STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335464	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Nursing at Meadow Hill	172 Meadow Hill Road Newburgh, NY 12550

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** 49372 Based on record review and interview during an abbreviated survey (NY00337556, NY00340055, NY00348324) the facility did not ensure a resident's right to be free from abuse for 2 (Resident #1 and Resident #2) out of 4 residents reviewed for abuse. Specifically, on 3/30/2024, Resident #2 was witnessed by 2 certified nurse assistants(Staff #6 and Staff #7) being fondled under their shirt by Resident #3. Resident #2 was removed from Resident #3's room and Resident #2's shirt was pulled down by the certified nurse assistant. 2) On 4/22/2024, Resident #1 stated that a certified nurse assistant(Staff #1) was grabbing and pulling their right arm roughly while attempting to change their shirt and Resident #1 sustained an ecchymosis to the area.There was no care plan to address potential victim for abuse. Findings include: The facilities Resident Abuse, Neglect, Exploitation or Misappropriation policy statement documented it is the policy of the facility that acts of physical, verbal, mental and financial abuse including neglect and exploitation directed against residents are absolutely prohibited. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, exploitation and misappropriation of property. Residents will not be subjected to abuse by anyone, including but not limited to, staff, other residents, consultants, volunteers, contractors, and staff from other agencies, family members, legal guardians, resident representatives, friends or other individuals. The policy defines sexual abuse as the non-consenting contact of any kind and includes but is not limited to sexual harassment, sexual coercion or sexual assault. Resident #2 (victim) was admitted to the facility with diagnosis including but not limited to Dementia, major depressive disorder, and poly osteoarthritis. A Comprehensive Minimum Data Set, dated dated dated [DATE] documented Resident #2 is severely cognitively impaired, the resident wanders significantly daily and wanders into other residents room. Resident #2 required set up assistance for meals, partial/moderate assistance for toileting and supervision for bed mobility and transfers. Resident #2 was always incontinent of bladder and bowel. (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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NAME OF PROVIDER OR SUPPLIER Sapphire Nursing at Meadow Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 172 Meadow Hill Road Newburgh, NY 12550	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the accident/incident report dated 3/30/2024 documented Resident #2 was unable to verbalize how the incident occurred. The Accident/Incident report documented 2 certified nurse assistants witnessed Resident #2 in Resident #3's room with Resident #3's hand inside Resident #2's blouse. The investigative summary documented Resident #2 has dementia with poor safety awareness. Resident #2 wanders within the unit. The Accident/Incident report documented Resident #2 with no history of going into other resident's rooms, and that they may have been called into the room by Resident #3. Resident #2 with no verbalization on how the incident occurred and had no recall of the event due to dementia. Resident #2 had no evidence of emotional distress or psychological effects from the incident. The accident /incident report documented that after thorough investigation, there is cause to believe an alleged resident abuse occurred. Safeguards in place to keep the resident safe and prevent re-occurrence. Resident #3 (pepertrator) was admitted to the facility with diagnosis including but not limited to Macular degeneration, Glaucoma and Type 2 Diabetes Mellitus. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 13/15, associated with intact cognition. Resident #3 had moderate difficulty hearing and impaired vision. Resident #3 exhibited behavioral symptoms directed towards others and rejected cares, required set up with eating and substantial/maximal assistance with toileting. Resident #3 required partial/moderate assistance with bed mobility and transfers and was frequently incontinent of urine and occasionally incontinent of bowel. Review of the accident/incident report dated 3/30/2024 documented Resident #3 was observed by staff with their hand inside Resident #2's blouse in their room. The investigative summary documented Resident #3 had sexually inappropriate behavior towards staff and others and usually kept to their room and did not congregate with other residents. The accident/incident report documented Resident #2 wanders on the unit and had no history of going into other resident's rooms. Most likely Resident #3 called Resident #2 into their room. Resident #3 was observed with their hand inside Resident #2's blouse and when confronted by staff, Resident #3 pulled their hand away and denied doing anything wrong. Resident #3 refused to be moved off the unit, police were called in to assist and Resident #3 then complied. Resident #3 then complained of pain despite pain medications being given and demanded to be sent to the hospital. Resident #3 was sent to the emergency room for a psychiatric and pain evaluation. The investigation concluded that there was cause to believe an alleged resident abuse occurred. Immediate safeguards were put in place to keep Resident #2 and other residents safe and prevent re-occurrence. During an interview on 5/7/2024 at 2:05 PM with the Director of Social Services, they stated Resident #3 was sexually inappropriate with Resident #2. They stated Resident #3 was observed by staff putting their hands under Resident #2's shirt. The Director of Social Services stated Resident #2 is very confused and non-verbal and could not verbalize what occurred. The Director of Social Services stated they did not enter a note regarding the incident with Resident #2 in their medical record. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2024 at 10:15 AM the Assistant Director of Nursing, they stated they were informed of the incident that occurred on 3/30/2024 by the Nursing Supervisor who notified them that 2 staff members reported they saw Resident #3 with their hand up Resident #2's shirt. The Assistant Director of Nursing stated they told the nursing supervisor to notify the residents families, the physician, and the Director of Nursing. The Assistant Director of Nursing stated they also instructed the Nursing Supervisor to remove Resident #3 from the unit. The Assistant Director of Nursing Stated Resident #3 had attempted to kiss another resident prior to this incident. The Assistant Director of Nursing stated the supervisor called back and to informed them that Resident #3 refused to move off the unit. The Assistant Director of Nursing stated they directed the Nursing Supervisor to notify the police, and upon police arrival, Resident #3 was escorted from their room on another unit. Stated the incident was witnessed by Certified Nurse Assistant (staff #6) and certified nurse assistant (staff #7), and that the incident took place in Resident #3's room. The Assistant Director of Nursing stated there is no video of the incident and that they called the Town of Newburgh police department and were informed no report was created, that there is only a log that the police responded to the facility, but no report about the incident was written. During a telephone interview on 5/15/2024 at 1:45 PM certified nurse assistant-witness Staff #7 they stated they recall the incident that occurred on 3/30/2024 with Resident #2 and Resident #3. Stated they were coming from the day room, closer to the 2 East unit with certified nurse assistant-witness Staff #6 . As they walked past Resident #3's room Staff #6 (certified nurse assistant-witness said what are you doing-stop that. Stated they were about a foot ahead of Staff #6 and they back stepped and saw Resident #3's hand coming from underneath the blouse of Resident #2. Staff #7 stated they went into Resident #3's room and removed Resident #2 and pulled their shirt down, then reported it to the nurse. Stated the nurse called the supervisor and they were told to do an incident report and write statements. Stated the nurse did a body check on Resident #2 and the resident did not seem to them to be in any distress. Stated Resident #2 was just kind of looking dazed when they removed them from Resident #3's room. Staff #7 stated they asked Resident #3 why they were doing that, and the resident did not respond. Stated Resident #2 wanders a lot and goes into other resident's rooms all the time. Stated staff have to redirect Resident #2 when they see them wandering. Stated if they are assigned to Resident #2, they have to observe them and see what they are doing. Staff #7 stated they have heard about Resident #3 touching resident's before but have not witnessed it before this incident. Stated Resident #3 always has something going on with them and their behaviors, but they are never assigned to them. Stated they have not seen any changes in Resident #2's behavior and they are still always wandering. During a telephone interview on 5/15/2024 at 5:15 PM Staff #6 (certified nurse assistant-witness #1) stated they recall the incident that occurred on 3/30/2024 with Resident #2 and Resident #3. Stated they were passing Resident #3's room and saw Resident #2 standing in front of Resident #3 and they had their arm under Resident #2's shirt. Stated Resident #3 was moving their hand up and down and in a circular motion under Resident #2's shirt. Staff #6 stated they stopped and said what are you doing and Staff #7 that was with them, went in took Resident #2 out of the room. Stated Resident #3 did not say anything in response and just moved their hand fast from under Resident #2's shirt. Staff #6 stated Resident #2 was just standing there innocently looking at Resident #3 and they did not know what was going on. Resident #1 was admitted to the facility with diagnosis including, but not limited to Dementia, weakness and Rheumatoid arthritis. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #1 minimal difficulty hearing and wears a hearing aid. Documented a BIMS score of 12. Required supervision for eating and bed mobility, dependent for toileting and required substantial/maximal assistance for transfers. No behaviors noted. Documented Resident #1 is frequently incontinent of bladder and bowel. Review of the accident/incident report dated 4/23/2024 documented alleged physical abuse/neglect/mistreatment, a purple discoloration was noted on Resident #1's right forearm, measuring 7.5 x 2.5 cm. Resident #1' daughter and the physician were notified of the skin discoloration on 4/23/2024. A description of the incident documented Resident #1 alleged that at 3:30 AM a staff member was trying to remove their shirt and was pulling and grabbing their right arm, and had their arm against their body, and they told the staff member to stop because they were hurting them. Resident #1 stated the staff member did not let go of their arm and continued to pull their arm trying to take it out of the sleeve and take their shirt off. Documented Resident #1 was observed with a purple discoloration to their right forearm upon skin assessment measuring at 7.5 x 2.5 cm. The Accident/incident report documented the incident occurred in Resident #1's room, the certified nurse assistant involved was trying to remove the shirt sleeve from Resident #1's right arm and was tugging at the sleeve which was tight and snug. The staff was pulling the right arm and firmly held the arm in the process. Stated the resident however indicated that the staff was hurting them and they did not stop to consider this during the undressing process. The investigative conclusion documented it revealed there is cause to believe alleged resident, abuse, mistreatment or neglect/injury of unknown origin/exploitation/misappropriation of resident property after a thorough/ complete investigation regarding the incident has occurred. Immediate safeguards are in place to keep the resident safe and prevent re-occurrence. Review of a progress note dated 4/23/2024 written by the Director of Nursing documented Resident #1 with a 7.5 cm x 2.5 cm purple discoloration to the right forearm with no associated swelling or change to range of motion noted. Complained of some light tenderness with touch. Skin is fragile with increased tendency to bruise easily which was also reported by Resident #1's daughter who was notified of the findings and of resident claim that staff on the overnight shift pulled on their arm while trying to take their long sleeve shirt or sweater off to dress them. Documented the physician was notified of the findings and an order was obtained for an x-ray of the right forearm and there was no fracture. Resident #1 was provided reassurance and emotional support and the Administrator was aware. During an interview on 5/7/2024 at 1:15 PM Resident #1 stated their whole forearm was purple from the incident. Stated they did an x-ray of their arm. Resident #1 stated when the certified nurse assistant was taking their blouse off they pulled their arm very hard and they told them to stop, and that they were hurting them, but the certified nurse assistant did it anyway. Stated the facility stated they talked to the person, but they could not explain who they were because of their age and memory not being so good. Stated they were not sure if the certified nurse assistant was dismissed [NAME] not. Stated now when the staff try to remove their shirt, they tell them to wait and let them help. Stated the staff is in a hurry to dress and undress them. Stated they are [AGE] years old. Stated their arm still hurts from the incident. Resident #1 stated they are not sure if the staff member had worked with them again or not because they could not remember what they looked like. The facility told them they were going to dismiss the certified nurse assistant and they do not know if they did. Resident #1 stated they are scared when a new aide takes care of them because they are not sure if they will hurt them. Verbalized again that they are always afraid now when someone comes into their room thinking it is the certified nurse assistant. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 5/7/2024 at 3:28 PM with Staff #4 (Unit manager-1 West) stated they were informed by Staff #3 (certified nurse assistant) that Resident #1 stated the night shift certified nurse assistant grabbed them and was rough with them and bruised their arm. Stated they did observe a darkened area to Resident #'1's right forearm. Stated Resident #1 did have a discoloration on their arm, but they did not do a full skin assessment of the resident. Stated they did not write a note about the observation either. Staff #4 stated an ecchymosis area classifies as a skin impairment and they should have documented in a progress note that they saw the area on Resident #1's arm and informed the Director of Nursing. Stated the certified nurse assistant does not work with Resident #1 but they are still on the unit 1 West, but that was not their decision. During an interview on 5/7/2024 at 4 PM the Director of Nursing stated they did not substantiate the allegation because the certified nurse assistant stated the bruise was there already, that she had noticed some discoloration prior to that area on Resident #1's forearm. Stated they changed the incident report to state that there was no cause today (5/8/2024), because the initial accident/incident report stated that there was cause to believe abuse occurred. Review of the accident/incident report provided now has all changed documentation stating the incident was not substantiated. The Director of Nursing stated that it was a preliminary report provided initially by accident and they had to modify it based on the final outcome of the investigation. Stated they will be assigning the certified nurse assistant to the other side of the building and that Resident #1 has not verbalized to them or the unit manager of their feelings they verbalized today prior. Stated Resident #1 is still anxious and fearful when they spoke with them and the unit nurse reassured Resident #1 that the certified nurse assistant has not been working with them. During an interview on 5/8/24 at 2:10 PM Staff #3 (certified nurse assistant) stated they went into Resident #1's room and they stated staff were cleaning them, and they pulled their arm, and they were really rough. Staff #3 stated Resident #1 told them what happened, and they stated they were wet, and Staff #1 (certified nurse assistant) was changing their shirt at 3:30 in the morning, they were being rough and pulled their arm. Staff #3 stated Resident #1 usually has on a long sleeve shirt and a little sweater. Staff #3 stated when they were talking with Resident #1 their arm was exposed and they could see the bruise immediately. Staff #3 stated when they took care of Resident #1 the day before the incident (4/21/2024), Resident #1 did not have the bruise on their arm. Staff #3 stated when the resident told them about the incident, they immediately approached the certified nurse assistant and the nurse, and they stated that Resident #1's name band was the cause of the bruise. Stated Resident #1 stated the name band had nothing to do with it. Stated Resident #1 is very anxious since after the incident, reminding them constantly to be careful and gentle with them. Stated the resident did not want to change her shirt after that day. Stated the certified nurse assistant is still working on the unit, but they are not allowed to be on the assignment with Resident #1. During an interview on 5/8/2024 at 3:55pm with Certified Nursing Assistant (Staff #1), they stated they went into Resident #1's to provide cares. Resident #1's clothing was damp so they proceeded to take their shirt off and when they took off the right sleeve, they heard a pop. Resident #1 stated they hurt them and they replied they were not hurting them. Staff #1 stated they noticed Resident #1 had some discoloration on their right arm and they did not pay attention to the discoloration and did not report the discoloration to anyone. When they left Residnet #1's room, Licensed Practical Nurse(Staff #2) went behind them and thats when they heard Residnet #1 crying. Certified Nurse Assisitant(Staff #1) stated they have not worked with the resident since the incident. They were suspended for 2days and provided a statement to Director of Nursing. (continued on next page)

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