

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Rutland Nursing Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  585 Schenectady Ave Brooklyn, NY 11203	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51390</p> <p>Based on observation, record review, and interviews, conducted during an Abbreviated Survey (NY00355337) the facility failed to ensure that a resident was treated with respect and dignity and cared for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This was evident for one (1) out of six (6) residents (Resident #6) sampled. Specifically, on 09/24/2024 Licensed Practical Nurse #1 reported when they entered Resident #1's room the Resident immediately started to cry stating Certified Nursing Assistant #1 told them none of the staff members liked them. A Neuropsychology progress note by the Psychiatrist dated 09/24/2024 documented Resident #6 was upset and reported Certified Nursing Assistant #1 went off on them and told them they were the worst person.</p> <p>The findings are:</p> <p>The policy titled Promoting/Maintaining Resident Dignity dated 03/01/2024 documented it is the practice of [NAME] Nursing Home to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality.</p> <p>Resident #6 was admitted to the facility with diagnoses including Cerebrovascular Accident with Right Hemiplegia, and Diabetes Mellitus.</p> <p>The Minimum Data Set (an assessment tool), dated 09/22/2024 documented Resident #6 had intact cognition.</p> <p>An updated Abuse Care Plan dated 05/24/2024 documented interventions for staff to provide Resident #1 with a calm and clutter free environment. Staff to check the Resident's mental status frequently and offer emotional support when applicable. Staff to redirect the Resident as needed and provide psychological and psychiatric services as needed. The care plan was updated on 09/24/2024 to reflect on the allegation.</p> <p>A Medical note by the medical doctor dated 09/24/2024 documented Resident #6 was assessed for report of Certified Nursing Assistant being rough during care. No body injuries were observed. Resident #6 to be seen by the Psychologist and emotional support provided.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Neuropsychology Progress Note, by the Psychiatrist, dated 09/24/2024 at 12:14 PM documented Resident #6 was upset over a staff (Certified Nursing Assistant #1) who went off on them because they said, ow (an interjection used to express sudden pain) while they were being cleaned. Resident #6 stated that Certified Nursing Assistant #1 made inappropriate and unprofessional statements including they (Certified Nursing Assistant #1) takes criticism from the staff, and they are not going to take it from residents. Resident #6 was very upset and needed assistance to calm down. Recommendations: Supportive therapy one to five times a month.</p> <p>The Facility's Investigative Summary dated 09/24/2024 documented Licensed Practical Nurse #1 reported that when they entered Resident #6's room, the resident immediately began crying. Licensed Practical Nurse #1 tried to calm Resident #6 down, but Resident #6 cried out louder stating Certified Nursing Assistant #1 told them that nobody among the staff members like them. Licensed Practical Nurse #1 tried to calm Resident #6 down with reassuring words of support but was unable to do so. The facility investigation documented Resident #6 reported that they said ouch (an interjection used to express sudden pain) and that Certified Nursing Assistant #1 was hurting them, Certified Nursing Assistant #1 said that was not true they were not hurting Resident #6. Certified Nursing Assistant #1 also told Resident #1 that the entire unit staff hate coming into their room because the resident is a problem, and that Resident #1 was verbally abusive to staff. Resident report stated the staff does not understand what having two strokes can do to someone's body and that when their body is not handled gently it hurts. The investigation concluded that emotional abuse took place as evidenced by Certified Nursing Assistant #1 admitting to telling Resident #6 off. Certified Nursing Assistant #1 also did not recognize Resident #6's complaint of pain during provision of care and did not follow protocol to stop care and alert a nurse.</p> <p>Licensed Practical Nurse #1 provided a typed statement to the facility dated 09/24/2024. According to the statement they responded to Resident #6 call bell and when they entered the room Resident #6 was lying in bed with their cell phone in their hand. Resident #6 saw them and immediately started crying. Resident #6 cried louder as they try to calm the Resident done. Resident #6 then reported that Certified Nursing Assistant #1 told them that not one of the staff members likes them. Resident #6 was alert and had no complaints of pain or discomfort. They spoke to Certified Nursing Assistant #1 who reported to them that Resident #6 was argumentative and was getting angry with them (Certified Nursing Assistant #1) during care. Resident #6 told them no to care for them anymore. Certified Nursing Assistant #1 also reported that they had completed the Resident's care before leaving the room.</p> <p>Registered Nursing Supervisor #3 provided a hand-written statement to the facility dated 09/25/2024. The statement states that Certified Nursing Assistant #1 called them and reported that they told off Resident #6 because the resident was extremely rude and was verbally abuse while they were performing incontinent care. Certified Nursing Assistant #1 stated they would take suspension for their actions, but they had to tell Resident #6 off. Resident #6 did allow them to provide care.</p> <p>The Neuropsychology Progress Note dated 10/02/2024 at 03:58 PM documented Resident #6 reported that Certified Nursing Assistant #1 did not return and that they were feeling much better.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/29/2025 at 10:01 AM, Resident #6 stated since it was the first time seen Certified Nurse Assistant #1, they asked them to explain how they were going to change their incontinent brief. Resident #6 stated they did not like Certified Nursing Assistant #1's explanation so they asked Certified Nursing Assistant #1 to leave their room. Resident #6 stated that when Certified Nursing Assistant #1 was leaving they (Certified Nursing Assistant #1) told them (Resident #6) that their family did not like them. Resident #6 stated that Certified Nursing Assistant #1 did not touch them and that they were not in pain.</p> <p>During an interview on 01/30/2025 at 09:22 AM, with Certified Nursing Assistant #1 that when they were cleaning Resident #6 the Resident told them that they were too rough and that they were taking too long. Certified Nursing Assistant #1 stated that Resident #6 began shouting while stating that they (Certified Nursing Assistant #1) did not know what they were doing. Certified Nursing Assistant #1 stated that they completed their task and left the room. Certified Nursing Assistant #1 stated they called Registered Nursing Supervisor #3 and told them that they told off Resident #6. Certified Nursing Assistant #1 did not further explain their conversation with Registered Nurse Supervisor #3.</p> <p>During an interview on 01/29/2025 at 2:00PM Licensed Practical Nurse #1 stated that Resident #6 liked Certified Nursing Assistant #1 but did not like the other night shift staff. Licensed Practical Nursing #1 stated there were no witnesses to the incident between Resident #6 and Certified Nursing Assistant #1. Licensed Practical Nurse #1 stated that Resident #6 reported to them that they did not like how Certified Nursing Assistant #1 spoke to them. Licensed Practical Nurse #1 stated that they notified the Director of Nursing that Resident #6 did not want Certified Nursing Assistant #1 in their room anymore.</p> <p>During an interview on 01/29/2024 at 4:30 PM the Director of Nursing stated they received an email from Resident #6 about the incident at 7:15 AM on 09/24/2024. The email stated that Certified Nursing Assistant #1 was rough with them during provision of care and told them that many of the staff dislike them because they are verbally abusive. The Director of Nursing stated they initiated an investigation and obtained statements from the 11:00 PM-7:00 AM staff. The Director of Nursing Stated Resident #6 had no complaints of pain when they were examined by the staff the Nurse Practitioner and was seen by Physician and Psychologist. The Director of Nursing stated they concluded verbal abuse did occur.</p> <p>10 NYCRR 483.10(a)(b) (1) (2)</p>		