STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335442	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champlain Valley Physicians Hosp Med Ctr S N F	75 Beekman Street Plattsburgh, NY 12901

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35228 Based on record review and interviews during an abbreviated survey (Case #s NY00343699 and NY00318831), the facility did not ensure that all alleged violations involving abuse was reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the State Survey Agency in accordance with State law through established procedures for 2 (Resident #s 1 and 3) of 4 residents reviewed for abuse reporting. Specifically, allegations of physical and sexual abuse that involved 2 residents was not reported by staff to facility administration within 2 hours. This is evidenced by: The Policy and Procedure titled Abuse Prevention, Investigation, and Reporting revised 8/07/2019, documented if an individual had knowledge that physical abuse had occurred, or had reason to believe so, they must notify the charge nurse, patient care coordinator, Director of Nursing, or Administrator. The Administrator or their designee, having reasonable cause would be responsible for notifying Department of Health. Incidents involving serious bodily injury must be reported within 2 hours after forming suspicion. All others must be reported within 24 hours. Resident #1: Resident #1 was admitted to the facility with diagnoses of Alzheimer's disease, diabetes, and depression. The Minimum Data Set (an assessment tool) dated 3/12/2024, documented the resident had severe cognitive impairment, could sometimes be understood, and could sometimes understand others. A document confirming the facility's submission of the Nursing Home Incident report documented the facility submitted it on 5/29/2024 at 10:59 AM. It documented the alleged incident occurred on 5/28/2024 at 9:00 PM. An email dated 5/29/2024 at 8:46 PM, written by Certified Nurse Aide #2 to Registered Nurse Manager #1 documented they reported they were working with Certified Nurse Aide #1 the evening of 5/28/2024 when Resident #1 grabbed Certified Nurse Aide #1 by their wrist. Certified Nurse Aide #1 pulled away, but then smacked Resident #1 on the top of their hand loudly and was kinda being nasty to Resident #1. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Investigation Report dated 6/03/2024 at 1:08 PM, documented the alleged incident occurred on 5/29/2024 at 7:00 PM (date and time differ from the facility submission of the alleged incident that documented it occurred on 5/28/2024 at 9:00 PM). It documented Certified Nurse Aide #2 reported Certified Nurse Aide #1 allegedly struck Resident #1 on the hand when the resident allegedly grabbed Certified Nurse Aide #1's wrist. Certified Nurse Aide #1 stated Resident #1 dug their hand into their wrist, and they had to pry the resident's hand off their wrist. Certified Nurse Aide #1 denied smacking the resident's hand. The Registered Nurses who was supervising had no knowledge of the incident, nor did other staff. During an interview on 6/06/2024 at 2:38 PM, Certified Nurse Aide #2 stated they and Certified Nurse Aide #1 were putting Resident #1 to bed about 8:00 PM (5/28/2024). Resident #1 grabbed Certified Nurse Aide #1's arm when they were rolling the resident to change them. Certified Nurse Aide #2 stated Certified Nurse Aide #1 pulled back hard to free their arm from the resident's grip and then slapped the resident on the top of their hand making a loud sound. They stated they waited to talk with their Union representative (Certified Nurse Aide #4) when they came in to work at 9:30 PM because they were more comfortable speaking with them about the incident and were not sure how to handle the situation. They stated the Union representative told them they had 24 hours to report abuse. They stated they sent an email to Registered Nurse Unit Manager #1 at 8:00 AM on 5/29/2024. Certified Nurse Aide #2 stated they wished they had reported the alleged abuse sooner but was overwhelmed and did not know how to handle the situation. During an interview on 6/07/2024 at 11:26 AM, Director of Nursing #1 stated they first learned of the alleged incident until 5/29/2024 at 10:30 AM and reported it to Department of Health shortly after they were told. They stated when they learned about the incident, it was reported to them Certified Nurse Aide #2 witnessed Certified Nurse Aide #1 smack Resident #1 on their hand when trying to remove their wrist from the resident's grip. Director of Nursing #1 stated Certified Nurse Aide #4 (regarding the 5/28/2024 incident) told them Certified Nurse Aide #2 did not know how to proceed and Certified Nurse Aide #4 told them to report it. Director of Nursing #1 stated it was unknown if Certified Nurse Aide #4 told Certified Nurse Aide #2 to report right then, or within a specific timeframe. They stated Certified Nurse Aide #2 should have told someone immediately about the alleged incident. They stated they could have told the charge nurse, and if they felt uncomfortable, they could have called the Patient Care Coordinator (a nursing supervisor) and management. Director of Nursing #1 stated the phone numbers were posted at the nurses' station, and the numbers were provided to staff upon hire. They stated Certified Nurse Aide #2 was worried about retaliation from their coworkers if they reported the alleged incident. Director of Nursing #1 stated abuse must be reported immediately, and administration had a 2-hour window to report it to Department of Health. During an interview on 6/07/2024 at 12:46 PM, Administrator #1 stated abuse was to be reported immediately upon happening, and within 2 hours to Department of Health. They stated they would be meeting with Certified Nurse Aide #2 and their Union Representative for verbal counseling regarding timely abuse reporting, and people to report to if they felt uncomfortable with notifying their direct supervisor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/2024 at 1:14 PM, Certified Nurse Aide #4 stated Certified Nurse Aide #2 reported to them (on 5/28/2024) that Nurse Aide #1 had slapped another resident. Certified Nurse Aide #2 told them they were afraid of retaliation. Certified Nurse Aide #4 stated they told Certified Nurse aide #2 no matter what, Certified Nurse Aide #2 still needed to report it. Certified Nurse Aide #4 stated they did not tell anyone about it after Certified Nurse Aide #2 reported it to them. They stated they should have also reported the alleged abuse rather than taking Certified Nurse Aide #2's word that they were going to report it. Resident #3: Resident #3 was admitted to the facility with diagnoses of diabetes, high blood pressure, heart disease. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood, and could understand others. An untimed statement dated 6/22/2024, written by Certified Nurse Aide #2, documented Certified Nurse Aide #2 witnessed Certified Nurse Aide #3 allegedly squish their breasts together and asked Resident #3 if they liked them while moving closer to the resident. Certified Nurse Aide #2 documented they had witnessed that while working with Certified Nurse Aide #3 that week. They also documented the last time they had worked with Certified Nurse Aide #3, they were taking care of a male resident (name not provided), and Certified Nurse Aide #3 stated 3 different times that Certified Nurse Aide #2 just wanted to see the resident's penis. Certified Nurse Aide #2 documented they were afraid to report it because they were afraid Certified Nurse Aide #3 would retaliate against them. During an interview on 6/06/2024 at 3:08 PM, Certified Nurse Aide #2 stated they witnessed Certified Nurse Aide #3 squishing Resident #3's breasts together, made a kissy sound and asked Resident #3 if they liked that. They stated they reported it to Registered Nurse Unit Manager #1 the same day (this statement differs from Certified Nurse Aide #2's written statement and the following interview with Director of Nursing #1). During an interview on 6/07/2024 at 12:09 PM, Director of Nursing #1 stated they interviewed Certified Nurse Aide #2 who told them about the breast squishing incident with Resident #3. Director of Nursing #1 stated Certified Nurse Aide #2 stated they did not report it because they were afraid of what others would think and was afraid of retaliation. 10 New York Codes, Rules, and Regulations 415.4 (b)(3)