

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Utica Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2535 Genesee Street Utica, NY 13501	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37516</p> <p>Based on record review, observation, and interviews during an abbreviated survey (NY00367007), the facility failed to ensure residents were free from abuse for 1 of 6 residents (Resident #1) reviewed. Specifically, Dietary Aide #4 witnessed Certified Nurse Aide #8 abuse Resident #1 and did not report the incident for three days. Additional staff were identified as having knowledge of the incident and failed to report to facility Administration timely. The facility's failure to protect residents from abuse resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #1 and placed all 104 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death.</p> <p>Findings include:</p> <p>The facility policy Seven Components of a Systemic Approach to Abuse Prohibition, effective 8/2020, documented abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, and pain and/or mental anguish. Some forms of abuse were physical, which included hitting or slapping; verbal, which included derogatory language and threats intended to frighten a resident; and mental, which included intimidation and deprivation of any goods or services.</p> <p>The facility policy Abuse- Investigation, protection and Reporting - Components #5, #6 and #7, effective 10/24/2022, documented all allegations/occurrences of all types of staff-to-resident abuse must be reported to the Administrator and to other officials, including the State Survey Agency and Adult Protective Services, where state law provided jurisdiction to nursing homes. During abuse investigations, residents would be protected from harm. Employees accused of participating in the alleged abuse would be immediately reassigned to duties that did not involve resident contact or would be suspended until the findings of the investigation had been reviewed by the Administrator.</p> <p>Resident #1 had diagnoses including dementia, unspecified psychosis, and anxiety disorder. The 9/20/2024 Minimum Data Set assessment documented the resident had intact cognition, did not exhibit behaviors, did not wander, and was independent with transfers and ambulation.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The comprehensive care plan, initiated 4/1/2024, documented the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions included to identify oneself at each interaction, face the resident when speaking, make eye contact, reduce distractions, use consistent, simple sentences, and stop and return if agitated. When revised on 10/30/2024, it documented the resident had the potential to be abused by others as they demonstrated kleptomaniac behaviors (kleptomania, an impulse control disorder that resulted in an urge to steal items) that had the potential to annoy others. Interventions included assess for causative factors to their kleptomania, redirect impulsive behavior, and encourage resident to seek staff assistance with problems with other residents.</p> <p>The undated and unsigned Facility Investigative Summary documented:</p> <ul style="list-style-type: none"> - On 12/31/2024, at approximately 12:00 PM, Dietary Aide #4 reported to the Director of Nursing, they observed Certified Nurse Aide #8 strike Resident #1 with an open hand on their face on 12/28/2024 between 11:30 AM and 12:00 PM. - Dietary Aide #4 reported Resident #1 knocked on the door leading from the dining room to the kitchen and asked them for ice and ginger ale. - Certified Nurse Aide #8 then approached Resident #1 and asked them why they were there and told the resident to go sit down. - Resident #1 re-stated to Certified Nurse Aide #8 they wanted ice and ginger ale, Certified Nurse Aide #8 replied, No and struck Resident #1 one time on their cheek with an open hand. - Resident #1 struck Certified Nurse Aide #8, and then sat down. - The Director of Nursing and Administrator were notified of the incident on 12/31/2024. The Director of Nursing assessed Resident #1 immediately once the report was made and there were no injuries or signs of psychological distress. <p>The Director of Nursing and Administrator interviewed staff witnesses on 12/31/2024. Verbal statements from two employees, Dietary Aide #4 and [NAME] #5, verified they had observed physical contact from Certified Nurse Aide #8 towards Resident #1. Dietary Aide #4 witnessed Certified Nurse Aide #8 slap Resident #1 on the face one time with an open hand. [NAME] #5 witnessed Resident #1 push Certified Nurse Aide #8, then Certified Nurse Aide #8 pushed Resident #1 back in the shoulder area. Certified Nurse Aide #8 denied striking Resident #1.</p> <p>Written staff statements obtained during the facility investigation included:</p> <ul style="list-style-type: none"> - Certified Nurse Aide #11 stated they were working on Resident #1's unit and heard about the incident, but they did not witness any arguments or altercations between Resident #1 and Certified Nurse Aide #8. - [NAME] #5 (statement dated 1/1/2025), reported they observed Certified Nurse Aide #8 slamming the door to the unit kitchen multiple times but did not see any hands-on physical contact (this statement was not consistent with the reported verbal statement given on 12/31/2024 during the facility investigation). <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- [NAME] Supervisor #7 stated they observed Resident #1 asking for something from Dietary Aide #4. As Dietary Aide #4 was getting what Resident #1 asked for, Certified Nurse Aide #8 slammed the door to the kitchen and yelled at Resident #1. They were unable to see what was going on behind the door. Certified Nurse Aide #8 came back through the door to the kitchen and told [NAME] Supervisor #7 Resident #1 was not to get anything until after lunch.</p> <p>- Housekeeper #10 reported that when they got on the service elevator on 12/31/2024, Dietary Aide #4 was also on the elevator and told them they witnessed a resident get slapped by a certified nurse aide over ice and ginger ale. The housekeeper told Dietary Aide #4 they had to report that, and because of what they were just told, the housekeeper also had to report the incident.</p> <p>- Licensed Practical Nurse #3 reported Resident #1 told them at lunch time on 12/28/2024 that someone had shoved them. When the licensed practical nurse asked the resident what happened, they stated they were going to call the State and not to worry about it. Resident #1 was visibly upset but had no injuries.</p> <p>- Dietary Aide #4 stated they were in the kitchen pouring drinks. Resident #1 knocked on the door, they opened the door, and gave them a cup. Thirty seconds later, Certified Nurse Aide #8 asked Resident #1 why were they there and told them to go sit down. The resident replied to Certified Nurse Aide #8, ice and ginger ale. Certified Nurse Aide #8 stated, No, screamed at them, slapped the resident on their face, then slammed the door in their face.</p> <p>- Certified Nurse Aide #8 stated that on 12/28/2024 at approximately 11:45 AM, Resident #1 was trying to enter the kitchen. They told the resident they could not go in there and the resident got upset. They told the resident as soon as there was soda brought to the kitchen they would bring it to them. Resident #1 tried to hit the aide, the aide backed up, and the resident could not hit them, which made them angrier.</p> <p>The supervisor abuse rounding form was completed 12/28/2024 and no abuse was reported to the supervisor on that date.</p> <p>There was no documented evidence Dietary Aide #4, [NAME] #5, [NAME] Supervisor #7, Licensed Practical Nurse #3, or Certified Nurse Aide #11 reported any concerns related to an alleged incident of staff to resident abuse on 12/28/2024.</p> <p>Certified Nurse Aide #8's Employee Timecard Report documented they continued to work and had access to all residents on 12/28/2024 (until 2:00 PM) and 12/31/2024 from 5:36 AM to 11:21 AM.</p> <p>During an interview on 1/6/2024 at 11:52 AM, Resident #1 stated there was a certified nurse aide on the unit (they did not know their name and was understood to be Certified Nurse Aide #8) that was recently terminated from employment. The unidentified certified nurse aide would throw ice cream cups at them and never give the resident coffee creamers or juice when they asked for them. The resident was not allowed in the kitchen on the unit. The certified nurse aide accused Resident #1 of stealing money from somebody. No staff had ever hurt them physically, but the certified nurse aide was very disrespectful.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 1/7/2025 at 10:03 AM, [NAME] #5 stated that on 12/28/2024, they were wiping down tables on Unit 4 when they saw Certified Nurse Aide #8 and Resident #1 talking by the kitchen door. The conversation got loud, and Certified Nurse Aide #8 went into the kitchen and closed the door. Certified Nurse Aide #8 gave Resident #1 a cup. The kitchen door opened and closed three times as the conversation between Certified Nurse Aide #8 and Resident #1 got louder. The resident eventually sat down at a table. They did not see Certified Nurse Aide #8 place their hands on the resident. [NAME] #5 was called in by Administration on 12/31/2024 to be interviewed about the 12/28/2024 incident.</p> <p>During an interview on 1/7/2025 at 10:25 AM Dietary Aide #4 stated that on 12/28/2024 they were in the Unit 4 kitchen pouring drinks and Resident #1 was requesting ice and ginger ale. Seconds later, Certified Nurse Aide #8 was screaming at Resident #1, telling them to sit down. Certified Nurse Aide #8 swung their hand towards Resident #1 and hit them on their face. Resident #1 hit Certified Nurse Aide #8 back. Certified Nurse Aide #8 yelled to Resident #1 that they were not getting ginger ale and told them to sit down, using profanities. There was another certified nurse aide behind the steam table during the incident, but they did not know who it was or if they saw anything. Dietary Aide #4 got on the elevator with [NAME] Supervisor #7 a few minutes later. [NAME] Supervisor #7 had been helping them pour drinks on Unit 4. Dietary Aide #4 told [NAME] Supervisor #7 what had happened, and they asked, are you serious? Dietary Aide #4 stated they thought by telling their supervisor they were doing the right thing and later realized they should have reported the incident to a nursing supervisor. On 12/31/2024, they told a nurse on another unit about the incident on 12/28/2024. The nurse told them to report it to the Director of Nursing right away and they did so.</p> <p>During an interview on 1/7/2025 at 11:15 AM [NAME] Supervisor #7 stated that on 12/28/2024, they were helping Dietary Aide #4 and [NAME] #5 on Unit 4. Right before lunch, they heard a commotion outside the kitchen door between Certified Nurse Aide #8 and Resident #1. Resident #1 asked for a drink with ice and Certified Nurse Aide #8 came in the door screaming to not give them any ice or soda until after supper. [NAME] Supervisor #7 stated they did not report the 12/28/2024 incident in a timely manner. On 12/31/2024, they reported the incident to Food Service Director #25 who directed them to go to the Administrator.</p> <p>During an interview on 1/7/2025 at 12:46 PM Licensed Practical Nurse #3 stated that on 12/28/2024, they overheard Resident #1 telling another resident someone had pushed them. When they asked the resident for more details, Resident #1 stated they had been pushed by someone, they would not say who, and they would, take care of it and would be, calling the state. Licensed Practical Nurse #3 had not heard or seen anything and was not sure if the resident was referring to another resident or staff.</p> <p>During an interview on 1/8/2025 at 10:50 AM Resident #1 stated a certified nurse aide (they did not know their name, but it was understood they were referring to Certified Nurse Aide #8) slammed the kitchen door on them when another staff was giving them juice. The certified nurse aide told them they did not need the juice and were very rude and inconsiderate to them. The resident and Certified Nurse Aide #8 were opening and closing the kitchen door and then the aide pushed them back. They could not recall being slapped on the face by staff. They were afraid of the certified nurse aide and were relieved that they no longer worked at the facility. They could not recall speaking with a social worker or psychologist about the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a phone interview on 1/8/2025 at 4:30 PM, the Administrator stated they were notified of the 12/28/2024 incident just before lunchtime on 12/31/2024. The Corporate Administrator was also in their office at the time. Dietary Aide #4 told them they saw Certified Nurse Aide #8 slap Resident #1 on the face 12/28/2024. The Administrator asked Dietary Aide #4 if there were any other staff witnesses and the dietary aide provided staff names. Certified Nurse Aide #8 denied slapping Resident #1 and they suspended Certified Nurse Aide #8. When they interviewed [NAME] #5 (via phone interview) the cook stated they saw Certified Nurse Aide #8 and Resident #1 pushing back and forth. [NAME] #5's story changed after the initial interview between seeing the pushing versus not seeing the pushing between Certified Nurse Aide #8 and Resident #1. [NAME] #5 and Certified Nurse Aide #8 were friends outside of work. They concluded abuse occurred based on statements made by Dietary Aide #4 and [NAME] #5. Dietary Aide #4 was a good employee and had no reason to make the incident up. The Director of Nursing assessed Resident #1 on 12/31/2024 and the resident had no injuries and denied being slapped. The surveillance cameras in the dining rooms did not always work and they attempted to view footage from the 12/28/2024, but there was none.</p> <p>During an interview on 1/8/2025 at 5:05 PM, Director of Nursing stated that on 12/31/2024, Dietary Aide #4 reported they observed staff slap a resident on Unit 4 on 12/28/2024, but did not know their name. Dietary Aide #4 identified Certified Nurse Aide #8 as the staff in question upon going to the unit with the Director of Nursing. Certified Nurse Aide #8 was immediately removed from the unit and interviewed. Certified Nurse Aide #8 denied the allegation and stated there had been a disagreement with Resident #1 in the kitchen: the resident pushed them, but they did not push back. [NAME] #5 reported Certified Nurse Aide #8 and Resident #1 were pushing each other. [NAME] #5 was asked why they did not report the incident and they stated they did not think Certified Nurse Aide #8 was hurting Resident #1, just directing them to sit down. [NAME] #5's written statement the next day changed, stating they did not see any physical contact between Certified Nurse Aide #8 and Resident #1, and that they were confused when asked about the discrepancy. They had heard Dietary Aide #4 had told their supervisor, [NAME] Supervisor #7, about the 12/28/2024 incident on that day, and [NAME] Supervisor #7 should have notified the nursing supervisor.</p> <p>During a phone interview on 1/13/2025 at 10:05 AM, Medical Director stated they were notified of the 12/28/2024 incident involving Resident #1 on 12/31/2024 when the Administration became aware. They heard the story had changed between some of the staff who were interviewed. It was reported to them Resident #1 was slapped by staff, and there was some pushing and shoving involved, and then the story changed where there was no physical contact. Resident #1 denied being slapped and never told any staff who interviewed them that it happened. This incident should have been reported promptly by the staff involved.</p> <p>10 NYCRR 415.4(b)(1)(i)</p> <p>-----</p> <p>Immediate Jeopardy was identified, and the Director of Nursing was notified on 1/8/2025 at 6:34 PM.</p> <p>Immediate Jeopardy was removed on 1/10/2025 at 4:02 PM prior to survey exit based on the following corrective actions taken:</p> <p>-Certified Nurse Aide #8 was terminated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-All staff that were aware of the abuse and failed to report it were terminated.</p> <p>-All staff working on 1/8/2025 were educated on abuse and reporting abuse, and education occurred shift to shift until 100% of all staff working were educated by 1/9/2025.</p> <p>-Resident #1 was assessed by the medical provider and seen by the psychiatric nurse practitioner.</p> <p>-All residents on the affected unit were evaluated to determine if they were victims of abuse or witness to any abuse.</p> <p>-As of 1/10/2025 88% of all staff received education on abuse, types of abuse, requirements for reporting abuse, the timeframe in which to report abuse, and the ramifications of not reporting abuse timely. Any staff who were not present during the training will be educated on their first day back to work prior to beginning their shift.</p> <p>- Verification interviews were completed with multiple staff from multiple departments to ensure understanding of the abuse education.</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37516</p> <p>Based on record review and interviews during an abbreviated survey (NY00367007), the facility failed to ensure an incident of staff abuse toward a resident was reported to the State Agency and to law enforcement for 1 of 3 residents (Resident #1). Specifically, Dietary Aide #4 witnessed Certified Nurse Aide #8 abuse Resident #1 and did not report the incident to Administration for three days. Multiple staff were identified who were made aware of the abuse allegations and did not report to Administration. Upon receipt of the reported incident, the facility did not report the allegation of abuse to the State Agency or law enforcement as required. Additionally, Certified Nurse Aide #8 continued to have access to residents following the witnessed abuse. The facility's failure to report abuse by staff to Administration, the State Agency, and law enforcement resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #1 and placed all 104 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death.</p> <p>Findings include:</p> <p>The facility policy, Seven Components of a Systemic Approach to Abuse Prohibition, revised 10/24/2022, documented all cases, wherein there was a suspicion that a crime had been committed, facility staff must call local law enforcement immediately, but no later than two hours, if the violation involved abuse or resulted in serious bodily injury.</p> <p>Resident #1 had diagnoses including dementia, unspecified psychosis, and anxiety disorder. The 9/20/2024 Minimum Data Set assessment documented the resident had intact cognition, did not exhibit behaviors, did not wander, and was independent with transfers and ambulation.</p> <p>The facility incident investigation for an incident occurring on 12/28/2024 and reported to Administration on 12/31/2024, documented:</p> <ul style="list-style-type: none"> - On 12/31/2024, at approximately 12:00 PM, Dietary Aide #4 reported to the Director of Nursing, they observed Certified Nurse Aide #8 strike Resident #1 with an open hand on their face on 12/28/2024 between 11:30 AM and 12:00 PM. - Dietary aide #4 reported Resident #1 knocked on the Unit 4 door leading from the dining room to the kitchen, asked them for ice and ginger ale, and handed the dietary aide their cup. - Certified Nurse Aide #8 approached Resident #1 and stated to them, why are you here? and to go sit down. - Resident #1 re-stated to Certified Nurse Aide #8 they wanted ice and ginger ale, Certified Nurse Aide #8 stated to them, No and struck Resident #1 one time on their cheek with an open hand. - Resident #1 struck Certified Nurse Aide #8 back, and then sat down. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- The Director of Nursing and Administrator were notified of the incident on 12/31/2024. The Director of Nursing assessed Resident #1 immediately once the report was made and there were no injuries or signs of psychological distress.</p> <p>Certified Nurse Aide #8 continued to work 12/28/2024 and 12/31/2024. Certified Nurse Aide #8 was suspended on 12/31/2024 once Administration was notified of the alleged abuse that had occurred on 12/28/2024, and subsequently was terminated on 1/3/2025.</p> <p>There was no documented evidence Certified Nurse Aide #8 was immediately removed from resident contact on 12/28/2024. There was no documented evidence law enforcement was notified of the alleged abuse.</p> <p>During a phone interview on 1/8/2025 at 4:30 PM the Administrator stated once they were notified on 12/31/2024 of the alleged abuse that occurred towards Resident #1 on 12/28/2024, they immediately began a facility investigation and did not think to call local law enforcement.</p> <p>The administrator was notified of the alleged abuse on 12/31/2024. The facility did not report the allegation to the State Agency until January 2, 2024, which is not in keeping with the required timeframe for reporting.</p> <p>During an interview on 1/8/2025 at 5:05 PM, the Director of Nursing stated it did not occur to them to notify law enforcement on 12/31/2024 after they were made aware of the allegation Certified Nurse Aide #8 abused Resident #1. They stated they realized at a later time that law enforcement should have been contacted immediately.</p> <p>During a phone interview on 1/13/2025 at 10:05 AM the Medical Director stated they were notified of the alleged abuse towards Resident #1 by the Director of Nursing on 12/31/2024. They heard the story changed a few times by staff witnesses. They were not aware the police were supposed to be called for all alleged abuse incidents.</p> <p>10 NYCRR 415.4</p> <hr/> <p>Immediate Jeopardy was identified, and the Director of Nursing was notified on 1/8/2025 at 6:34 PM.</p> <p>Immediate Jeopardy was removed on 1/10/2025 at 4:02 PM prior to survey exit based on the following corrective actions taken:</p> <ul style="list-style-type: none"> -Local law enforcement was notified of the alleged abuse toward Resident #1 on 1/8/2025. -Resident #1 was assessed by the medical provider and assessed by the psychiatric nurse practitioner. -All residents on the affected unit were evaluated to determine if they were victims of abuse or witness to any abuse. No other residents identified. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The Administrator and Director of Nursing were educated by the Corporate Administrator on the need to report all allegations of staff abuse towards a resident to local law enforcement. Education included the process for reporting, whom to report, the timeframe in which to report, and the professional and criminal ramifications of not reporting.</p> <p>- On 1/10/2025 the Administrator and Director of Nursing reported they had received the education.</p> <p>-Certified Nurse Aide #8 was terminated.</p> <p>-All staff that were aware of the abuse and failed to report it were terminated.</p> <p>-All staff working on 1/8/2025 were educated on abuse and reporting abuse, and education occurred shift to shift until 100% of all staff working were educated by 1/9/2025.</p> <p>-As of 1/10/2025 88% of all staff received education on abuse, types of abuse, requirements for reporting abuse, the timeframe in which to report abuse, and the ramifications of not reporting abuse timely. Any staff who were not present during the training will be educated on their first day back to work prior to beginning their shift.</p> <p>- Verification interviews were completed with multiple staff from multiple departments to ensure understanding of the abuse education.</p>		