

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 10/24/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538</p> <p>Based on record review and interview during a recertification and abbreviated survey (Case # NY00316460), the facility did not ensure each resident was free from misappropriation of resident property and exploitation for 1 (Resident #78) of 3 residents reviewed. Specifically, former Activities Director # 1 used Resident #78 ' s checkbook to write checks that were deposited into their personal account and a partner ' s account amounting to over \$11,000.</p> <p>This is evidenced by:</p> <p>Resident #78 was admitted with the diagnoses of end stage renal disease, non-traumatic intracranial hemorrhage, and dementia. The Minimum Data Set (an assessment tool) dated 2/22/2023, documented the resident could be understood, usually understand others, and had moderate cognitive impairment.</p> <p>The facility's Abuse Prevention and Investigation Policy effective 8/2020 documented the facility was committed to providing residents an environment that was free from verbal, mental, and physical abuse, mistreatment, neglect, misappropriation of resident property, and Exploitation through the following Seven Components of a Systematic Approach to Abuse Prohibition. Misappropriation of property was defined in the policy as: The use of deliberate means to exploit, misplace, or the wrongful use of a resident ' s belongings or money-whether permanently or temporarily, without the resident ' s consent.</p> <p>The undated facility document titled Job Description, Activity/Recreation Director, documented one of the essential job functions was to assist residents in handling personal funds.</p> <p>The facility's investigative report dated 5/12/2023 documented the Administrator #1 was notified by Plattsburgh Police Department that the facility Activities Director #1 had been cashing personal checks from Resident #78 and depositing them into their account and an account of their partner. The transactions dated back to 2020, with the most recent being February 2023. The amount taken totaled over \$11,000. On 5/15/2023 Activities Director #1 was arrested and charged with grand larceny and check fraud and their employment was terminated.</p> <p>The police Incident Report dated 5/15/2023 documented that a request for a welfare check was received from the North [NAME] Credit Union on 5/02/2023 due to suspicious activity and depletion of Resident #78 ' s bank account.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Police Case Supplemental Narrative Report dated 5/16/2023 documented that Activities Director #1 was interviewed at the Police Department on 5/15/2023. They admitted to filling out, signing checks, and keeping some of the money. Activities Director #1 was arrested on charges of forgery and grand larceny.</p> <p>During an interview on 10/24/2024 at 11:15 AM, Administrator #1 stated there had been no incidents of financial exploitation since this case. All residents that had a personal checkbook or credit card were encouraged to keep it in their locked drawer, which is offered to all residents on admission. Administrator #1 further stated that such items could be kept in the Administrator ' s office for safekeeping. When a resident requests for staff to make a withdrawal or purchase, it is done by Administrator #1 with a witness. The facility had no indication of any issues with the accused staff until they were notified by the Police Department, at which time Activity Director #1 was immediately suspended and then terminated. Administrator #1 further stated they were not informed of the final disposition of the legal matter; however, the resident was reimbursed for the money taken.</p> <p>Past Non-compliance -F602</p> <p>Based on the following corrective action taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey:</p> <ul style="list-style-type: none"> - Facility staff cooperated with the local Police Department to facilitate their investigation and arrest of the perpetrator. - The alleged perpetrator was not permitted entrance to the facility to protect the residents from further misappropriation. - The incident was reported appropriately to the State Survey Agency. - A thorough investigation was completed, and it was determined there were no other victims of misappropriation. - The facility policy titled, Personal Funds-Resident, was updated to include securing personal checkbooks, bank cards, and cash in a locked drawer or in the Administrators office. - Education was provided on 5/26/2024 to all facility staff on abuse, abuse reporting, misappropriation of property, exploitation, and updated facility policy and procedures on resident funds <p>At the time of survey, there were no additional incidents of misappropriated personal property identified.</p> <p>10 New York Codes, Rules, and Regulations: 415.4(b)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>51609</p> <p>Based on record review and interviews during a recertification and abbreviated survey (Case #NY00347220), the facility did not ensure each resident had an environment that was as free of accident hazards as was possible to prevent accidents for 1 (Resident #20) of 4 residents reviewed for accident hazards. Specifically, when Resident #20 was holding a lit sparkler, the tip fell on their thigh and resulted in a burn.</p> <p>This is evidenced by:</p> <p>Resident #20 was admitted to the facility with diagnoses of dementia, edema, and asthma. The Minimum Data Set (an assessment tool) dated 09/25/2024 documented they could be understood, usually understand others, and was cognitively intact.</p> <p>The Policy and Procedure titled, Accident/Incident- Investigation and Reporting, dated 12/2023 documented guidelines for the completion, investigation, care plan intervention, and timely regulatory reporting of all accidents and incidents with appropriate follow up and monitoring post-incident occurrences.</p> <p>A Progress Note dated 07/04/2024 documented Resident #20 attended an outside festivity for the holiday and received a burn from the sparkler they were holding.</p> <p>Review of the facility incident report dated 07/04/2024, documented Resident #20 was participating in a July 4th holiday activity outside and was holding a sparkler. It documents Activity Director #1 standing right next to the resident. As soon as the sparkler tip fell on to Resident #20 's lap, Activity Director #1 contacted the nurse, who then assessed and treated Resident #20. The nurse notified the family, provider, and Director of Nursing #1. Resident #20 was noted to be psychosocially okay following the incident.</p> <p>During an interview on 10/22/2024 at 09:50 AM, Activity Director #1 stated that they offered each resident that could hold a sparkler to hold one and stood by each resident as they handed them a lit sparkler to hold and watch. They further stated that since children were holding sparklers, they thought it okay for residents to, as well. When Activity Director #1 was with Resident #20, the ashes fell on the resident ' s polyester pajama pants and burned a hole in them. This startled both Activity Director #1 and Resident #20, and Activity Director #1 retrieved the nurse. On the scene, the nurse assessed Resident #20 and removed pants, applied cold compress, applied bacitracin, and covered with a non-stick gauze pad</p> <p>During an interview on 10/22/2024 at 10:04 AM, Director of Nursing #1 stated the incident timeline was as Activity Director #1 stated, Resident #20 was outside during a facility activity when asked if they wanted to hold a sparkler and while holding it the tip fell off into their lap. Director of Nursing #1 stated that Resident #20 received. Director of Nursing #1 went through the treatment and healing of the area, reddened and then open on Resident #20 ' s right thigh. Director of Nursing #1 stated they would no longer provide sparklers to residents for them to hold in their hands, as it was a hazard and ' best to avoid. '</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of survey, there were no additional incidents of accidents due to sparklers identified. 10 New York Codes, Rules, and Regulations: 415.12(h)(2)		