

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2025
NAME OF PROVIDER OR SUPPLIER  Ferncliff Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  21 Ferncliff Drive Rhinebeck, NY 12572	
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 - 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.  (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review during an abbreviated survey (# 2658277), the facility failed to ensure residents were free from physical abuse by a staff member for one (1) of three (3) residents (Resident # 1) reviewed for Abuse. Specifically, on 10/13/2025, Resident #1 who had severe cognitive impairment was slapped in the face by Licensed Practical Nurse #3 after an argument between Resident #1 and Licensed Practical Nurse #3 over a piece of cake. Subsequently, Resident #1 sustained redness and swelling to their right cheek and was crying. Resident #1 was led to their room by Certified Nurse Aide #1 where they consoled them and encouraged the resident to relax. Applying the reasonable person concept, this resulted in psychosocial harm to Resident #1 that was not Immediate Jeopardy. The findings include: The policy titled Resident Abuse Reporting and Investigation last reviewed 08/28/2023, documented to protect residents and ensure freedom from abuse and mistreatment. Resident #1 had the following diagnoses: diabetes mellitus (condition that occurs when blood sugar is too high), major depressive disorder (mental health condition characterized by persistent feeling of sadness or loss of interest in activities), and dementia (condition characterized by progressive or persistent loss of intellectual functioning). The care plan titled Behavior Symptoms initiated 01/29/2022 documented Resident #1 required ongoing redirection, monitoring, and structured activities to alter behavior problems; identify reason and pattern of behavior. The care plan titled Victimization: At Risk Due to Dementia initiated 04/12/2022 documented Resident #1 will not be victimized or harmed by others. Counseling as needed, separate from others as needed, and engage in activity of choice. The 09/12/2025 annual Minimum Data Set (a resident assessment tool) documented Resident #1 had severe cognitive impairment and had no behaviors. The 10/31/2025 Accident and Incident Report documented that at approximately 1:30PM-1:45PM on 10/31/2025, Resident #1 took another resident's cake while in the dining room during lunch. Licensed Practical Nurse #3 got into an argument with the resident about the cake. The resident stood up and spit in Licensed Practical Nurse #3's face and Licensed Practical Nurse #3 slapped Resident #1 on the right cheek. The incident was witnessed by Certified Nurse Aide #1 and Certified Nurse Aide #2 and statements were collected. The Assistant Director of Nursing #1 was notified by Certified Nurse Aide #1. The physician was notified immediately, and Licensed Practical Nurse #3 was removed from the facility. The family was notified as well as law enforcement and the State Department of Health. Nurse Practitioner #8 note, dated 10/31/2025 at 2:50 PM, documented Resident #1's right cheek with mild erythema (redness) and mild swelling. Monitor for pain and change in condition. The Resident may have Tylenol for discomfort, and to be seen by social work for supportive care. The Director of Social Work note, dated 10/31/2025 at 3:09 PM, documented Resident #1 denied any recollection of physical contact or trauma today. No signs of fear, distress, or anxiety noted. Social work provided support and comfort with plan to check up on resident for signs of anxiety, fear and distress. The Nursing note, dated 11/02/2025, documented follow up, no redness to right cheek, redness resolved, resident refused any interventions. Physician #9 note, dated 11/02/2025, documented assessment performed after alleged physical assault by staff, no visible trauma, resident does not recall the event, maintain safety and continue to monitor. Psychiatric Nurse Practitioner #7 note, dated 11/03/2025, documented that Resident #1 was pleasant and had no signs of distress. During an observation on 11/04/2025 at 11:11 AM, Resident #1 was assisting activities staff by adding slices of cucumber to water for the hydration station. Resident #1 smiled, stated their name for the writer and gave a brief explanation of the meaning of their name. Resident #1 appeared happy and content with no redness or swelling to the right side of their face. During an interview on 11/04/2025 at 1:27 PM, Certified Nurse Aide #1 stated that they were present in the dining room during the incident on 10/31/2025. Certified Nurse Aide #1 stated they observed Licensed Practical Nurse #3 slap Resident #1 after Resident #1 spit in their face. Resident #1 started crying and they walked over and escorted them out of the dining room to their room where they consoled them and encouraged them to relax. Certified Nurse Aide #1 stated that Certified Nurse Aide #2 reported the incident to Assistant Director of Nursing #1 and Licensed Practical Nurse #3 was escorted from the unit. During a telephone interview on 11/04/2025 at 1:50 PM, Certified Nurse Aide #2 stated that they witnessed the incident on 10/31/2025 and observed Resident #1 and Licensed Practical Nurse #3 arguing. The staff present tried to get Licensed Practical Nurse #3 to walk away but the argument continued. Resident #1 then spit on Licensed Practical Nurse #3 and Licensed Practical Nurse #3 immediately slapped Resident #1. Licensed Practical Nurse #3 walked</p>		