STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37516 Based on record review and interview during the abbreviated (NY00348553) survey conducted 3/21/2025, the facility did not ensure an elopement incident was reported to the State Agency as required for 1 of 3 residents reviewed (Resident #1). Specifically, Resident #1 eloped 6/29/2024 when they removed a window panel from an unoccupied room on their unit, climbed out the window and were discovered standing in the fenced-in courtyard with their walker. The facility did not report the elopement incident to the New York State Department of Health as required. Findings include: The August 2016 New York State Department of Health Incident Reporting Manual documented at least one of the following elements must be present for an incident to be reportable to the New York State Department of Health: - Resident with cognitive impairment or elopement risk left the facility undetected, or eloped from physician, other outside appointment, or facility outing. - Resident, despite cognition, was at risk for elopement and remained missing after a search of the building was conducted. - Resident with a pass failed to return from an outing. The facility policy Wandering Management and Elopement Prevention, effective 2/8/2023, documented all residents would be assessed for risk of elopement upon admission, quarterly, with significant change in condition and when behaviors indicated utiliizing the specified assessments in the electronic medical record. Residents who were determined to be at risk for elopement would have a wander alert bracelet applied. The facility policy Accident and Incident Reporting and Investigation, effective 5/15/2024, documented that an accident/incident report would be completed to accurately describe an accident or incident, and to address any corrective action related to the safety of the resident and prevent such occurrences in the future. The Administrator/Director of Nursing would determine if the accident/incident rose to the level of abuse/neglect, mistreatment, or misappropriation of property. If it did, a report would be submitted within 24 hours to the designated reporting agency. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 had diagnoses including unspecified dementia, impulse disorder and displaced supracondylar fracture of the distal femur (a break with misalignment in the lower part of the thigh bone just above the knee joint). The 6/25/2024 Minimum Data Set assessment documented the resident had moderate cognitive impairment, had hallucinations and delusions, wandered 1 - 3 times in 7 days, had no upper and lower extremity impairments, used a walker for ambulation, required supervision or touching assist for ambulation, received antipsychotic and antianxiety medications routinely and used a wander/elopement alarm daily. The Comprehensive Care Plan initiated on 5/8/2023 documented the resident was an elopement risk/wanderer related to dementia and adjustment disorder. Interventions included distract resident from unsafe wandering by offering pleasant diversions, structured activities, food, conversation, television, books, toileting, walking inside and outside, and wander alert bracelet to left wrist. The facility window security check audit documented the last time windows were checked prior to the 6/29/2024 incident was 6/12/2024, and there were no concerns. The 6/20/2024 Wandering Risk assessment documented the resident was at high risk to wander. That assessment was done on the day it was decided the resident would be transferred to the secure care unit at the facility. The 6/24/2024 Wandering Risk assessment documented the resident was at high risk to wander. The resident's wander alert bracelet was last signed for as being on the resident in the Medication Administration Record on 6/29/2024 at 12:03 AM. The facility Accident and Incident Report documented the incident occurred 6/29/2024 (the facility had the date on the report documented as 6/30/2024, which was incorrect) at 1:15 AM and included: - Resident #1 was last observed by Certified Nurse Aide #24 walking down the hall at 1:00 AM. Certified Nurse Aide #24 then went into another resident's room to provide care. - Certified Nurse Aide #24 exited the other resident's room at 1:10 AM and noticed Resident #1 was not in the hallway. They immediately began looking for the resident. They called Registered Nurse Supervisor #15 at 1:10 AM. - At 1:15 AM Certified Nurse Aide #24 noticed the window in an unoccupied room was pushed out of the windowsill while they were looking for the resident. They then observed Resident #1 ambulating in the secured resident courtyard with their walker. Certified Nurse Aide #24 exited the building through the window to assist the resident. - Former Administrator #32 was notified at 1:20 AM. - The Director of Nursing was notified at 1:25 AM. - At 2:00 AM Maintenance Mechanic #25 was called in to the facility by the Director of Operations regarding the window in the unoccupied room from which the resident exited. - At 2:05 AM the resident's family representative was notified of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 2:10 AM the on-call provider, Nurse Practitioner #27, was notified with no new orders. - At 2:50 AM Maintenance Mechanic #25 replaced and secured the window in the unoccupied room. Maintenance Mechanic #25 stated the window glass was not broken and the entire panel had been pushed out of the frame and was leaning against the building. The L bracket window stops were still attached to the window. They slid the interior window back into the opening and replaced the two L bracket stops so the window could not be opened. They called Registered Nurse Supervisor #15 to inspect the replaced window and they were confident the window was secure. They then checked all of the other windows on the unit to make sure they were secure. A 6/29/2024 at 10:18 AM nursing progress note by the Director of Nursing documented they had received a call at home from Registered Nurse Supervisor #15 on 6/29/2024 at 1:25 AM regarding Resident #1 who had allegedly pushed out a windowpane in an unoccupied room on the secure care unit. The resident was observed outside the window standing in the fenced-in courtyard with their walker. The resident stated they were going on a nighttime walk. The resident was easily reidirected back into the building onto the secure care unit by Registered Nurse Supervisor #15 and Certified Nurse Aide #24. Maintenance Mechanic #25 was notified and serviced the window in the unoccupied room. The resident's family member was made aware of the incident and the on-call medical provider was notified. The resident was placed on 1:1 supervision per nursing judgment until further notice. The facility Accident and Incident Report and Summary of Investigation Outcome by the Director of Nursing, documented as completed 6/30/2024 and coordinated and signed off 7/1/2024, documented the resident was returned to the secure care unit with assistance of staff and immediately placed on 1:1 supervision. The window was replaced by Maintenance Mechanic #25, and all other windows on the unit were checked by Maintenance Mechanic #25 immediately. Nurse Practitioner #13 was notified of Resident #1 having increased pain in their right knee, an x-ray was ordered, and the resident was noted to have an obique fracture of the distal femur (a diagonal break in the lower part of the thigh bone just above the knee joint). Nurse Practitioner #13 was updated, the family representative was notified, and the resident was transferred to the hospital for further evaluation. The resident underwent surgical intervention and had an open reduction internal fixation of the right supracondylar femur periosthetic fracture. The resident returned to the nursing home on 7/2/2024 to their former unit (unsecured unit) to reside in the same room with their spouse. The report documented New York State Department of Health was not notified because abuse was ruled out and there were no care plan violations. During an interview on 3/7/2025 at 11:00 AM the Director of Operations stated Resident #1 pushed the window in the unoccupied room on the secure care unit off its tracks on 6/29/2024 around 1:00 AM. Maintenance Mechanic #25 was called in to the facility and they arrived around 2:00 AM to fix the window and check the rest of the windows on the secure care unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/2025 at 2:35 PM the Director of Nursing stated when Resident #1 went out the window of the unoccupied room on the secure care unit on 6/29/2024, Certified Nurse Aide #24 had last seen the resident watching television and walking the hall. They had gone into a room to help a co-worker with another resident and when they came out of the room they did not see Resident #1. While looking for the resident they saw the window was out in the unoccupied room. The resident was standing in the courtyard with their walker. Registered Nurse Supervisor #15 and Certified Nurse Aide #24 brought the resident back inside and an assessment was done. The resident had no apparent injury at the time. Maintenance Mechanic #25 was called to come into the facility and they replaced the window in the unoccupied room. They also checked the rest of the windows on the unit to make sure they were secure. They did not report the incident to New York State Department of Health because they thought since the elopement was on facility property in a fenced-in courtyard they did not need to report it. They had access to a New York State Department of Health Incident Reporting Manual. Former Administrator #32 was aware of the incident and the incident was discussed in morning report. Later, the resident was complaining of right knee pain so they got an x-ray which showed a distal femur fracture (a break at the end of the thigh bone) They did not know when the resident would have gotten the distal femur fracture because the resident was standing with their walker when they were found. The resident had a history of a previous fracture in the same leg. The resident was sent to the hospital for further evaluation and they had the right distal femur surgically repaired. The resident returned to the facility on [DATE] and was placed back in their original room on the unsecured unit with their spouse. During a phone interview on 3/12/2025 at 8:18 AM Registered Nurse Supervisor #15 stated Certified Nurse Aide #24 called them right away on 6/29/2024 when they discovered Resident #1 was not where they had last left them on the unit. When they arrived on the unit, the window in the unoccupied room was pushed out of the tracks and they observed Resident #1 with their walker about 200 feet away to the right of the building near the fence. They and Certified Nurse Aide #24 brought the resident back into the building in a wheelchair. They called the medical provider, family representative and Director of Nursing to update. They did an assessment on the resident and at first they were fine, with range of motion and no swelling in their right leg. Later in the shift the resident was complaining of pain, so they called the medical provider and an order was obtained for an x-ray of their right leg. Based on the x-ray results the resident was sent to the hospital for further evaluation. Staff routinely checked the resident on the shift as they did with all the residents on the secure care unit. Moving Resident #1 to the secure care unit was one of the safety interventions enacted due to their exit-seeking behavior on their previous unit. During a phone interview on 3/12/2025 at 2:35 PM Maintenance Mechanic #25 stated they were called into the facility on night shift 6/29/2024 after Resident #1 had pushed the window out in the unoccupied room on the secure care unit. They arrived to the facility at 2:00 AM. The window had been pushed out of the tracks and the glass was not broken. They put the window back in place and checked the rest of the windows on the unit and everything was okay. They continued to check the window in the unoccupied room every day for about a week and there were no further issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 3/12/2025 at 6:06 PM Certified Nurse Aide #24 stated Resident #1 periodically walked the halls on the unit.They had never seen Resident #1 in the unoccupied room on the unit. During the evening of 6/28/2024, the resident started walking the halls around 9:30 PM and then was observed sitting at a table watching television. They had to help a co-worker in another resident room at 1:00 AM (6/29/2024). When they came out of the room at 1:10 AM they did not see Resident #1 anywhere, so they called Registered Nurse Supervisor #15 and continued to search on the unit. When they got to the unoccupied room at 1:15 AM they saw the window panel out. They looked out the window and Resident #1 was standing in the courtyard with their walker. There were no pieces of furniture near the window that the resident could have used to go out the window. They did not see any objects on the resident that could have been used to remove the window panel. The only items in the resident's walker basket were pens and a hand-held game system. After the incident 6/29/2024 a staff person sat 1:1 with the resident for the rest of the shift. During a follow-up phone interview on 3/13/2025 at 1:55 PM with the Director of Nursing they stated facility incident reports were typically done for resident-to-resident altercations, accusations made by residents, injuries or injuries of unknown origin. They did a facility accident/incident report for the 6/29/2024 incident involving Resident #1. There was no denying the resident was exit-seeking. They reiterated they did not report the 6/29/2024 elopement out the window in the unoccupied room to the New York State Department of Health because with the resident being on facility grounds in a fenced-in courtyard they did not consider it a reportable incident, and they believed former Administrator #32 thought the same. 10 NYCRR 415.4