STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335425	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shaker Place Rehabilitation and Nursing Center	780 Albany Shaker Road Albany, NY 12211

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** Based on record review and interviews conducted during an abbreviated survey (Case #NY00377666), the facility did not ensure the residents' right to be free from abuse for one (1) (Resident #1) of one (1) resident reviewed for abuse. Specifically, on 4/09/2025 at 2:15 AM, Certified Nurse Aide #1 self-reported that they tapped Resident #1 on their right hand when the resident was combative during a shower. This is evidenced by: See cross references of F-609 and F-610. Resident #1 was admitted to the facility with diagnoses of anxiety disorder (mental health condition characterized by excessive fear or anxiety that interferes with daily activities), cognitive communication deficit (communication difficulties that arise from cognitive impairments), and insomnia (sleep disorder that can make it hard to fall asleep or stay asleep). The Minimum Data Set (an assessment tool) dated 2/10/2025, documented the resident was understood, could understand others, and had moderate cognitive impairments. The facility Policy and Procedure titled, Abuse Prohibition Program, updated 12/2022, documented the facility had procedures in place to screen and train employees, protect residents, and to prevent, identify, investigate and report abuse, neglect, mistreatment, and misappropriation of resident property. Physical abuse included hitting, slapping, pinching, and kicking, controlling behavior though the use of corporal punishment. The Alteration in Plan of Care related to Non-compliance Care Plan initiated 11/20/2024, documented Resident #1 was combative and non-compliant with transfers, ambulation status, showers, and activities of daily living with goal that Resident #1 would not have injury or ill effects from non-compliance. In a Skin Observation Tool dated 4/10/2025 at 2:53 PM, Registered Nurse #1 documented that Resident #1's right dorsal (back of the) hand had a diffuse, irregular fading, light purplish bruise with yellowish edges. It noted that there were four (4) purple bruises in linear fashion to the resident's right upper arm measuring 1.0 centimeters each. The resident's range of motion was within normal limits. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quality Assurance Investigation Report dated 4/10/2025, documented that Certified Nurse Aide #1 self-reported and admitted to tapping Resident #1's hand when the resident was combative during care. This initially resulted in a reddened area and subsequently a bruise. It was determined that Certified Nurse Aide #1 used their hand to block Resident #1 from hitting them, which caused a bruised area to the resident's right upper arm. The incident was witnessed by Certified Nurse Aide #2. Staff interviews and statements were collected, and an investigation was completed resulting in the termination Certified Nurse Aide #1, Certified Nurse Aide #2, and Registered Nurse #2. It was determined that the staff did not follow facility policy and best practices for management of combative behavior. The report concluded the incident was consistent with physical abuse and it was reported to the Department of Health and the [NAME] County Sheriff's Department. For Quality Assurance, 10 random staff interviews would be conducted weekly for all shifts for one month, and then monthly for 2 months to ensure retention of knowledge of abuse education provided. During an interview on 4/17/2025 at 10:34 AM, Resident #1 stated they did not recall the altercation that occurred with Certified Nurse Aide #1 on 4/09/2025. During a telephone interview on 4/17/2025 at 1:02 PM, Certified Nurse Aide #1 stated they gave Resident #1 a shower around 2:00 AM on 4/09/2025 because they were on the overnight shower schedule. Certified Nurse Aide #1 stated Resident #1 was combative during the shower. Certified Nurse Aide #1 stated they unintentionally tapped the resident's hand and after they finished the resident's care; Certified Nurse Aide #1 reported the incident to Licensed Practical Nurse #1. During a telephone interview on 4/18/2025 at 1:56 PM, Certified Nurse Aide #2 stated Certified Nurse Aide #1 requested they help them with Resident #1's shower on 4/09/2025 because the resident was combative. Certified Nurse Aide #2 stated they assisted by holding the shower hose. They stated during this time, Resident #1 was swatting at Certified Nurse Aide #1. They stated Certified Nurse Aide #1 must have had enough and tapped Resident #1 on the hand and said, stop doing that. They stated it was not in an aggressive way. When asked how Resident #1 responded to the tap, Certified Nurse Aide #2 stated the resident's behavior got worse, swatting Certified Nurse Aide #1 again. During a telephone interview on 4/18/2025 at 9:09 AM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 approached them around 2:15 AM on 4/09/2025 after giving a shower to Resident #1 and stated they 'lost it' and hit the resident's hand. Certified Nurse Aide #1 informed them that Certified Nurse Aide #2 was with them during the shower. Licensed Practical Nurse #1 stated they instructed Certified Nurse Aide #1 to stay in the office while they checked on Resident #1. They observed a reddened area on Resident #1's hand. They stated that they immediately called Registered Nurse #2 to inform them of the incident and that they would send Certified Nurse Aide #1 to the nursing supervisor's office. Licensed Practical Nurse #1 stated they questioned Certified Nurse Aide #2, who initially denied the accusation until they discovered Certified Nurse Aide #1 had reported themselves. Licensed Practical Nurse #1 further stated that Certified Nurse Aide #2 witnessed Certified Nurse Aide #1 hit Resident #1 in the thigh. Licensed Practical Nurse #1 stated that they sent both Certified Nurse Aides #'s 1 and 2 to the supervisor's office. Licensed Practical Nurse #1 stated Certified Nurse Aide #1 only turned themselves in because they were afraid that Certified Nurse Aide #2 would report them. (continued on next page)

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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	During an interview on 4/17/2025 at 2:14 PM, Director of Nursing #1 stated Licensed Practical Nurse #1 informed them of the alleged abuse on 4/10/2025 at 8:45 AM, reporting that Resident #1 was resistive to care being provided by Certified Nurse Aide #1, who 'lost it' and tapped the resident's hand. The incident was witnessed by Certified Nurse Aide #2. Certified Nurse Aide #1 self-reported the incident to Licensed Practical Nurse #1. Director of Nursing #1 stated that Licensed Practical Nurse #1 informed Registered Nurse #2 of the incident and sent the two (2) Certified Nurse Aides to the supervisor's office. The Certified Nurse Aides were sent back to the unit to work after speaking with Registered Nurse #2. Per Director of Nursing #1, Registered Nurse #2 denied any knowledge of the alleged abuse and stated they were only made aware that the resident was combative. Director of Nursing #1 stated that they were made aware of the alleged abuse on 4/10/2025 at approximately 8:45 AM, at which time Certified Nurse Aide #'s 1 and 2, and Registered Nurse #2 were suspended and later terminated. They stated a report was made to the Department of Health and to the [NAME] County Sheriff's Department. A skin assessment was completed for Resident #1 and bruising was noted. Their family and the physician were notified of the incident. Director of Nursing #1 stated it was concluded that Certified Nurse Aide #1 did tap Resident #1's hand. As a result, Certified Nurse Aide #1 was terminated. Certified Nurse Aide #2 was terminated because they witnessed the abuse, but did not report it and continued to work. Registered Nurse #2 was terminated because she was informed of the abuse by three (3) different staff members and did not follow the facility policies and procedures for abuse. Director of Nursing #1 stated the facility completed skin assessments for all residents on the unit with no identified concerns. Social work interviewed residents with a Brief Interview for Mental Status score above 8 and called family members for residents with a score of 8 or lower with no concerns reported. Director of Nursing #1 stated they started a house wide education on abuse, and staff could not work until educated. They further stated that even if staff received abuse education prior to the 4/10/2025, they had to be reeducated before working again. During an interview on 4/17/2025 at 2:28 PM, Administrator #1 stated they were notified of the incident on 4/10/2025 at 9:00 AM, and that Director of Nursing #1 immediately started an investigation. Administrator #1 stated Registered Nurse #2 did not seem to handle the situation appropriately, because Certified Nurse Aide #1 was not immediately removed and did not notify the Director of Nursing and Administrator. Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of surveyor entrance for this survey: On 4/10/2025, conducted skin assessments of all residents on the [NAME] Unit. Facility submitted a report to law enforcement. Incident was reported to the resident's representative and the physician. Social Services conducted interviews with all residents that resided on the [NAME] Unit with a Brief Interview for Mental Status of 8 or greater to confirm that there were no other care concerns. Social Services contacted all resident representatives if the resident's Brief Interview for Mental Status score was lower than 8 to confirm there were no care concerns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse Prohibition Program education was initiated on 4/10/2025 to all staff which included procedures on prevention, identification, investigation and reporting of abuse, neglect, mistreatment, and misappropriate of resident property. Education completed on 4/22/2025. For Quality Assurance, 10 random staff interviews would be conducted weekly for all shifts for one month, and then monthly for 2 months to ensure retention of knowledge of abuse education provided. 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. Based on record review and interviews conducted during an abbreviated survey (Case #NY00377666), the facility did not ensure that all alleged violations involving abuse were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures for one (1) (Resident #1) of one (1) resident reviewed. Specifically, Certified Nurse Aide #1 self-reported physical abuse to Resident #1 on 4/09/2025 at approximately 2:15 AM to Licensed Practical Nurse #1. The allegation was reported to the New York State Department of Health on 4/10/2025 at 10:33 AM. This is evidenced by: See cross references of F-609 and F-610. Resident #1 was admitted to the facility with diagnoses of anxiety disorder (mental health condition characterized by excessive fear or anxiety that interferes with daily activities), cognitive communication deficit (communication difficulties that arise from cognitive impairments), and insomnia (sleep disorder that can make it hard to fall asleep or stay asleep). The Minimum Data Set (an assessment tool) dated 2/10/2025, documented the resident was understood, could understand others, and had moderate cognitive impairments. The facility Policy and Procedure titled, Abuse Prohibition Program, updated 12/2022, documented all allegations of abuse should be reported to the Executive Director/designee immediately. If there was suspected abuse, the Executive Director should report immediately, but no later than 2 hours after the allegation was made, if the allegations involved abuse, to other officials (State Survey Agency). During a telephone interview on 4/17/2025 at 1:02 PM, Certified Nurse Aide #1 stated they gave Resident #1 a shower around 2:00 AM on 4/09/2025 because they were on the overnight shower schedule. Certified Nurse Aide #1 stated Resident #1 was combative during the shower and at one point they unintentionally tapped the resident's hand. After they finished the resident's care, Certified Nurse Aide #1 reported the incident to Licensed Practical Nurse #1 at approximately 2:15 AM. The facility Quality Assurance Investigation Report dated 4/10/2025, documented that Certified Nurse Aide #1 self-reported and admitted to tapping Resident #1's hand when the resident was combative during care on 4/09/2025 at approximately 2:00 AM. This initially resulted in a reddened area and subsequently a bruise. A Complaint/Incident Investigation Report documented the incident was reported to the New York State Department of Health on 4/10/2025 at 10:33 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/18/2025 at 9:09 AM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 approached them on 4/09/2025 around 2:15 AM after giving a shower to Resident #1 and stated they 'lost it' and hit the resident's hand. Certified Nurse Aide #1 informed them that Certified Nurse Aide #2 was with them during the shower. Licensed Practical Nurse #1 observed a reddened area on Resident #1's hand. They stated that they immediately called Registered Nurse #1 to inform them of the incident and sent both Certified Nurse Aides #'s 1 and 2 to the supervisor's office. Licensed Practical Nurse #1 stated they were confused when the aides returned to the unit to finish their shifts. During an interview on 4/17/2025 at 2:14 PM, Director of Nursing #1 stated they were informed of the alleged abuse on 4/10/2025 at 8:45 AM by Licensed Practical Nurse #1. During an interview on 4/17/2025 at 2:28 PM, Administrator #1 stated once they were made aware of the allegation on 4/10/2025 at 9:00 AM, Director of Nursing #1 immediately started an investigation and reported to the Department of Health and to law enforcement. They stated Registered Nurse #1, and Certified Nurse Aide #s 1 and 2 were terminated. 10 New York Codes, Rules, and Regulations 483.12 (c) (1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews conducted during an abbreviated survey (Case # NY00377666), the facility did not ensure alleged violations of abuse were thoroughly investigated for one (1) (Resident #1) of one (1) resident reviewed for abuse. Specifically, Certified Nurse Aide #1 was not removed immediately from resident care when there was an allegation of physical abuse made on 4/09/2025, to prevent further abuse from occurring. Certified Nurse Aide #1 was allowed to finish their shift on 4/09/2025 and also worked 11:00 PM- 7:00 AM shift on 4/09/2025 into 4/10/2025. This is evidenced by: See cross references of F-600 and F-609. The facility Policy and Procedure titled, Abuse Prohibition Program, updated 12/2022, documented the facility should take necessary measures to protect residents from harm or potential abuse during any investigation of an allegation of abuse. The facility should take steps to assure the resident identified as the alleged victim was safe from further incidents. If a staff member was identified as the alleged perpetrator, the staff member's manager, supervising nurse, or executive director should immediately remove the employee from the work area and relocate them to an area of the facility away from resident contact. Once an employee statement was obtained, the employee should be sent home and may be suspended pending investigation. The Quality Assurance Investigation Report dated 4/10/2025, documented that Certified Nurse Aide #1 self-reported and admitted to tapping Resident #1's hand when the resident was combative during care on 4/09/2025 at approximately 2:00 AM. This initially resulted in a reddened area and subsequently a bruise. During a telephone interview on 4/17/2025 at 1:02 PM, Certified Nurse Aide #1 stated they gave Resident #1 a shower around 2:00 AM on 4/09/2025 because they were on the overnight shower schedule. Certified Nurse Aide #1 stated Resident #1 was combative during the shower and at one point they unintentionally tapped the resident's hand. After they finished the resident's care, Certified Nurse Aide #1 reported the incident to Licensed Practical Nurse #1 at approximately 2:15 AM, who then informed Registered Nurse #2. Certified Nurse Aide #1 stated Registered Nurse #2 allowed them to finish their shift, that Resident #1 was removed from their assignment, and that they did not work with Resident #1 the remainder of the shift. Certified Nurse Aide #1 stated they also worked the following 11:00 PM to 7:00 AM shift on 4/09/2025 into 4/10/2025. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/18/2025 at 9:09 AM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 approached them on 4/09/2025 around 2:15 AM after giving a shower to Resident #1 and stated they 'lost it' and hit the resident's hand. Certified Nurse Aide #1 informed them that Certified Nurse Aide #2 was with them during the shower. Licensed Practical Nurse #1 observed a reddened area on Resident #1's hand. They stated that they immediately called Registered Nurse #1 to inform them of the incident and sent both Certified Nurse Aides #'s 1 and 2 to the supervisor's office. Licensed Practical Nurse #1 stated they were confused when the aides returned to the unit to finish their shifts, and that Registered Nurse #1 said to them Certified Nurse Aide #1 was just overwhelmed. Licensed Practical Nurse #1 stated Certified Nurse Aide #1 worked the following night 4/09/2025 on 11:00 PM -7:00 AM shift. Licensed Practical Nurse #1 stated they did not feel like the other residents were safe and followed Certified Nurse Aide #1 around throughout the shift in attempt to ensure safety of the residents. During an interview on 4/17/2025 at 2:14 PM, Director of Nursing #1 stated the Certified Nurse Aides were sent back to the unit to work after speaking with Registered Nurse #2 on 4/09/2025. Per Director of Nursing #1, Registered Nurse #2 denied any knowledge of the alleged abuse and stated they were only made aware that the resident was combative. They further stated they were made aware of the alleged abuse on 4/10/2025 at approximately 8:45 AM, at which time Certified Nurse Aides #'s 1 and 2, and Registered Nurse #2 were suspended and later terminated. During an interview on 4/17/2025 at 2:28 PM, Administrator #1 stated they were notified of the incident on 4/10/2025 at 9:00 AM, and that Director of Nursing #1 immediately started an investigation. Administrator #1 stated Registered Nurse #2 did not seem to handle the situation appropriately, because Certified Nurse Aide #1 was not immediately removed and did not notify the Director of Nursing and Administrator. 10 New York Codes, Rules, and Regulations 483.12(c)(3)