any staff statements regarding the incident and that the investigation should include statements from staff working at the time of the incident.</p> <p>During an interview on 4/9/24, at 8:43 AM the Administrator stated they should be notified immediately of any suspected abuse and that the Nurse Managers are responsible for investigating any alleged incident of possible abuse and notifying Administration. The Administrator stated that on 3/25/24 Licensed Practical Nurse Manager #1 reported an incident to them and told them another resident was a witness. The Administrator stated they interviewed this resident who was alert and oriented and said nothing happened. The Administrator stated staff who were present should have been interviewed regarding the incident and it should have been reported to the Department of Health within five days and it was not.</p> <p>10 NYCRR 415.4</p>		