STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335537	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rutland Nursing Home, Inc	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)
F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (NY00371268), the facility failed to ensure that a resident was free from resident-to-resident abuse. This was evident for one (1) out of five (5) residents (Resident #1) sampled. Specifically, on 01/31/2025 at 2:50 PM, Licensed Practical Nurse #1 witnessed an altercation between Resident #1 and Resident #2 in the elevator at the lobby level . Licensed Practical Nurse #1 separated the residents. Resident #1 and Resident #2 were assessed by Registered Nurse Supervisor #1 and there were no injuries. The facility failed to ensure timely safety measures to prevent further abuse. On 01/31/2025 at 5:25 PM, Resident #1 complained of left side chest pain and stated that Resident #2 entered their room and hit them. Resident #1 was transferred to the emergency room for evaluation and returned to the facility on [DATE] at 7:00 AM with diagnoses of an acute fracture (break) to the left fourth rib. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings are: The facility's policy and procedure on Abuse, Mistreatment, Neglect, Exploitation, Misappropriation and Reporting dated 11/2024, documented the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The objective of the policy is to comply with the seven-step approach which includes protection. Residents must be protected from offenders. Resident #1 was admitted to the facility with diagnoses including a stroke with left sided weakness, depression and adjustment disorder with mixed emotional features. The Minimum Data Set (an assessment tool) dated 12/27/2024, documented Resident #1's cognition was intact, and they were able to self-propel their wheelchair. A care plan titled: Risk for Abuse dated 06/18/2024, documented Resident #1 was at high risk for abuse due to previous history of altercations and abuse to others. Resident #1 was impulsive and displayed aggressive threatening behavior to peers. Resident #1 argued with peers frequently and had been abused by others. The interventions included: verbal counseling, emotional support, and referrals to the psychiatrist as needed. The Risk for Abuse care plan was updated on 01/31/2025 with interventions for 1:1 monitoring for safety after the second incident occurred. Resident #2 was admitted to the facility with diagnoses that included neuralgia/neuropathy (nerve pain/nerve damage), depression, and adjustment disorder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Minimum Data Set, dated [DATE], documented Resident #2 was cognitively intact, and required one (1) person supervision with activities of daily living. Resident #2 was wheelchair bound and was able to self-propel their wheelchair. The facility's Incident Overview and Occurrence Report dated 01/31/2025 at 2:50 PM, documented the first incident occurred in the elevator at the lobby level and was witnessed by Licensed Practical Nurse #1. Resident #1 was the initial aggressor who hit Resident #2 in the torso. Resident #2 then hit Resident #1 in the chest area as Resident #1 was being removed from the elevator by Licensed Practical Nurse #1. Residents #1 and #2 were separated and both residents were assessed by Registered Nurse Supervisor #1 and the Medical Doctor between 3:30 PM and 4:00 PM. The families were notified, social work, and psychiatric consultations were placed, and emotional support provided. There were no injuries. On 01/31/2025 at 4:10 PM, Law enforcement was called, responded, and both residents refused to press charges. On 01/31/2025 at 5:25 PM, Resident #1 complained of pain to the left side of their chest, and stated they were hit by Resident #2 in their room. Resident #1 was transferred to the hospital emergency department for further evaluation. On 02/01/2025 at 7:00 AM, Resident #1 returned to the facility with diagnosis of an acute left rib fracture. Resident #2 was moved to another unit in the facility. On 02/03/2025 at 7:00 AM, while Resident #1 was being assessed by Medical Doctor #1 they decided to press charges against Resident #2 and Law Enforcement was called. Resident #2 was arrested and removed from the facility. Resident #2 returned to the facility on [DATE] with an Order of Protection to stay away from Resident #1. In a Nursing Note dated 01/31/2025 at 4:00 PM, Registered Nurse Supervisor #1 documented an altercation occurred in the elevator. Resident #1 reported being punched in torso by Resident #2. Medical Doctor #1, and Social Worker #1 were informed. The Residents were separated, physical assessment was done, and emotional support was provided. There was no sign of injuries and close visual monitoring was arranged to be started. There was no documented evidence that close visual monitoring was implemented to protect the residents. In a Nursing Progress Note dated 01/31/2025 at 5:25 PM, Registered Nurse Supervisor #1 documented there was an unwitnessed altercation in Resident #1's room. Resident #1 was complaining of pain to the left side of the chest. Medical Doctor #2 was informed, and Resident #1 was transferred via ambulance to the hospital emergency department for further evaluation. The Emergency Department Summary documented on 01/31/2025 6:50 PM, Resident #1 arrived in the emergency room, complaining of chest pains. A chest x-ray and a cat scan of the chest was done on 02/01/2025 at 12:37 AM. Resident #1 was diagnosed with a Closed Fracture of the fourth (4th) left side rib. On 02/01/2025 at 7:11 AM, Resident #1 was discharged back to the facility. In a Social Worker Incident Report dated 02/03/2025, Social Worker #1 documented Resident #1 stated they first hit Resident #2 in the elevator on 01/31/2025, and that Resident #2 hit them in return and staff separated them. Resident #1 stated they went directly to their room after the elevator incident; while eating their meal a few hours later, Resident #2 entered their room, and they had another altercation. The [NAME] County Criminal Court Order of Protection dated 02/04/2025 documented that Resident #2 must stay away from Resident #1. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/14/2025 at 3:12 PM, Licensed Practical Nurse #1 stated Residents #1 and #2 were in the elevator in their wheelchairs next to each other facing the back of the elevator. Licensed Practical Nurse #1 stated they heard Resident #1 was talking to themself, then Resident #1 asked Resident #2 What are you are looking at? and hit Resident # 2 in the torso. Licensed Practical Nurse #1 stated they immediately intervened by removing Resident #1 from the elevator at which time Resident #2 hit Resident #1 in their chest area. Licensed Practical Nurse #1 stated two Certified Nursing Assistants in the lobby assisted with removing Resident #1 from the elevator. Licensed Practical Nurse #1 stated Resident #2 remained in the elevator. Licensed Practical Nurse #1 informed Registered Nurse Supervisor #1 and Licensed Practical Nurse #1 stated they were interviewed by police officers on 01/31/2025 about the incident in the elevator. During an interview on 05/14/2025 at 2:06 PM, Licensed Practical Nurse # 2 stated that Resident #1 and Resident #2, always go on and off the unit independently. The staff on the unit were unaware of the altercation in the elevator until they were informed by Registered Nurse Supervisor #1. Licensed Practical Nurse #2 stated on 01/31/2025 about 4:00 PM, Resident #1 came to the unit and was assessed by the Registered Nurse Supervisor #1. Licensed Practical Nurse # 2 stated they then went to take Resident # 2's vital signs after 5:00 PM and Registered Nurse Supervisor #1 called to inform them that Resident #1 would be put on 1:1 supervision. They were then informed that Resident #1 would be transferred to the emergency room after another altercation occurred with Resident #2. During interviews on 05/14/2025 between 2:51 PM and 3:00 PM, Certified Nursing Assistants #3, #4 and #5 (who were present on the unit on 01/31/2025 with Licensed Practical Nurse # 2), stated at about 5:25 PM, they heard a commotion coming from Resident #1's room and they all responded. Those interviewed stated Resident #2 was in Resident #1's room and said nothing. Those interviewed stated Resident #1 stated that Resident #2 hit them on their left side of the chest which was very painful. Those interviewed stated Resident #2 was removed from the room and Registered Nurse Supervisor #1 was called. Those interviewed stated Resident # 1 was transferred to the hospital emergency room for further evaluation as requested by the on-call Medical Doctor #2. During a telephone interview on 05/19/2025 at 1:40 PM, Registered Nurse Supervisor #1 provided the following details regarding the incidents involving Resident #1 and Resident #2: they were informed about the elevator altercation on 01/31/2025 at 3:30 PM by the Assistant Director of Nursing #1 and Licensed Practical Nurse #1. Social Worker #1 spoke to both residents who refused to be moved off their unit. The Senior Director of Nursing was informed of the resident's refusal to move and instructed that Resident #1 should be placed on 1:1 monitoring. Licensed Practical Nurse #1 was informed to assign a Certified Nursing Assistant but then later called Registered Nurse Supervisor #1 and told them that another altercation occurred in Resident #1's room. Registered Nurse Supervisor #1 returned immediately to the unit where Resident #2 was in the hallway agitated and yelling. Resident #2 was removed as far away as possible from Resident #1 and went off the floor. Resident #1 was visibly in pain and bracing their left side. The Director of Nursing and the medical doctor on call were informed and ordered Resident #1 be transferred to the emergency room for evaluation. Resident #1's family was informed, and a message was left for Resident #2's family. Resident #1 returned to the facility on [DATE] at 7:00 AM from the emergency room. The imaging reports in the electronic medical record revealed there was an acute fracture of the fourth (4th) rib that was not identified on previous reports. The Director of Nursing was informed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/15/2025 at 5:15 PM, the Director of Nursing stated they were not in the facility on the evening of 01/31/2025 but were called immediately after the elevator altercation. Registered Nurse Supervisor #1 was told to move Resident #2 to a separate floor, call law enforcement, and put Resident # 1 on 1:1 supervision. The Director of Nursing stated they were informed that the 71st precinct officers responded, and Resident #1 did not want to speak to them. After the elevator altercation Resident #1 remained in the lobby for 45 minutes to one (1) hour and was calmed down by staff in the lobby. Resident #2 went to the cafeteria and then to their floor. Registered Nurse Supervisor #1 assessed both residents asked them about moving to another unit, and they both refused. While Licensed Practical Nurse #1 was determining which Certified Nursing Assistant would be assigned to 1:1 monitoring for the evening shift, the second incident occurred in Resident #1's room. The Director of Nursing stated that after the first incident, time elapsed before Resident #1 was placed on 1:1 supervision. The Director of Nursing stated video surveillance cameras are not in the elevator but are in the main lobby only and the video surveillance showed Resident #1 was being removed from the elevator by staff. The video surveillance was given to the Attorney General's office. During a telephone interview on 06/12/2025 at 3:50 PM, the Administrator stated they received a call from the Nursing Director about the elevator incident before it was reported to the Department of Health and were told that the staff separated Resident #1 and Resident #2 and there were no injuries. The Administrator stated law enforcement was called and came to the facility. The Administrator stated they were informed of the second incident by the Director of Nursing but did not recall the time they were informed, and they were also told and made aware that Resident #1 sustained a fracture. During a telephone interview on 06/12/2025 at 2:00 PM, Medical Doctor #1 stated they saw Resident #1 after they returned from the hospital. Medical Doctor #1 stated Resident #1 was seen by on-call Medical Doctor #2 who gave the orders on the weekend to have Resident #1 transferred to the emergency department. Medical Doctor #1 stated Resident #1 and Resident #2 were assessed on 02/03/2025 and the imaging results for Resident #1 were reviewed. Medical Doctor #1 stated Resident #2 was complaining of pain to the face, there was no swelling, the police took Resident #2 to the Emergency Department before taking Resident #2 to central booking where Resident #2 was charged, and the order of protection was issued before Resident #2 was allowed to be returned to the facility. 10 NYCRR 415.4(b)(1)(i)