STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335475	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charles T Sitrin Health Care Center Inc	2050 Tilden Ave New Hartford, NY 13413

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48052 Based on record review and interviews during the abbreviated survey (NY00368525) the facility failed to ensure residents were free from abuse for one (1) of seven (7) residents reviewed (Resident #1). Specifically, Resident #1 was physically removed, against the resident's will, from the dining room by Licensed Practical Nurse #4, who then continued to have an altercation in the hallway, which resulted in the resident falling several times. 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 173 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death. Findings include: The facility policy, Prohibition of Abuse Policy and Procedure Including Definitions of Abuse and All Other Terms Associated with Abuse and Serious Bodily Injury, revised 10/2024, documented all residents would be treated with respect and consideration. Employees were expected to behave in an orderly fashion and any action which was injurious, insulting, or detrimental to a resident was prohibited. Staff were in-serviced at general orientation, annually, and as needed on abuse. Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Involuntary seclusion was the separation of a resident from other residents against the resident's will. The facility would maintain a proactive atmosphere to prevent abuse, neglect, mistreatment, and exploitation of residents. The facility policy, Neuro-Patient/Resident Behavioral Review, revised 8/2024, documented the interdisciplinary team would identify residents who had behaviors that interfered with activities of daily living, interactions, and care. The interdisciplinary team would develop and implement interventions to diminish disruptive, inappropriate, and harmful behaviors, and provide guidance and education to family and care providers for effective intervention for positive behaviors and interactions. All staff hired to the neuro unit received an eight-hour Strategies for Crisis Intervention and Prevention training to learn strategies for behavior de-escalation and appropriate measures for physical intervention. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had diagnoses which included Huntington's disease (a neurogenerative disorder that affected the brain and nervous system), chorea (involuntary irregular movements), and ataxia (lack of muscle coordination). The 12/9/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment with inattention, disorganized thinking, had no behaviors, utilized a walker for mobility, and was independent with all activities of daily living. The 11/19/2024 Behavior Management Plan documented the resident had problem behaviors of agitation and impulsivity. The resident's triggers for behavior included when staff attempted to provide the resident with assistance, administer medications, informed the resident they could not do something due to safety concerns, when the resident asked for food or a drink that was not immediately provided, and when the resident's personal mail was opened for them. Signs of escalation included increased chorea, raising their voice or mumbling angrily, huffing and puffing, not making eye contact, and aggressively moving or pushing their walker. Interventions included: allow the resident independence in their activities of daily living; not offer assistance if their safety was maintained; if the resident appeared unsafe completing a task, offer assistance but refrain from providing the assistance until the resident had agreed; provide a snack or drink when requested; if unable to provide the item immediately, provide a timeframe for when the item would be provided; if showing signs of escalation, attempt re-direction to preferred activities such as video games, watching movies, or having a cup of coffee or soda. The 1/10/2025 facility incident report prepared by the Director of Nursing documented Certified Nurse Aide #5 reported an incident that occurred on 1/3/2025 at approximately 6:00 PM between Licensed Practical Nurse #4 and Resident #1. The camera footage was reviewed with findings the resident was handled roughly by Licensed Practical Nurse #4 and the resident fell at least three (3) times. The incident was reported to Physician #18, the resident's family member, and the local police department. A full skin assessment was completed. The resident was noted to have multiple abrasion areas to their back in various stages of healing which had a treatment date of 12/28/2024, a superficial abrasion to their right wrist and left posterior shoulder, a large hematoma to their right side with yellow-purple discoloration, and their left buttock had swelling. Staff statements documented: - the Program Director of the Neurocare Unit stated on 1/10/2024, Certified Nurse Aide #5 reported they were told by Licensed Practical Nurse #4 about an incident they had with Resident #1 on 1/3/2025 in the dining room. The Program Director of the Neurocare Unit reviewed the footage from the dining room on 1/3/2025. The footage showed at approximately 6:07 PM in the dining room, Licensed Practical Nurse #4 was aggressive with Resident #1, who did not appear to be exhibiting any behaviors which would have warranted their removal from the dining room. Licensed Practical Nurse #4 pushed the resident's walker and table away and pulled the resident out of the dining room by the back of the chair. The altercation ended in the hallway at approximately 6:20 PM and Licensed Practical Nurse #4 became physical with the resident multiple times, resulting in the resident falling at least three times. - Resident #1 was interviewed and stated they spat out their food and they were made to leave the dining room. Resident #1 did not want to discuss the incident further. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	- Certified Nurse Aide #5 stated on 1/4/2025, Licensed Practical Nurse #4 approached them and stated there was an incident with Resident #1 in the dining room the prior evening. The nurse asked Certified Nurse Aide #5 what to do if a resident had a behavior and needed to be taken down or use the Strategies for Crisis Intervention and Prevention (SCIP) on the resident. Certified Nurse Aide #5 asked the nurse the reason they were asking. Licensed Practical Nurse #4 stated Resident #1 choked on their fish and the nurse wanted the resident to stop eating it. The nurse said the resident became aggressive and started throwing drinks and pushing their table; Licensed Practical Nurse #4 had to remove the resident from the dining room in their chair. Licensed Practical Nurse #4 said none of the staff assisted them and Licensed Practical Nurse #4 did what they had to do to remove the resident from the dining room. Certified Nurse Aide #5 found the story odd. They stated Resident #1mentioned that morning they were hungry and upset over the fish but the aide was unaware of what the resident meant. Certified Nurse Aide #5 reported it to the Program Director of the Neurocare Unit on 1/10/2025 due to another conversation about Resident #1 with Licensed Practical Nurse #4 on 1/9/2025, which made the aide question the nurses' story. - Licensed Practical Nurse #4 stated they entered the dining room to get another resident's dinner and was told by a certified nurse aide (unnamed) that Resident #1 had vomited and needed to leave due to a gastrointestinal illness. Licensed Practical Nurse #4 observed the resident take a large bite, cough, and spit the food onto the plate. The nurse asked the resident if they felt okay and the resident said it was the fish and they were not sick. The nurse offered the resident an alternative, the resident became agitated, pushed their walker and the table and cursed. The resident wanted coffee, they told the resident they would get it and bring it to the resident's room. The resident pushed Licensed Practical Nurse #4 back and the nurse reminded the resident not to put their hands on people. The nurse felt the resident could hurt someone in the dining room as they were escalating and shoving things away. They encouraged the resident to remain calm and leave the dining room. The resident was agitated and began pushing things away from them, and Licensed Practical Nurse #4 took the back of the resident's chair and pulled it from the dining room out the door. The resident jumped from the chair and banged on the dining room door and pushed Licensed Practical Nurse #4 several times. Licensed Practical Nurse #4 grabbed the resident by the center of their shirt and lowered the resident to the floor as the resident kept losing their balance while pushing the nurse. The resident calmed down after several minutes. Licensed Practical Nurse #4 informed Registered Nurse Supervisor #7 of the incident, and they had lowered the resident to the floor to their buttocks by their shirt. - Registered Nurse Supervisor #7 stated on 1/3/2025, Licensed Practical Nurse #4 approached them during their rounds on the neuro unit and informed them there was an incident with Resident #1 in the dining room where the resident became violent, and no staff assisted to calm the resident down. Licensed practical Nurse #4 stated no one wanted to assist as they did not have the proper training when an agitated patient presented with aggressive behavior. They inquired if anyone was hurt and Licensed Practical Nurse #4 stated no. - Certified Nurse Aide #6 stated on 1/3/2025 during dinner, Resident #1 was eating, and they gagged or vomited a little. Licensed Practical Nurse #4 told the resident they had to go back to their room. The resident stated no and was debating with the nurse for a while. Licensed Practical Nurse #4 then pulled Resident #1 from the dining room in their chair. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Certified Nurse Aide #8 stated on 1/3/2025, Resident #1 was eating quickly which led to them vomiting and coughing forcefully. The resident was prompted to slow down, and Licensed Practical Nurse #4 approached the resident to get them out of their chair and out of the dining room. It agitated the resident. There was a lot of arguing that could be heard behind the door outside of the dining room. Certified Nurse Aide #8 stayed in the dining room with the other residents to keep them safe. - Dietary Aide #17 stated on 1/3/2025, Resident #1 vomited, Licensed Practical Nurse #4 told the resident to go back to their room, and the resident refused. The dietary aide heard Licensed Practical Nurse #4 yell at Resident #1 and pull the resident out of the dining room by their chair. Licensed Practical Nurse #4 was pushing the resident out of the room when the resident tried to re-enter. - Licensed Practical Nurse #11 stated they heard Licensed Practical Nurse #4 try to redirect Resident #1, who was trying to re-enter the dining area. Licensed Practical Nurse #4 was saying No! You cannot hurt other people and it looked like Resident #1 was charging toward the nurse who put their hands up in a stop motion below their waist. Resident #1 fell as they charged the nurse, and the resident stated, You pushed me down. Licensed practical Nurse #11 went to intervene, and Licensed Practical Nurse #4 informed them the resident was trying to hit another female resident in the dining room. The resident kept stating they wanted to go into the dining room, and they thought Licensed Practical Nurse #4 was trying to redirect the resident. They told Licensed Practical Nurse #4 to call the supervisor, to let the resident calm down, and that the resident could not re-enter the dining room due to it being locked from the outside so there was no need to stand in front of the door. -Certified Nurse Aide #10 stated on 1/3/2025, Licensed Practical Nurse #4 and Resident #1 had a verbal conversation about the resident leaving the dining room, and the resident refused to leave. The aide was feeding another resident and did not get involved. Certified Nurse Aide #10 left the dining room did not know what happened after. The facility's surveillance videos from the neurocare unit on 1/3/2025 from 5:58 PM through 6:45 PM included: - at 6:05 PM, Licensed Practical Nurse #4 approached Resident #1 who was sitting at their table in the dining room. Licensed Practical Nurse #4 pushed the table slightly away from Resident #1 and stood in front of an unidentified resident as they appeared to talk with Resident #1. Licensed Practical Nurse #4 then pushed the table further from Resident #1, then moved it in front of the resident. The resident remained seated their chair, appearing calm. Licensed Practical Nurse #4 made gestures that appeared to indicate for the resident to get up. - At 6:06 PM, Licensed Practical Nurse #4 pushed Resident #1's walker away and turned the four-legged stationary chair so the resident's back was facing the table. The resident attempted to push away while in the chair, Licensed Practical Nurse #4 spun the chair so the back was to Licensed Practical Nurse #4. Licensed Practical Nurse #4 moved the chair backwards with the resident in it while the resident resisted and held onto the pillar wall nearby. Resident #1 then stood up and sat on a rolling stool nearby. Licensed Practical Nurse #4 attempted to pull the resident off the stool by holding the resident under the arms while Resident #1 struggled against them. Once the resident was up from the stool, Licensed Practical Nurse #4 walked with their hands on the resident's torso until the resident sat back into the stationary chair. Licensed Practical Nurse #4 put their face close to Resident #1 while gesturing with their hands and pointing in the resident's face. The resident had not shown any aggression toward the nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- From 6:07 PM to 6:08 PM, Licensed Practical Nurse #4 got behind the resident who was on the chair, put their left hand on the resident's shoulder, and pulled the chair back through the dining area with the resident in it while the resident kicked their legs and attempted to remove themselves from the chair. Licensed Practical Nurse #4 pulled the resident back into the chair by the shoulder of their shirt when they attempted to get up. Resident #1 continued to struggle in the chair while Licensed Practical Nurse #4 held their shirt. The resident slid down in the chair at the entry to the dining room and their shirt slid up to their mid-abdomen. Resident #1 appeared to have slipped completely out of the chair, and they hit the floor with their buttocks while Licensed Practical Nurse #4 had ahold of their shirt. Resident #1 got to their hands and knees and attempted to kick out at the nurse while the nurse still had ahold of the resident's shirt. Licensed Practical Nurse #4 closed the door to the dining room, the door struck the resident's foot as it closed. Resident #1 attempted to knock on the door to the dining room and Licensed Practical Nurse #4 was blocking the shut door with their body. - From 6:10 PM to 6:12 PM, Resident #1 was in the hall at the closed dining room door and did not appear to be causing a disturbance. Licensed Practical Nurse #4 came up and positioned themselves between the resident and the door and physically moved the resident backwards. Licensed Practical Nurse #4 moved Resident #1 away from the door as they held the resident's upper arm while pushing on their upper body. The resident stumbled backwards and fell to the floor on their buttocks. The resident's phone dropped to the floor in the struggle. Resident #1 and Licensed Practical Nurse #4 continued to struggle in camera range with Licensed Practical Nurse #4 physically attempting to move the resident around, grabbing at the resident's arms, and pushing at their chest. Licensed Practical Nurse #4 picked up the resident's phone and put it behind the nurses' station. The resident left the area and walked down the hallway towards the other entrance to the dining room and Licensed Practical Nurse #4 ran after the resident. - From 6:13 PM to 6:14 PM, Resident #1 came back to the dining room entrance at the nurses' station, Licensed Practical Nurse #4 followed the resident and got between them and the door. They continued to struggle until Licensed Practical Nurse #4 wrapped their arms around the resident's chest and took them to the floor. Resident #1 got up and headed toward the door again and Licensed Practical Nurse #4 pushed the resident backwards with their hands on the resident's chest. Resident #1 ran down the hallway toward the other entrance to the dining room and Licensed Practical Nurse #4 ran after the resident. - From 6:15 PM to 6:18 PM, Resident #1 paced from the door back to the nurses' station but did not appear aggressive. - At 6:18 PM, Licensed Practical Nurse #4 gave the resident back their phone from behind the nurses' station then continued to put themselves between the dining room door and the resident. - From 6:19 to 6:20 PM, Resident #1 walked away from the situation and down the hallway toward their room. Licensed Practical Nurse #4's timecard and work schedule documented they worked and continued to have access to all residents on 1/4/2025 on the neuro unit, 1/8/2025 on other units, and 1/9/2025 on the neuro unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/28/2025 at 2:18 PM, Certified Nurse Aide #6 stated they received no specialized training for the neuro unit at the facility. There was a task list that was available to all staff on the unit that identified the residents' behavioral triggers. If a resident had behaviors, they moved other residents in the area away to safety. Resident #1 did not have a lot of behaviors, they mainly kept to themselves playing video games and using their phone. On 1/3/2025, Resident #1 coughed or gagged on their food and Licensed Practical Nurse #4 told the resident to leave the dining room. Resident #1 told the nurse they were not going to leave and continued to sit at their table. Licensed Practical Nurse #4 pulled the resident's chair and pulled them out of the dining room. They did not see Resident #1 act aggressive toward Licensed Practical Nurse #4 at any time. The resident would sometimes refuse to do something and would be fine if they were left alone. During a phone interview on 1/28/2025 at 3:00 PM, Licensed Practical Nurse #4 stated they worked for an agency and often worked on the neuro unit. They stated the only training they received for that unit was one in-service regarding Strategies for Crisis Intervention and Prevention (SCIP) provided by the facility. They had not had any training on Huntington's disease and learned by reading the care plans. They stated on 1/3/2025, Certified Nurse Aide #6 called them over as the resident had vomited. Another certified nurse aide (not identified) told them the resident needed to leave the dining room. Licensed Practical Nurse #4 stated Resident #1 could escalate quickly. The nurse tried to get the resident something else to eat and the resident pushed away from the table. The nurse told the resident Let's go and the resident swore at them and at other residents. Other residents were telling Resident #1 to be quiet as Resident #1 was very angry and loud. Licensed Practical Nurse #4 pulled the resident's chair to the dining room door as they would have been in trouble if Resident #1 hurt anyone in the dining room. The resident went to one knee softly from the chair as the dining room door closed and the resident was very volatile and immediately slammed the nurse into a wall. Resident #1 was kicking and punching at the door. Licensed Practical Nurse #4 stepped out of the way a couple of times. When the resident dropped their phone, the nurse picked up and put it on the top of the desk so it wouldn't get broken, not behind the desk. They stated they never struck the resident, hit the resident, or tried to hurt the resident. The nurse grabbed the resident by their shirt to keep the resident from falling and gently lowered them to the floor. The nurse attempted to call the supervisor, but no one answered the supervisors' phone. They informed the supervisor of the incident when the supervisor rounded on the floor. The nurse said they lifted the resident out of the rolling chair in the dining room because they saw the resident was going to fall forward. They had pulled the resident's walker away as the resident has a history of pushing it at others when agitated. During an interview on 1/29/2025 at 11:07 AM, Certified Nurse Aide #8 stated on 1/3/2025, Resident #1 had just gotten off a clear liquid diet, so they were eating their food quickly when it was given to them. They choked a little which was not uncommon for them, and it resolved quickly. Licensed Practical Nurse #4 was irritable about it and argued the resident was not supposed to be in the dining room. The aide's back was turned most of the time and they only saw License Practical Nurse #4 trying to get Resident #1 out of the chair. The aide did not see Licensed Practical Nurse #4 drag the chair with the resident in it. Resident #1 was only a little aggressive after Licensed Practical Nurse #4 yelled at the resident regarding the choking. If Resident #1 became agitated and was then left alone, they calmed down. The aide was taught to move other residents out of the area instead of trying to move the agitated resident. No other residents in the dining room were agitated by Resident #1 that they were aware of. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/29/2025 at 12:10 PM, the Program Director of the Neurocare unit stated they assisted with staff training on the unit in conjunction with nursing. The full-time staff hired to the neurocare unit received Strategies for Crisis Intervention and Prevention and an in-depth training on Huntington's disease, Amyotrophic lateral sclerosis (a neurodegenerative disease), and all of the aspects of interdisciplinary care. The staff who floated to the unit and the agency staff received an overview training on Huntington's disease and Amyotrophic lateral sclerosis. If a resident had behaviors, the staff were to utilize the interventions on the resident's behavior plan. Strategies for Crisis Intervention and Prevention were a last resort when all interventions on the behavior plan have been exhausted and did not work. When it had to be utilized, a supervisor was to be notified, and a behavior note was to be documented. Staff should never remove a resident from the dining room by pulling them out on a stationary chair. Staff should never attempt to remove a resident from a chair by pulling them up by under their arms. During an interview on 1/29/2025 at 1:10 PM, the Director of Nursing stated abuse training was given to all staff, including agency staff, yearly. The Program Director of the neuro unit determined the appropriate level of training for the staff on the unit. Resident #1 being pulled out of the dining room on the stationary chair was uncalled for. It was aggressive and could make the resident feel abused, as they could not see backwards and had no control over what was going on. The chair could have also broken which would have caused harm to the resident. If a resident's behaviors were escalated but was in a safe situation, the staff should back off and let the resident calm down. Licensed Practical Nurse #4 continued to escalate the situation by going after the resident. The actions of Licensed Practical Nurse #4 were abusive. The nurse dragged the resident out of the dining room and the resident fell a couple of times due to the nurse's aggression. The resident should have been left in the dining room as they were not behavioral and there were no signs or documentation of the resident choking. During an interview on 1/30/2025 at 9:49 AM, Licensed Practical Nurse #11stated they worked on the neuro unit a few times prior to 1/3/2025 and had not received any formal training for the unit. They were told a few residents had behaviors. On 1/3/2025, they heard Resident #1 state Licensed Practical Nurse #4 pushed them down. Licensed Practical Nurse #11 tried to calm the situation and informed Licensed Practical Nurse #4 they didn't need to stand in front of the dining room door as it was locked. Licensed Practical Nurse #11 was trained in Strategies for Crisis Intervention and Prevention years ago and they did not believe that was what Licensed Practical Nurse #4 utilized, rather they believed the nurse abused the resident. During an interview on 1/30/2025 at 2:28 PM, the [NAME] President of Long-term Care stated the only unit they used physical intervention on was the neuro unit. They used Strategies for Crisis Intervention and Prevention as a last resort if the interventions on the behavior plan did not work. If the training was utilized, there was to be a behavior progress note and an accident and incident report. They reviewed the footage of the incident on 1/3/2025 and stated the behavior of Licensed Practical Nurse #4 was unwarranted and it was abuse. Licensed Practical Nurse #4 should not have removed Resident #1 from the dining room. The resident was sore the next day and had some bruising and abrasions that could have been from the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/30/2025 at 2:48 PM, the Medical Director stated they had not watched the videos of the incident but was made aware. The described actions of Licensed Practical Nurse #4 were abusive and harmful toward the resident. A resident being pulled backwards could cause mental harm and potential physical harm if the resident was to fall or if the chair broke. The nurse's actions were not consistent with any facility protocol. The nurse should have backed away and let the resident calm down instead of being aggressive with the resident and continuously confrontational. During an interview one 2/3/2025 at 1:14 PM, Resident #1's Health Care Proxy (relative) stated they were made aware on 1/10/2025, of the incident that took place on 1/3/2025. They were informed Resident #1 was removed from the dining room and when Resident #1 attempted to re-enter the dining room, the staff member prevented it by pulling on the resident's clothing which resulted in a couple of falls. The were informed the resident was removed from the dining room by their chair being pulled backwards and they fell . Resident #1 was not behavioral and did not need to be removed from the dining room. The resident's relative had not talked to the resident regarding the situation as they did not want to potentially trigger the resident. The resident would have been upset about being removed from the dining room because they love food and would not have understood what was happening. They also would have been upset when their phone was removed from their possession as that was how the resident communicated with family and watched movies. 10 NYCRR 415.4(b)(1)(i) ____ Immediate Jeopardy was identified, and the facility [NAME] President of Long-term Care and Chief Executive Officer were notified on 1/30/2025 at 5:27 PM. Immediate Jeopardy was removed on 2/2/2025 at 10:21 AM prior to survey exit based on the following corrective actions: - As of 1/31/2025 at 4:15 PM, 100% of staff were educated on abuse, responding to abuse, signs of abuse, steps to take to protect residents, and reporting abuse. - As of 2/1/2025 at 9:00 AM, 100% staff currently working on the neuro unit were trained in Strategies for Crisis Intervention and Prevention. The remaining staff will be educated prior to the start of their next shift or would be removed from the schedule until completed. - As of 2/1/2025 at 3:26 PM, all residents present in the dining room or the hallway for the incident were assessed by a licensed social worker for any harm. - As of 2/1/2025 at 4:30 PM, 87% of all facility staff, including float and ancillary staff were trained on an overview of the Strategies for Crisis Intervention and Prevention. - Staff education sign in sheets were reviewed and compared to the current staff list and no discrepancies were identified. - Staff education was verified during an onsite visit from 1/31/2025 to 2/2/2025. Multiple interdisciplinary staff were interviewed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Staff were able to report content of education and confirmed the day they received the education and the facility staff who presented the education.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charles T Sitrin Health Care Center Inc	2050 Tilden Ave New Hartford, NY 13413

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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 - Immediate jeopardy to resident health or safety

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

48052

Based on record review and interviews during the abbreviated survey (NY00368525) the facility failed to ensure an incident of staff abuse toward a resident was reported to the State Agency, law enforcement, and the Administrator for one (1) of seven (7) residents reviewed (Resident #1). Specifically, facility staff witnessed or were present when Licensed Practical Nurse #4 abused Resident #1 and the incident was not reported to facility Administration, law enforcement, and the New York State Department of Health for seven (7) days. Additionally, Licensed Practical Nurse #4 continued to have access to residents following the witnessed abuse. The facility's failure to report abuse to Administration, law enforcement, and the State Agency resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #1 and placed all 173 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death.

Refer to F 600 Free from Abuse and Neglect.

Findings include:

The facility policy, Prohibition of Abuse Policy and Procedure Including Definitions of Abuse and All Other Terms Associated with Abuse and Serious Bodily Injury, revised 10/2024, documented all employees were ethically responsible to immediately report any observations of abuse, neglect, mistreatment, exploitation, resident-to-resident abuse, or misappropriation of resident property or any crime to the resident to their supervisor.

The facility policy, Resident Allegations and Facility Protocols, revised 10/2024, documented federal and state regulations required providers investigate incidents and complaints. An allegation was required to be reported to the State Department of Health within two (2) hours of receiving notification and knowledge of an alleged incident. All investigations were to be thoroughly documented. The resident would be evaluated for any sign of physical and emotional abuse as well as psychosocial changes from their baseline. The perpetrator would be suspended pending investigation if abuse was probable based on witness statement or assigned to another house or unit from the resident involved if abuse could not be determined.

Resident #1 had diagnoses including Huntington's disease (a progressive neurodegenerative disorder), chorea (involuntary, irregular movements), and ataxia (lack of muscle coordination). The 12/9/2024 Minimum Data Set documented the resident had severely impaired cognition, inattention, disorganized thinking, had no behavioral symptoms, utilized a walker for mobility, and was independent with all activities of daily living.

The 1/10/2025 at 3:03 PM facility report to the New York State Department of Health documented the incident occurred on 1/3/2025 at 6:05 PM and facility management became aware of the incident at approximately 12:00 PM on 1/10/2025.

The 1/10/2025 facility incident investigation completed by the Director of Nursing for an incident occurring on 1/3/2025 and reported to Administration on 1/10/205 documented:

(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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Certified Nurse Aide #5 reported to the Program Director of the Neurocare Unit an incident that occurred on 1/3/2025 at approximately 6:00 PM between Licensed Practical Nurse #4 and Resident #1. The camera footage was reviewed in which the resident was seen being handled roughly by a staff member and the resident fell at least three times. - The incident was reported to the Department of Health, Physician #18, the resident's family, and the local police department on 1/10/2025. Staff statements in the facility investigation included: - the Program Director of the Neurocare Unit (where Resident #1 resided) documented on 1/10/2025 at 11:30 AM, Certified Nurse Aide #5 reported they were told by Licensed Practical Nurse #4 about an incident on 1/3/2025 in the dining room between Licensed Practical Nurse #4 and Resident #1. The Program Director of the Neurocare Unit reviewed the video surveillance footage from the dining room for 1/3/2025. They documented Licensed Practical Nurse #4 was extremely aggressive with Resident #1 and Resident #1 appeared to not be exhibiting any behaviors warranting removal from the dining room. The findings of the video surveillance footage was reported to the [NAME] President of Long-term Care and they obtained statements from the staff. They also obtained a statement from Licensed Practical Nurse #4 and suspended them pending the investigation. - Licensed Practical Nurse #4 stated they informed Registered Nurse Supervisor #7 of the incident, and they had lowered the resident to the floor to their buttocks by their shirt. - Registered Nurse Supervisor #7 documented on 1/3/2025, Licensed Practical Nurse #4 approached them during their rounds on the neuro unit and informed them there was an incident with Resident #1 in the dining room where the resident became violent, and no staff assisted to calm the resident down. They inquired if anyone was hurt and Licensed Practical Nurse #4 stated no. - Certified Nurse Aide #6 stated on Friday, 1/3/2025 during dinner Licensed Practical Nurse #4 pulled Resident #1 from the dining room in their chair. - Certified Nurse Aide #8 stated Resident #1 was prompted to slow down with eating, and Licensed Practical Nurse #4 approached the resident to get them out of their chair and out of the dining room. There was a lot of arguing that could be heard behind the door outside of the dining room. They stayed in the dining room with the other residents to keep them safe. - Dietary Aide #17 stated on 1/3/2025 they heard Licensed Practical Nurse #4 yelling at Resident #1 and pull the resident out of the dining room by their chair. Licensed Practical Nurse #4 was pushing the resident out of the room when the resident tried to re-enter. - Licensed Practical Nurse #11 stated they heard Licensed Practical Nurse #4 trying to redirect Resident #1. Resident #1 fell as they charged the nurse, and the resident stated, You pushed me down. They went to intervene and calm the situation. They told Licensed Practical Nurse #4 to call the supervisor and let the resident calm down. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Certified Nurse Aide #10 stated on 1/3/2025, Licensed Practical Nurse #4 and Resident #1 had a verbal conversation about the resident leaving the dining room, but the resident refused to. They were feeding a resident and did not get involved. They left the dining room with the resident they were assisting and did not know what happened after that. Licensed Practical Nurse #4's timecard and work schedule documented they worked and continued to have access to all residents on 1/4/2025 on the neuro unit, 1/8/2025 on other units, and 1/9/2025 on the neuro unit. During an interview on 1/28/2025 at 2:18 PM, Certified Nurse Aide #6 stated on 1/3/2025 Licensed Practical Nurse #4 pulled the resident's chair and pulled them out of the dining room. They did not see Resident #1 act aggressive toward Licensed Practical Nurse #4 at all. They did not report the incident because they did not see anything reportable. During a phone interview on 1/28/2025 at 3:00 PM, Licensed Practical Nurse #4 stated they attempted to call the supervisor when the resident's behavior escalated, but no one answered the supervisors' phone. They informed Registered Nurse Supervisor #7 of the incident when the supervisor rounded on the floor and told them no one assisted due to not being trained. They stated they informed Licensed Practical Nurse #9 of the incident the next day as they wanted advice on how to handle behaviors on the unit. During an interview on 1/29/2025 at 11:07 AM, Certified Nurse Aide #8 stated on 1/3/2025 their back was turned most of the time and they only saw License Practical Nurse #4 trying to get Resident #1 out of the chair, and did not see Licensed Practical Nurse #4 drag the chair with the resident. They stated they did not report the incident due to the situation being odd. They stated it was hard to differentiate behavioral issues from normal behaviors on the unit and when a nurse wanted to control the situation, they did not think they could get involved. They were informed Licensed Practical Nurse #4 told a supervisor, so they thought everyone was aware. During an interview on 1/29/2025 at 12:10 PM, the Program Director of the Neurocare unit stated they were unaware Licensed Practical Nurse #4 reported to Registered Nurse Supervisor #7 they were concerned about the training of the staff due to no one assisting with a behavioral episode that required intervention on 1/3/2025. During an interview on 1/29/2025 at 1:10 PM, the Director of Nursing stated staff should report potential abuse to their supervisor immediately after making sure the resident was safe. If abuse was thought to have occurred, the employee was immediately suspended pending investigation. All staff who witnessed the incident on 1/3/2025 should have notified the supervisor immediately. Licensed Practical Nurse #4 only reported Resident #1 was behavioral to Registered Nurse Supervisor #7. The supervisor asked if anyone was hurt and Licensed Practical Nurse #4 told them no and the situation was dealt with. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/30/2025 at 9:49 AM, Licensed Practical Nurse #11 stated on 1/3/2025, they did not see much of the incident between Resident #1 and Licensed Practical Nurse #4, but they heard Resident #1 say Licensed Practical Nurse #4 had pushed them down. They tried to calm the situation and informed Licensed Practical Nurse #4 they did not need to stand in front of the dining room door as it was locked. They stated they did not report the incident because they did not see the resident fall and because Licensed Practical Nurse #4 told them they informed the supervisor about the incident. During an interview on 1/30/2025 at 10:20 AM, Registered Nurse Supervisor #7 stated they were passing through the neuro unit when they were informed by Licensed Practical Nurse #4 that Resident #1 was behavioral and they had not received any help from the staff. They asked if anyone was hurt, and Licensed Practical Nurse #4 told them no. They did not report the concern and instructed Licensed Practical Nurse #4 to write a behavior note but did not follow up on it as they were reviewed in morning meeting by the interdisciplinary team. During an interview on 1/30/2025 at 2:28 PM, the [NAME] President of Long-term Care stated staff received abuse training during orientation, annually, and as needed based on what was going on in the building. Staff were trained if the abuse was occurring to ensure the resident was safe. It was also dependent on the position of the employee, if it was a direct care staff member they could intervene or they could get a supervisor. A supervisor should be informed if abuse was witnessed. During an interview on 2/3/2025 at 1:12PM, Dietary Aide #17 stated that on 1/3/2025 Licensed Practical Nurse #4 pulled the resident by their chair and dragged them out of the dining room. When the resident attempted to go back into the dining room, the Licensed Practical Nurse was pushing the resident out. They did not know why they did not report the incident to anyone. 10NYCRR415.4 (b) (2) ____ Immediate Jeopardy was identified, and the facility [NAME] President of Long-term Care and Chief Executive Officer were notified on 1/30/2025 at 5:27 PM. Immediate Jeopardy was removed on 2/2/2025 at 10:21 AM prior to survey exit based on the following corrective actions: - As of 1/31/2025 at 4:15 PM, 100% of staff were educated on abuse, responding to abuse, signs of abuse, steps to take to protect residents, and reporting abuse. - Staff education sign in sheets were reviewed and compared to the current staff list and no discrepancies were identified. - Staff education was verified during an onsite visit from 1/31/2025 to 2/2/2025. Multiple interdisciplinary staff were interviewed. - Staff were able to report content of education and confirmed the day they received the education and the facility staff who presented the education.