

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2024
NAME OF PROVIDER OR SUPPLIER Plattsburgh Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8 Bushey Boulevard Plattsburgh, NY 12901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33538</p> <p>Based on record review and interviews during an abbreviated survey (Case #NY00332449), the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse, to the Administrator of the facility and to the State Survey Agency for 1 (Resident #1) of 3 residents reviewed. Specifically, the facility did not ensure that an allegation of physical abuse observed by staff on 1/26/2024 at 9:15 PM was reported to the New York State Department of Health within 2 hours after the allegation was made. The allegation was reported to the New York State Department of Health on 1/29/2024 at 10:36 AM.</p> <p>This is evidenced by:</p> <p>The facility Policy and Procedure titled Abuse Identification, effective 8/2020, documented all staff members were responsible for reporting indicators of abuse to the supervisor immediately. All alleged violations of abuse would be reported immediately, but no later than 2 hours if the alleged violation involved abuse. All reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source will be thoroughly investigated and promptly reported to local, state, and federal agencies.</p> <p>Resident #1:</p> <p>Resident #1 was admitted to the facility with diagnoses of dementia with behaviors, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and anxiety. The Minimum Data Set (an assessment tool) dated 12/01/2023 documented the resident could rarely or never be understood, or understand others, and had severe cognitive impairment.</p> <p>A handwritten statement signed by Certified Nurse Aide #3, dated 1/27/2024, documented they told the shift supervisor when they saw the resident being dragged down the hall by Certified Nurse Aides #1 and 2 on 1/26/2024.</p> <p>A handwritten statement signed by Certified Nurse Aide #4, dated 1/27/2024, documented that they saw Certified Nursing Aides #1 and 2 dragging a resident by their arms on 1/26/2024.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A typed statement by Registered Nurse Supervisor #1 documented they remember hearing the resident crying in the hallway which was not unusual, and did not recall any other information pertaining to the event or any reports or allegations made.</p> <p>An Incident Report completed on 1/29/2024 documented the evidence was substantiated by video surveillance and witness statements. On 1/26/2024 at 9:15 PM, Certified Nurse Aides #1 and 2 were observed on either side of Resident #1 holding the resident's arms and dragging the resident approximately 10 feet down the hall.</p> <p>The New York State Department of Health Incident Report Submission for Case #NY00332449 documented the facility submitted an incident report for this event on 1/29/2024 at 10:36 AM.</p> <p>During an interview on 2/01/2024 at 10:30 AM, Director of Nursing #1 stated the incident occurred on 1/26/2024 at around 9:15 PM. They stated they were not aware until they came in Monday morning, 1/29/2024 to find written statements from staff under their office door. They further stated they immediately notified the Administrator, an investigation was started, and the Department of Health was notified as well as local Law Enforcement.</p> <p>During an interview on 2/02/2024 at 12:50 PM, Administrator #1 stated they were aware of the 2-hour reporting time. They stated that they still could not determine who [which staff] did not do what they should have done. Administrator #1 further stated that Certified Nurse Aide #3 stated they told Registered Nurse Supervisor #1, and the Registered Nurse Supervisor denied being told; either way it was not reported as it should have been.</p> <p>10 New York Codes, Rules and Regulations 415.4(b)(2)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>33538</p> <p>Based on record review and interviews during an abbreviated survey (Case #NY00332449), the facility did not ensure that in response to allegations of abuse, immediate and effective measures were put in place to ensure that further potential abuse while an investigation was in progress for 1 (Resident #1) of 3 residents reviewed. Specifically, the administrative staff were not informed and involved as necessary and did not remove the alleged perpetrators from resident care when allegations of abuse were reported by staff on 1/26/2024 at 9:15 PM.</p> <p>This was evidenced by:</p> <p>The facility Policy and Procedure titled Abuse Identification, effective 8/2020, documented all staff members were responsible for reporting indicators of abuse to the supervisor immediately. Employees accused of participating in the alleged abuse would be immediately reassigned to duties that do not involve resident contact or would be suspended until the findings of the investigation have been reviewed by the Administrator.</p> <p>Resident #1:</p> <p>Resident #1 was admitted to the facility with diagnoses of dementia with behaviors, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and anxiety. The Minimum Data Set (an assessment tool) dated 12/01/2023 documented the resident could rarely or never be understood, or understand others, and had severe cognitive impairment.</p> <p>A handwritten statement signed by Certified Nurse Aide #3, dated 1/27/2024, documented they told the shift supervisor when they saw the resident being dragged down the hall by Certified Nurse Aides #1 and 2 on 1/26/2024.</p> <p>A handwritten statement signed by Certified Nurse Aide #4, dated 1/27/2024, documented that they saw Certified Nursing Aides #1 and 2 dragging a resident by their arms on 1/26/2024.</p> <p>A typed statement by Registered Nurse Supervisor #1 documented they remember hearing the resident crying in the hallway, which was not unusual, and did not recall any other information pertaining to the event or any reports or allegations made.</p> <p>An Incident Report completed on 1/29/2024 documented the evidence was substantiated by video surveillance and witness statements. On 1/26/2024 at 9:15 PM, Certified Nurse Aides #1 and 2 were observed on either side of Resident #1 holding the resident's arms and dragging the resident approximately 10 feet down the hall.</p> <p>During an interview on 2/01/2024 at 10:30 AM, Director of Nursing #1 stated the incident occurred on 1/26/2024 at around 9:15 PM. They stated they were not aware until they came in Monday morning, 1/29/2024 to find written statements from staff under their office door. The two staff accused completed their 2:00 PM to 10:00 PM shifts on 1/26/2024 and were not on the schedule to work the weekend. On 1/29/2024, they were both suspended pending the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/02/2024 at 11:55 PM, Certified Nurse Aide #3 stated they observed two Certified Nurse Aides, one on each arm, sliding the resident down the hall, one foot on the floor, the other foot up in the air. They stated they stopped them and told the Registered Nurse Supervisor #1.</p> <p>During an interview on 2/02/2024 at 12:50 PM, Administrator #1 stated the accused staff should have been removed from the building as soon as the accusations were made by the other staff. Administrator #1 also stated Registered Nurse Supervisor #1 was involved in a recent incident where staff were accused of abuse and Registered Nurse Supervisor #1 knew what to do, however in this incident they deny being told about the incident and that was why nothing was done.</p> <p>10 New York Codes, Rules and Regulations 415.4(b)(3)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33538</p> <p>Based on record review and interviews during an abbreviated survey (Case #NY00332449), the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, Resident #1's care plan was not followed resulting in an abuse allegation. Resident #1 was not assessed by a Registered Nurse, the resident's family and physician were notified following the allegation.</p> <p>This was evidenced by:</p> <p>Resident #1:</p> <p>Resident #1 was admitted to the facility with diagnoses of dementia with behaviors, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and anxiety. The Minimum Data Set (an assessment tool) dated 12/1/2023 documented the resident could rarely or never be understood, or understand others, and had severe cognitive impairment.</p> <p>The Comprehensive Care Plan titled Potential to be abused, initiated 10/11/2019, documented the following interventions: respect personal space if re-direction attempts are unsuccessful walk away and allow resident time to calm down and re-approach at a later time.</p> <p>An Incident Report completed on 1/29/2024 documented witnesses reported on 1/26/2024 at 21:15 two Aides were observed holding either side of resident's hand/arm dragging them down hall approximately 10 feet before being stopped. Assessment found a 5 centimeter purple bruise under the left axilla. Medical Doctor Notified 1/29/2024 at 11:00 AM and Resident's family notified 1/29/2024 at 11:00 AM.</p> <p>The medical record did not contain documentation of Physician or family notification from the time of the incident on 1/26/2024 until 1/29/2024.</p> <p>The medical record did not contain documentation of an assessment of the resident was completed from the time of the incident on 1/26/2024 until 1/29/2024.</p> <p>A handwritten statement signed by Certified Nurse Aide #1 on 1/30/2024 documented the resident had been yelling and hitting staff trying to meet the resident's needs. This had been going on for over an hour. Resident was assisted carried to hallway.</p> <p>An undated handwritten statement signed by Certified Nurse Aide #2 documented, they picked the resident up out of the chair and helped the resident to walk.</p> <p>During an interview on 2/02/2024 at 11:20 AM, Certified Nurse Aide #1 stated the resident needed incontinence care and was refusing to get up to go to their room for care. The resident was yelling and distraught. They stated they asked Certified Nursing Aide #2 to help them get the resident up. They further stated they believed the resident was having leg pain and that by helping the resident to stand and supporting some of their weight to walk would help.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/02/2024 at 12:15 PM, Director of Nursing #1 stated the Nurse Manager found a bruise on the resident and reported it to them - Director of Nursing #1 - on Monday morning, 1/29/2024. They stated they - Director of Nursing #1 - notified the doctor and there were no new orders. There was no assessment done prior to that and the Physician was not notified of the incident until after the bruise was found.</p> <p>During an interview on 2/2/2024 at 12:30 PM, Physician #1 stated they were not notified of the incident until Monday morning, 1/29/2024. They were told there was a bruise that was not indicative of being caused by the incident. Physician #1 further stated that they did not examine the resident as they were told there were no other injuries and did not feel the bruise warranted any treatment.</p> <p>10 New York Codes, Rules and Regulations 415.12</p>		