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	11/13/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 21414 Based on observation, record review, and interview during the recertification survey, the facility did not ensure necessary housekeeping and maintenance services were provided to maintain a clean, sanitary, comfortable, and homelike environment on resident unit #s 1, 2, and 3 and the lobby/administrative areas. Specifically, floors and windows were not clean, and walls were not in good repair. This is evidenced by: During observations on 11/07/2024 at 10:38 AM through 11:40 AM, the floors in the following areas were soiled with dirt or were soiled dirt and cobwebs next to walls and in corners: Meeting Room. Ice Machine room. Director of Nursing office. Medical Records office. Activities room. Main Dining Room. Unit #1 Dirty Utility room. Unit #3 short hall foyer, long hall foyer, janitor closet & floor sink, electrical closet, and Clean Utility room. Resident room #s: 2, 10, 11, 12, 14, 101, 107, 112, 116, 118, 119, 120, 122, 124, 123, and 127. Additionally, the walls were scraped in room #s 101, 107, 116, 117, 122, and 124; and the window tracks were soiled with dirt and dead insects in room #s 101, 107, 119, 122, and 123. The undated document titled Housekeeping Aide Job Description documented that Housekeeping Aides were to clean resident room floors and walls daily and report maintenance issues to their supervisor. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/07/2024 at 11:41 AM, Director of Housekeeping #1 stated that they would clean the rooms and window tracks and would contact the maintenance department to repair the wall scrapes. 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 33538 Based on observation, record review, and interview during a recertification survey and abbreviated survey (Case #NY00351614), the facility did not ensure it protected the resident's right to be free from abuse and neglect for one (Resident #68) of three residents reviewed. Specifically, the facility investigation determined the likely cause of the resident's elopement on 8/15/2024 was, they were placed in the locked utility room by a terminated employee. This is evidenced by: The Facility's Policy titled, Abuse last reviewed 6/01/2024 documented the following: the facility prohibits the mistreatment, neglect, abuse, and misappropriation of resident property by anyone. Resident #68 was admitted to the facility with diagnoses of dementia with behaviors, chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), and. schizoaffective disorder. The Minimum Data Set (an assessment tool) dated 10/12/2024, documented the resident could be understood, could sometimes understand, and had severely impaired cognition for daily decision making. The facility's investigation form dated 8/19/2024, documented that at approximately 4:15 PM on 8/15/2024 the resident was noticed missing from the secure locked unit with no indication of door alarms from secure locked unit. The resident was found in a non-patient care utility area that was equipped with a coded locked door. The resident had no injuries or any signs of distress or pain. The investigation team did not feel the resident would have been able to manipulate a keypad and guess the correct code to enter the locked area due to dementia. Corporate Communications contacted local news station and confirmed a Certified Nurse's Aide contacted the news station reporting a missing person. Four Aides were terminated between 2:15pm and 3:10 PM on 8/15/24. The State Police were contacted by the Administrator to investigate the possibility that a staff member may have placed the resident in the locked utility area and a formal deposition was given. During an observation on 11/08/2024 at 12:15 PM, the doors exiting Unit 3 were locked, requiring a keypad entry, or pushing the door resulting in an alarm. The first door to the boiler room was locked, requiring a keypad entry that resulted in an alarm. The second door was not locked; however, it was heavy and required significant effort to open. The room was very warm, and loud with multiple large pieces of equipment running. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on11/08/2024 at 11:20 AM, Administrator #1 stated the code gray was called when the resident was discovered not on the locked unit when the evening meal was served. Prior to the discovery no door alarms had gone off indicating someone had opened the door without using the code. Administrator #1 found the resident in the locked utility/boiler room. All doors and alarms were tested and functioning. They were unable to determine how the resident could have gotten through the locked unit doors and into the locked boiler room without sounding any alarms. The local police department came to the facility to investigate a missing person reported to them by a news station. The news station was contacted and reported a Certified Nurse Aide called them to report a missing resident. There were 4 Certified Nurse Aides that were terminated at around 3:00 PM and the Administrator believed one of them came back into the building, put the resident in the boiler room and called the news station. A report was filed with the police, but they were unable to contact 3 of the terminated employees as they were out of state contracted staff, they had likely returned home, after being terminated. During an interview on 11/13/2024 at 11:20 AM, Assistant Administrator #1 stated they assisted with the investigation and follow-up after the incident. It was determined the resident did not elope but was put in the boiler room by one of the terminated staff. They stated they could not determine which staff because they did not have cameras in the facility. The policy was changed to include escorting terminated staff from the building and changing the entry codes immediately. 10 New York Codes Rules and Regulations 415.4(b)(1)(i)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43805 Based on record review and interviews during a recertification survey, the facility did not ensure comprehensive care plans were reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions for 1 (Resident #84) of 20 residents reviewed. Specifically, for Resident #84, the facility did not ensure an interdisciplinary care plan meeting was held to review the comprehensive care plan. Resident #84 was admitted to the facility with the diagnoses of cerebral infarction (stroke), gastro-esophageal reflux disease and hemiplegia and hemiparesis following cerebral infarction (paralysis on one side after stroke). The Minimum Data Set (an assessment tool) dated 9/27/2024 documented the resident was usually understood, could usually understand others, and had a mild cognitive impairment. The Policy and Procedure titled Care Planning - Interdisciplinary Team dated 8/2019, documented the Interdisciplinary Team was responsible for the review and updating of care plans including inviting and encouraging the resident, the resident's family and/or the resident's legal representative/guardian or surrogate to participate in the development of and revisions to the resident's care plan. During an interview on 11/06/2024 at 9:53 AM, Resident #84 stated they, their spouse, and health home care coordinator were setting up all discharge needs on their own. During an interview on 11/06/2024 at 9:53 AM, Family Member #1 stated they had requested a meeting with the social worker but one had not been scheduled yet. Family Member #1 stated there had been no care plan meeting for the resident's entire stay. During an interview on 11/13/2024 at 8:49 AM, Social Worker #1 stated that families were called by them when scheduling a care planning meeting. They stated Resident #84 had not had a care plan meeting and one should have been held in mid-October 2024. Social Worker #1 stated that they did not understand how the resident was not scheduled for a care planning meeting at the appropriate time. 10 New York Codes, Rules, and Regulations 415.11(c)(2)(i-iii)