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	06/29/2026

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the services provided or arranged by the facility were provided by qualified persons for three of three licensed nurses reviewed (Licensed Practical Nurses #5, #11 and #12) reviewed. Specifically, Licensed Practical Nurses #5, #11 and #12 performed cardiopulmonary resuscitation on Resident #1 without having valid cardiopulmonary resuscitation certification. Findings included: The facility policy Code Blue/Cardiopulmonary Resuscitation Policy, revised 05/2024, documented a code blue page alert was utilized to alert individuals within the facility to an acute medical emergency in a particular area of the building. Residents who had full code status would be delineated by a red name wristband and a red heart cardiopulmonary resuscitation sign in their room. Registered staff would verify the code status, assess the resident, and initiate the code team response by alerting additional staff in the area for assistance. Cardiopulmonary resuscitation must be initiated for all witnessed and unwitnessed arrests for residents with full code status. Trained staff would begin cardiopulmonary resuscitation and automated external defibrillator usage as indicated and resuscitative measures continued.Resident #1 had diagnoses including Huntington's disease (a progressive neurological disorder), suicidal ideations and post-traumatic stress disorder.The [DATE] physician order documented the resident's code status as full code (perform chest compressions/cardiopulmonary resuscitation when there is no pulse and/or respirations) with no limitation on medical interventions.The [DATE] at 9:05 AM facility investigation report completed by Registered Nurse #3 documented Resident #1 was observed lying on the floor next to their bed. The resident did not appear to be breathing and did not have a pulse. There was a cord wrapped around their neck. Code blue (emergency response) was called, and staff began cardiopulmonary resuscitation. The resident was transferred to a hospital. Staff investigation statements documented:-[DATE] by Licensed Practical Nurse #5. During a medication pass the resident was found on the floor in their room and was unresponsive. They saw the red wrist band on the resident indicating they were a full code and called a Code Blue. Three nurses from the rehabilitation unit responded with a crash cart and they initiated cardiopulmonary resuscitation and applied an automatic external defibrillator. Cardiopulmonary resuscitation continued until the paramedics arrived and took over. -[DATE] by Licensed Practical Nurse #11. At 9:02 AM on [DATE] there was an announcement for a Code Blue on the neurodegenerative unit. They observed a small patient on the floor with blood coming from the mouth and nose with a cord wrapped around their neck two times. The resident did not have a pulse or respirations. Cardiopulmonary resuscitation was initiated, and they completed multiple rounds of compressions. Licensed Practical Nurse #12 proceeded to take over compressions for Licensed Practical Nurse #11 while they suctioned the resident.-[DATE] by Licensed Practical Nurse #12. When they entered Resident #1's room Licensed Practical Nurse #11 was performing compressions (CPR). They jumped in to assist in reviving the resident until emergency medical services took over.The facility provided a list of staff with current cardiopulmonary resuscitation certification. There was no documented evidence that Licensed Practical Nurse #5, Licensed Practical Nurse #11 and Licensed Practical Nurse #12 were certified in cardiopulmonary resuscitation. During an interview (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] at 1:08 PM Licensed Practical Nurse #5 stated they completed online modules for cardiopulmonary resuscitation but had not finished hands on, so they were not currently certified.During an interview on [DATE] at 9:42 AM Licensed Practical Nurse Educator #13 stated they did not track cardiopulmonary resuscitation certifications for staff.During an interview on [DATE] at 12:29 PM Licensed Practical Nurse #11 stated any staff that was certified or was trained could perform cardiopulmonary resuscitation. They stated they did not possess a current certification in cardiopulmonary resuscitation.During an interview on [DATE] at 1:22 PM Director of Nursing stated any staff that was not certified in cardiopulmonary resuscitation could perform cardiopulmonary resuscitation under the good Samaritan law. The Education department tracked staff's cardiopulmonary resuscitation certifications. 10 New York Codes Rules and Regulations 415.11(c)(3)(ii)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident received adequate supervision and failed to identify and reduce hazards and risks for one of one resident (Resident #1) reviewed. Specifically, Resident #1 was admitted to the Neurodegenerative Unit with a history of suicidal ideations and hearing voices they referred to as demons. On [DATE], Resident #1 was found unresponsive in their room with a cord wrapped around their neck; cardiopulmonary resuscitation was initiated; Emergency Medical Services arrived and transported the resident to the hospital where they were pronounced deceased . This resulted in Immediate Jeopardy to Resident #1 and placed all 13 residents on the Neurodegenerative Unit with history of suicidal ideations at risk for the likelihood of serious harm, serious impairment, serious injury, or death. Findings include: The 01/2022 facility policy Suicidal Ideation, documented staff who witnessed a resident in the Neurodegenerative Care Unit make a suicidal statement would immediately notify the nursing supervisor, provider, licensed clinical social worker, the [NAME] President of Long-Term Care Services and the Director of Nursing. Resident #1 had diagnoses including Huntington's disease (a progressive neurological disease), suicidal ideations, dementia with psychotic disturbances, post-traumatic stress disorder, epilepsy (seizure disorder), and mild intellectual disabilities. The [DATE] Behavior Management Plan completed by Neurodegenerative Unit Program Director/Social Worker #9 documented the resident may verbalize suicidal ideations or attempt to bring a pillowcase to their neck. If the resident made suicidal statements or attempted to bring a pillowcase to their face/neck, remain with the resident to maintain safety and immediately notify nursing/social work. The resident referred to their suicidal ideation thoughts as demons. When expressing these thoughts or speaking of voices in their head, staff can call the resident's pastor at any time of day or night to bring comfort to the resident. The [DATE] Neurodegenerative Unit Program Director/Social Worker #9 progress note documented the resident, at times, heard voices in their head, which they referred to as demons. At breakfast, the resident stated, voices are saying bad things to me. The resident was provided with emotional support, mood state was stable, no concerns at this time. There was no documented evidence Neurodegenerative Unit Program Director/Social Worker #9 asked the resident for clarification of the bad things the voices were saying or the attending physician was notified of the voices. The [DATE] at 12:30 PM Neurodegenerative Unit Program Director/Social Worker #9 progress note documented the resident became agitated stating they felt they were trapped in a cage and wanted to go outside. The resident eventually calmed down, went to their room but almost immediately exited their room and began walking fast paced toward the TV room. The resident entered the TV room, walked toward the window and grabbed a vase off the windowsill. The vase was secured from the resident's hand and additional staff were called. The resident could not be safely calmed and attempted to hit the social worker and the nurse with the vase, kicked and attempted to bite the social worker's arm. Re-direction was attempted by offering a movie, video game, 1:1 card games, taking a nap, or calling their pastor. The resident was not amenable to any of these options. The resident leaned their head on the social worker's shoulder and was agreeable to sit down. Once calmed the resident briefly went to their room and almost immediately exited their room and walked to the TV lounge with a fast pace, was asked if they wanted to watch a movie and agreed. Upon entering the lounge the resident walked toward the windows, grabbed a vase off the windowsill and aggressively hit the window. The vase was secured, and the charge licensed practical nurse and a certified nurse aide arrived to assist. They held the resident and after approximately 8 minutes, the resident was calmed. The resident was assisted to the nursing desk, their pastor was called and the resident stated they felt better. Staff were told to immediately report to the resident's room if they heard noises which could indicate the resident was hitting the window. To ensure safety, all decorative objects were removed from the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	windowsills in the TV room. The [DATE] at 9:26 PM Licensed Practical Nurse #5 progress note, documented the resident approached the nursing station at 7:30 PM stating they wanted to call their aunt, and they did not like being at the facility and felt like they were in prison. The resident continually made the comment they wanted to leave and did not like it here. After the phone call, the resident went back to their room and went to bed. The [DATE] at 9:05 AM incident report completed by Registered Nurse #3 documented the resident was observed lying on the floor next to their bed; did not appear to be breathing and did not have a pulse. There was a cord wrapped around their neck. Code Blue (emergency alert) was called, staff began cardiopulmonary resuscitation and 911 was called. The resident was transferred to the hospital by Emergency Medical Services at 9:34 AM. There were no predisposing environmental, physiological, or situational factors. Local law enforcement and the medical examiner were made aware. The [DATE] hospital record documented the resident had ligature marks (an impression or pattern left on the skin by a constricting material) on the anterior (front) neck upon admission and was pronounced deceased at 9:53 AM.During an interview on [DATE] at 10:34 AM, Certified Nurse Aide #7 stated they were not aware of the demons the resident spoke of, but knew the resident had suicidal ideations. They stated before the resident was admitted , Neurodegenerative Unit Program Director/Social Worker #9 sent out information received from Developmental Disabilities Services Office regarding the resident. At their previous residence, the resident escaped out of a window, tried to jump off a bridge, tried to put a pillowcase to their neck, and escaped into traffic. They were never told the resident was an imminent danger to themselves. There was no way to know if the resident was a hazard to themselves, two days was not enough time to know how the resident would react. On [DATE], they last saw Resident #1 at approximately 7:00 AM lying in their bed, however they did not enter the room at that time. At approximately 8:50 AM, Licensed Practical Nurse #5 came to the dining room and informed them the resident was cold and unresponsive. When they and Licensed Practical Nurse #5 entered the resident's room, the window screens were busted out and the resident was found on the floor. When they rolled the resident over, they saw a cord wrapped around the resident's neck, not anchored to anything but wrapped tightly and tied off. During an interview on [DATE] at 11:37 AM, Neurodegenerative Unit Program Director/Social Worker #9 stated when the resident was admitted they were concerned about risk of elopement as the resident had tried to jump out of a window at their previous residence. They stated there were zero warning signs the resident wanted to harm themselves and nothing of concern. They did a self-harm assessment on admission, determined there was no risk and added the behavior care plan because of the resident's history of suicidal ideation. The resident talked about voices in their head. They stated they put all their focus on the resident's risk of elopement. The resident was never placed on frequent checks as they determined there was nothing of concern at the time. They and the staff monitored changes in mood state and behaviors outside their baseline. The resident was not there long enough to get a baseline.During an interview on [DATE] at 1:08 PM, Licensed Practical Nurse #5 stated they were aware Resident #1 had a history of suicidal ideation. Residents who were at risk of harming themselves should have their call bell taken away and given something else to use, or if they said they were going to suffocate themselves their pillow should be removed and possibly place the resident on frequent checks. Resident #1 was not on hourly checks. At approximately 8:50 AM on [DATE], they found the resident unresponsive lying on the floor of their room face down with their upper body under the bed. They placed their hand on the resident's back, and it felt cold. They also attempted to arouse the resident by saying their name and there was no response. They left the room to get help. Certified Nurse Aide #7 and Licensed Practical Nurse #5 entered the room and turned the resident over onto their back and that is when they noticed the cord around the resident's neck. During an interview on [DATE] at 1:28 PM, Attending Physician #10 stated many people at the facility worked on determining the resident's risk for self-harm. When a resident had a history of suicidal ideation, everything was based on the resident's needs. They spoke with the resident regarding suicidal ideations during their initial evaluation and the resident stated they were not (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	thinking or planning suicide. They only asked the resident about suicidal ideations because of the resident's history of suicidal ideation. If there was an immediate risk, they would have sent the resident to the Emergency Department for evaluation. The best they could do to keep a resident safe was to talk to the resident and make the best determination they could. During an interview on [DATE] at 2:15 PM, the Administrator stated Neurodegenerative Unit Program Director/Social Worker #9 thoroughly screened all the residents with referrals. Residents with behaviors like suicidal ideation had a behavioral care plan. They looked for a change in behavior or when a resident verbalized suicidal ideations. Resident #1 was set up with a behavioral care plan prior to their admission from Developmental Disabilities Services Office. Developmental Disabilities Services Office never said the resident was a danger to themself or made us aware of any of the apparent self-harm attempts. They did not know the resident jumped out of a window, ran into traffic, or tried to jump off a bridge. Developmental Disabilities Services Office told us the resident was non-ambulatory and could not feed themselves, which was not the case. There were no signs of depression or suicidal ideation. Three days was probably not enough time to get to know the resident. 10 NYCRR 415.12(h)(2)_____Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 12:39 PM. The Administrator was notified on [DATE] at 2:15 PM the Immediate Jeopardy was lifted based on the following corrective action plans:-All staff were educated on suicide prevention and awareness. All licensed staff were educated on the facility's suicidal ideation evaluation form. The facility attestation documented 86% of staff were educated with a plan to educate any remaining staff prior to the beginning of their next work assignment. The educational presentation was reviewed by New York State Surveyors and determined to be complete and an acceptable plan.-Staff interviews conducted on [DATE] verified understanding and retention of education provided-Suicidal ideation evaluation form was created and all residents on the Neurodegenerative Unit with a history of suicidal ideations were evaluated.-All residents with a history of suicidal ideations were immediately assessed by the attending physician and a licensed master social worker.