STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335478	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Center for Rehabilitation and Healthcare	81 Park Street Elizabethtown, NY 12932

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35228 Based on observations, record review, and interviews during an abbreviated survey (Case #s sNY00328017 and NY00340585), the facility did not ensure the resident had a right to a dignified existence for 1 (Resident #1) of 7 residents reviewed for residents' right to a dignified existence. Specifically, Resident #1's colostomy bag was exposed, their upper body was not covered, and breasts were exposed, and the resident's lower body was not appropriately clothed, as they were observed lying on their bed and walking in the hallway with only a brief on. This is evidenced by: The facility's Corporate Compliance Manual updated 7/12/2021, documented residents must be afforded their right to a dignified existence. Resident #1 was admitted to the facility with diagnoses of post-traumatic stress disorder (a mental health condition that's triggered by an event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), vascular dementia (loss of memory, language, problem-solving and other thinking abilities caused by decreased blood flow to the brain), and diabetes. The Minimum Data Set (an assessment tool) dated 3/27/2024, documented the resident had severe cognitive deficit, could be understood, and could usually understand others. During an observation on 5/01/2024 from 12:03 PM- 12:26 PM on Resident #1's unit, Resident #1 was unkempt, with only a brief and t-shirt on. Their abdomen and colostomy bag were exposed, and the bed pad was wet and had a dried ring of a urine appearing substance. During an observation on 5/01/2024 at 1:33 PM, Resident #1 was seen in the hallway outside of their room wearing only a brief. During the afternoon of 5/03/2024, Investigator #1 stated they walked by Resident #1's room and observed their shirt pulled up with their breasts exposed. The Comprehensive Care Plan for Verbal/Physical Behaviors initiated on 8/09/2021, documented the resident may disrobe (taking their clothes off) and to redirect negative behavior as needed. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nurse Aide Kardex (an electronic system that contains directions for providing resident-specific care) as of 5/08/2024, documented to monitor/record occurrence of disrobing (taking their clothes off) and redirect the resident to their room. During an interview on 6/05/2024 at 2:16 PM, Registered Nurse #3 stated as soon as staff see Resident #1 disrobed, they would cover the resident and redirect them to their room to help them redress. They would also try to divert their attention with an activity. Registered Nurse #3 stated staff tried to find the cause that may have led to the behavior. For example, if the disrobing behavior caused by a family issue, did the resident possibly have a urinary tract infection, were they too warm, did they need to be toileted, or changed. During an interview on 6/10/2024 at 2:03 PM, Director of Nursing #1 stated Resident #1 had a history of disrobing. If the resident was observed in the hallway, staff were educated to redirect the resident to their room and help them redress. They stated the resident could become combative and staff were supposed to stay in the room with them until they were able to redress the resident since it would not be safe to leave the resident alone with their door closed. Director of Nursing #1 stated staff were educated to go into the resident's room to have them pull their shirt down if it was pulled up and their breasts were exposed. They stated they were not always on the unit so did not know if staff were consistently redirecting the resident when they exposed themselves. They stated the resident could be difficult to redirect when unclothed because Resident #1 would state they could do whatever they wanted to because of how old they were. Director of Nursing #1 stated if there was a problem redirecting the resident, they would ask other staff for assistance. 10 New York Codes, Rules, and Regulations 415.3(c)(1)(i)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35228 Based on record review and interviews during an abbreviated survey (Case #sNY00328017 and NY00340585), the facility did not ensure the resident had a right to personal privacy and confidentiality of their personal and medical records for 2 (Residents #1 and #2) of 2 residents reviewed for the right to personal privacy and confidentiality. Specifically, the facility did not maintain confidentially for Residents #1 and 2 when staff were texting Health Insurance Portability and Accountability Act (HIPAA)-protected information to other staff members using an application on their personal cell phones not sanctioned by the facility. This is evidenced by: The Policy and Procedure titled, Cell Phone Use last revised 10/2019, documented to maintain the privacy and confidentiality rights of our residents and to be in compliance with the Health Insurance Portability and Accountability Act, the use of any non-company issued personal electronic device, such as cellular telephones was prohibited in resident areas. Inappropriate use of a cellular device by an employee included, but is not limited to, sharing Health Insurance Portability and Accountability Act protected information via unsecured networks such as text message. Resident #1 was admitted to the facility with diagnoses of post-traumatic stress disorder (a mental health condition that's triggered by an event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), vascular dementia (loss of memory, language, problem-solving and other thinking abilities caused by decreased blood flow to the brain), and diabetes. The Minimum Data Set (an assessment tool) dated 3/27/2024, documented the resident had severe cognitive deficit, could be understood, and could usually understand others. Resident #2 was admitted to the facility with diagnoses of epilepsy (a brain disease where nerve cells don't signal properly that causes seizures), diabetes, and chronic obstructive pulmonary disease (narrowing of airways in the lungs making it difficult to breathe). The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood, and could understand others. During an interview 5/02/2024 at 11:36 PM, Licensed Practical Nurse #1 stated the following incident was texted to them using a texting application the facility had sent them an invitation to use the application and download it on their phone. Licensed Practical Nurse #1 read the message verbatim to the surveyor (Note: Both residents' names were written in full in the texts): - At 8:21 AM on 4/27/2024, Registered Nurse #2 texted that they had a concern regarding Residents #1 and 2. I went into a room to do an assessment (across the hall from Resident #1's room). I noticed Resident #2; they went into Resident #1's room and closed the door. After doing my assessment, I went to Resident #1's room and saw the resident lying in bed. They were already at the edge of the bed about to fall. Resident #1's shirt is up until below their breasts, their pant down up to their thighs. Resident #1 was still wearing pull up and bra on. I told them breakfast is coming and Resident #2 need to step out the room because I needed to do assessment on Resident #1. Resident #1 is back to their room now. I don't know if I need to write this up, please advise. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Essex Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 81 Park Street Elizabethtown, NY 12932	

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Then at 8:26 AM on 4/27/2024, Registered Nurse #2 texted, Resident #1 has dementia and Resident #2 I think is in the right mind. I'm also concerned Resident #1's child stops by from time to time. - At 9:31 AM on 4/27/2024, Registered Nurse #2 texted, The Certified Nurse Aide just caught them again doing the act, Resident #1 and Resident #2. ' Review of the noted texting application revealed it was not a Health Insurance Portability and Accountability Act (HIPAA)-compliant telecommunication service. During an interview on 5/03/2024 at 12:26 PM, Administrator #1 stated on 5/02/2024, they heard rumors of a sex act between Residents #1 and 2. They stated they heard a Certified Nurse Aide who no longer worked at the facility had told Certified Nurse Aide #1 about either on 4/29/2024 or 4/30/2024. They stated when they, themselves, came to the facility on [DATE], they rounded on all the units and asked questions. Administrator #1 stated the rumor was likely started from this information being shared by the staff on 4/29/2024 and 4/30/2024 as well as by the texts sent by staff that the other nurses could read. Administrator #1 stated they had started Health Insurance Portability and Accountability Act training, and that the texting application that staff were using was not sanctioned by the facility or ownership group. During an interview on 5/03/2024 at 2:09 PM, Licensed Practical Nurse #3 stated they were using a texting application they installed on their personal phone for things such as communicating with other nurses to ask if they had supplies. They stated they went to another unit to let one of the nurses know the nurse needed to be added back onto the application. Licensed Practical Nurse #3 stated they were informed that they were no longer using the application. During an interview on 5/03/2024 at 2:26 PM, Registered Nurse #2 stated they used the texting application on their personal phone. During an interview on 5/03/2024 at 2:28 PM, Registered Nurse #3 stated they did not like the staffs' use of the texting application. They stated there should have been open verbal communication. Registered Nurse Unit Manager #3 stated they did not like texts sent back and forth between staff, that it was unprofessional and a violation of the Health Insurance Portability and Accountability Act. Registered Nurse #3 stated the staff used the texting application on their personal phones, and that staff do not have work-issued cell phones. 10 New York Codes, Rules, and Regulations 415.3(d)(1)(ii)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35228 Based on record review and interviews during an abbreviated survey (Case #sNY00328017 and NY00340585), the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the State Survey Agency in accordance with State law through established procedures for 2 residents (Resident #1 and #2) of 2 residents reviewed for incident reporting. Specifically, an allegation of sexual abuse that involved 2 residents and alleged to have occurred on 4/27/2024 was not reported to the New York State Department of Health within 2 hours. This is evidenced by: The Policy and Procedure titled, Abuse and last revised on 12/2022, documented to notify the local law enforcement and appropriate State Agency(s) immediately (no later than 2 hours after allegation/identification of allegation) by Agency's designated process after identification of alleged/suspected incident. An addendum to the Intake Information form dated 5/06/2024, documented the facility reported the allegation of sexual abuse alleged to have occurred on 4/27/2024 to the New York State Department of Health on 5/03/2024. During an interview on 5/02/2024 at 11:36 AM, Licensed Practical Nurse #1 stated they came to work at 11:00 PM on 4/27/2024. They received a report from the evening nurse who did not work the day shift on 4/27/2024. Licensed Practical Nurse #1 stated they received information second hand about the alleged incident so the next morning (4/28/2024) they asked the staff that had been working on the day shift of 4/27/2024 what had happened. They were told by Registered Nurse #2 they had to remove Resident #2 from Resident #1's room because it looked suspicious. Resident #1 had their shirt pulled up, their brief was on, but their slacks were pulled down. Licensed Practical Nurse #1 stated they would report abuse to the Administrator who was the abuse coordinator for the facility. During an interview on 5/03/2024 at 11:27 AM, Director of Nursing #1 stated they had received no reports of a sexual act between Resident #s 1 and 2. They stated they would have expected the Complainant who reported the alleged incident to the New York State Department of Health to have reported it to facility Administration so they could have kept the residents safe. It was upsetting that the Complainant did not do that. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/3/2024 at 12:26 PM, Administrator #1 stated at 10:29 AM on 4/27/2024, they received a text message from Licensed Practical Nurse #2 who asked them to call Registered Nurse #2. Administrator #1 stated they attempted to call Registered Nurse #2, but they did not answer so they called Business Office Manager #1 who was the manager on duty assigned to be in the building on 4/27/2024. The Administrator asked them if they had heard about any issues on Unit 3 because they could not reach Registered Nurse #2. The Administrator stated that was when they were told that Resident #2 was found in Resident #1's room with the door closed. At that time, they notified Regional Administrator #1 and Regional Clinical Director #1 of the alleged incident. They stated they were not aware until 5/02/2024 that Resident #2 was in Resident #1's room twice with the door closed on 4/27/2024. They would have expected to be informed of both incidents. They stated as soon as staff were aware, whether by eyewitness, overhearing anything, by resident or family reports for example, staff were to contact the Director of Nursing or Administrator. The Administrator stated the facility had 2 hours to report abuse to New York State Department of Health. The Administrator stated they had called their regional team and reported that their findings were not definitive. They stated their regional team told them the incident did not meet the criteria for reporting because there was not a witness that anything had occurred. 10 New York Codes, Rules, and Regulations 415.4(b)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35228

Based on observations, record review, and interviews during an abbreviated survey (Case #sNY00328017 and NY00340585), the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 3 residents (Resident #s 1, 3, and 7) of 7 residents reviewed for activities of daily living. Specifically, (a) Resident #1's appearance was unkempt, they were wearing only a t-shirt and brief, and their bed had a dried ring of a urine appearing substance on the incontinence pad. (b)Resident #3's fingernails were not clean, and their hair was greasy. (c)Resident #7's hair was greasy, their fingernails were not clean, and the upper right leg of their slacks was soiled. This is evidenced by:

The Policy and Procedure titled Activities of Daily Living Care and Support revised 3/13/2024, documented activity of daily living care and support would be provided for residents who were unable to carry out Activities of Daily Living independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, that included but not limited to supervision and assistance with hygiene (bathing, dressing, grooming, and oral care) and toileting.

Resident #1 was admitted to the facility with diagnoses of post-traumatic stress disorder, vascular dementia (dementia caused by decreased blood flow to the brain), and diabetes. The Minimum Data Set (an assessment tool) dated 3/27/2024, documented the resident had severe cognitive deficit, could be understood, and could usually understand others.

The Resident #3 was admitted to the facility with diagnoses of dementia, multiple sclerosis, and diabetes. The Minimum Data Set, dated dated dated [DATE], documented the resident had moderate cognitive impairment, was sometimes understood, and could usually understand others.

Resident #7 was admitted to the facility with diagnoses of Alzheimer's Disease, need for assistance with personal care, and mood disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood, and could sometimes understand others.

Resident #1

During an observation on 5/1/2024 from 12:01 PM- 12:26 PM on Resident #1's unit, Resident #1 was unkempt, with only a brief and t-shirt on. Their abdomen and colostomy bag were exposed, and the bed pad was wet and had a dried ring of a urine appearing substance.

The Comprehensive Care Plan for Required Assist with Activities of Daily Living related to dementia, being legally blind, and colostomy status was initiated on 10/19/2020. The care plan documented the resident was to have a shower/bath on the Monday and Thursday day shift. There was no documentation in the resident's care plan they refused care.

The Certified Nurse Aide Kardex (documented the care a resident was to be provided) as of 5/08/2024 documented the resident was to have a shower or bath Monday and Thursday on the day shift. It did not document the resident refused care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Document Survey Report dated 4/2024 documented the Certified Nurse Aide care provided daily on all 3 shifts. No resident care was documented as provided on the 7:00 AM- 3:00 PM shift for 4/04/2024, 4/18/2024, 4/24/2024, 4/29/2024, or 4/30/2024, on the 3:00 PM- 11:00 PM for 4/02/2024, 4/03/2024, 4/08/2024, 4/11/2024 4/20/2024, 4/22/2024, 4/23/2024, 4/24/2024, 4/25/2024, 4/27/2024, 4/28/2024, or 4/30/2024, or on the 11:00 PM- 7:00 AM shift on 4/01/2024, 4/05/2024, 4/10/2024, or 4/11/2024. Resident #3 During an observation on 5/03/2024 at 10:59 AM, Resident #3's fingernails were not clean, and their hair was greasy. The Comprehensive Care Plan for Required Assist with Activities of Daily Living related to confusion, and dementia was initiated on 5/30/2023. The following interventions were initiated by Licensed Practical Nurse #5: 5/26/2023- shower/bath Tuesday and Friday day shift. There was no documentation in the resident's care plan they refused care. The Certified Nurse Aide Kardex (documented the care a resident was to be provided) as of 5/09/2024 documented the resident was to have a shower or bath Tuesday and Friday on the day shift. It did not document the resident refused care. The Document Survey Report dated 4/2024 documented the Certified Nurse Aide care provided daily on all 3 shifts. No resident care was documented as provided on the 7:00 AM- 3:00 PM shift for 4/08/2024, 4/21/2024, 4/24/2024, or 4/28/2024, on the 3:00 PM- 11:00 PM for 4/2/2024 or 4/14/2024, or on the 11:00 PM- 7:00 AM shift on 4/01/2024, 4/03/2024, 4/6/2024, 4/07/2024, 4/15/2024, or 4/20/2024. Resident #7 During an observation on 5/03/2024 at 11:11 AM, Resident #7 was sitting in the hallway. Their hair was combed but greasy. Their fingernails were not clean, and the upper right leg of their slacks was soiled. The Comprehensive Care Plan for Required Assist with Activities of Daily Living related to confusion, and dementia was initiated on 9/14/2023. It documented the resident was to have a shower/bath Wednesday and Saturday evening shift. The Certified Nurse Aide Kardex (documented the care a resident was to be provided) as of 5/09/2024 documented the resident was to have a shower or bath Wednesday and Saturday on the evening shift. The Document Survey Report dated 4/2024 documented the Certified Nurse Aide care provided daily on all 3 shifts. No resident care was documented as provided on the 7:00 AM- 3:00 PM shift for 4/08/2024, 4/21/2024, 4/24/2024, or 4/28/2024, on the 3:00 PM- 11:00 PM for 4/02/2024, or on the 11:00 PM- 7:00 AM shift on 4/01/2024, 4/02/2024, 4/03/2024, 4/06/2024, 4/07/2024, 4/10/2024, 4/15/2024, or 4/20/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/03/2024 at 2:16 PM, Certified Nurse Aide #3 stated the residents got nail care when they were washed up, or if they could not get it done then, they did nail care on rounds or during down time. Certified Nurse Aide #3 stated residents were showered on a schedule. Some showers were given on different shifts. When it was not a resident's shower day, they were washed up in their room. Certified Nurse Aide #3 stated if a resident refused their shower, they would tell the nurse and ask the resident if they wanted to get washed up in their room. During an interview on 5/03/2024 at 2:28 PM, Registered Nurse Unit Manager #3 stated nail care should be done when the residents were showered and as needed. They stated nail care consisted of trimming long nails, filing until smooth and cleaning under them. Registered Nurse Unit Manager #3 stated showers were scheduled for residents 1-2 times a week. They stated if a resident refused a shower, staff were supposed to reapproach and if the resident still refused, they were supposed to tell the charge nurse. If that failed, they were to tell the Unit Manager. They stated they put residents who refused their shower on the list for the next shift, or on the as needed list for the Certified Nurse Aides for the next day. During an interview on 6/10/2024 at 1:43 PM, Licensed Practical Nurse Manager #4 stated nail care was provided to the residents by Certified Nurse Aides, Nurses, and Activities staff. The residents were showered twice a week but did not always allow their hair to be washed. They stated Resident #3, who required total care chronically refused it. Sometimes staff could get the resident to the shower, other times they refused. They stated the resident could be combative with care. They stated Resident #3's care plan would need to be updated to document refusal of care. Licensed Practical Nurse #4 observed Resident #7's hair during this interview and stated it was greasy. They asked Resident #7 if they would allow them to wash their hair and Resident #7 stated yes. They stated the resident could be easily redirected and cooperative with care most of the time. They stated the all in one bodywash/shampoo did not always work to effectively clean the residents' hair. Licensed Practical Unit Manager #4 stated recently the team discussed the use of dry shampoo for in-between showers or if a resident's hair looked greasy, but they had not heard back if the facility would be ordering it. During an interview on 6/10/2024 at 2:11 PM, Director of Nursing #1 stated when a resident refused a shower, the Certified Nurse Aide was supposed to tell the nurse, make sure the reason for the refusal was documented, and then the Certified Nurse Aide was to reapproach the resident to shower them. They stated the nurse needed to know why a resident was refusing to be showered. Director of Nursing #1 stated they noticed there were quite a few residents whose hair was greasy, and they wondered if maybe it was the product they were using. They stated recently when they saw a resident with greasy hair and when asked why, resident stated they did not like to get their hair wet under the shower head. They stated they had purchased one inflatable shampoo board for each unit as an alternative to shampooing residents' hair in the shower. They approached the Administrator at the end of last week to discuss possibly ordering dry shampoo. The Director of Nursing stated any time residents were showered and whenever it was noticed residents' nails were dirty, nail care should be provided. They stated Resident #7 was cooperative with care but could be anxious and Resident #3 needed to be reapproached frequently for care due to refusals. They stated when Resident #3 said no, they meant no. The Director of Nursing stated refusals of care should be documented and there should be care plans in place for residents who refused care. 10 New York Codes, Rules, and Regulations 415.12(a)(2)