STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335548	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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. 13699 Based on observations, record review, and interviews during the abbreviated survey (NY00364719), the facility failed to protect the resident's right to be free from physical abuse for 1 of 5 residents (Resident #1) reviewed. Specifically, Resident #1 was pushed by a staff member into a wall, causing a nosebleed and fractured nose. This resulted in harm, past noncompliance, to Resident #1 that was not Immediate Jeopardy. Findings include: The facility policy, Abuse, dated 6/1/2024, documented the facility prohibited abuse of residents and exploitation of the mentally and physically disabled resident in the facility. Abuse included willful infliction of injury, and intimidation resulting in physical harm, pain, or mental anguish. Physical abuse included hitting, slapping, pinching, scratching, spitting, holding roughly, kicking, etcetera. It also included controlling behavior through corporal punishment. Resident #1 had diagnoses including Parkinson's Disease (a progressive neurological disorder), osteopenia (bone loss), and anxiety. The 9/10/2024 Minimum Data Set assessment documented the Brief Interview for Mental Status (a cognitive function assessment, scored 0-15, with 15 indicating no impairment) was 12 (showing moderate cognitive impairment). The resident had behavioral symptoms including physical behaviors directed toward others, rejection of care, wandering which occurred one to three days, and other behavioral symptoms not directed towards others such as pacing, hitting or scratching self and/or verbal symptoms. The resident required supervision or was independent with activities of daily living including transfers and walking, had no falls, wore a wander alert device, and took antianxiety and antipsychotic medications. The Comprehensive Care Plan initiated 1/5/2024 documented: - the resident exhibited behavior symptoms (related to anxiety, dependent personality disorder, bipolar disorder, and major depressive disorder) such as mood swings, frequent verbalization of feeling anxious, verbal and physical outbursts, frequently asking when medications were due, frequently requesting something for anxiety, difficulty sleeping, intrusive wandering, restlessness, anxiety, inability to remain still, attempting to take medications from the medication cart and from the nurses' hands when they prepared medications, and going into trash containers. (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	- Interventions included: medications as ordered, distract with preferred activities, psychiatric evaluation as needed, notify physician for new or escalating behavior, reapproach for care or other needs when more agreeable, redirect to a less stimulating environment or room, reapproach in a calm manner. - The care plan was reviewed and updated on 6/19/2024 with additional interventions including: acknowledge/encourage expression of feelings, and offer decaffeinated coffee when behaviors escalate. The Comprehensive Care Plan initiated 7/8/2024 documented: - the resident was at risk for misappropriation, neglect, abuse and/or exploitation related to intrusive wandering, agitation when redirected, repetitive approaching of staff, and physical and verbal aggression. - Interventions included: monitor for signs of abuse and report, separate from aggressor, intervene, and attempt to calm the resident when they began to display escalating behaviors. The 11/18/2024 at 7:27 PM Psychiatric Nurse Practitioner #10 progress note documented the resident was seen for a follow-up, medication management, and reported worsening anxiety symptoms. The resident reported worsening anxiety the past two weeks, affecting sleep and quality of life. Recommendations included: begin Atarax (antihistamine also used to treat anxiety and tension) 10 milligrams every 12 hours, continue melatonin (sleep aid), buspirone (anti-anxiety), olanzapine (anti-psychotic), and lithium (mood stabilizer), monitor for mood dysregulation, open blinds during the day for natural light, minimize nighttime interruptions, and follow up in one to two months or as needed. The 12/12/2024 at 10:46 AM Interdisciplinary Team high risk meeting progress note entered by Social Worker #5, documented the resident's anxiety had increased with increased aggression toward staff when the resident requested medication. The resident was to be seen by psychiatry regularly. The 12/15/2024 at 3:17 PM Licensed Practical Nurse #1 progress note documented the resident was going into other residents' rooms and approaching a family member requesting something for anxiety. The 12/15/2024 at 7:41 PM Director of Nursing progress note documented nursing became aware of an incident that occurred on 12/15/2024 at 5:37 PM. It was reported to the Director of Nursing by Certified Nursing Assistant #2 that Licensed Practical Nurse #1 had pushed Resident #1 up against the wall with the resident's face on the wall. The Director of Nursing directed Registered Nurse Supervisor #4 to suspend Licensed Practical Nurse #1 pending investigation and notified the Administrator. Registered Nurse Supervisor #4 completed an assessment. The resident had dried blood on their nose, the on-call medical provider was notified and ordered an X-ray. The police were called, and the resident's family was notified of what happened. The care plan interventions were reviewed, and implementation verified. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The untimed 12/16/2024 Medical Director progress note documented the resident was seen for a report of being against the wall, hitting their face and had a small nosebleed. The on-call provider ordered an x-ray but did not order to send the resident to the hospital. The x-ray showed an acute fracture to the tip of the nasal bone. The Medical Director recommended the resident be evaluated at the hospital. The 12/16/2024 hospital record documented the resident arrived at 12:55 PM for evaluation following an alleged assault. The resident reported they were pushed by a nurse the prior evening, fell to the ground, and had a nosebleed. The resident denied hitting their head or having any pain and had no specific complaints related to the assault. The resident complained of anxiety, and stated it was a chronic problem. The physical exam did not reveal any injuries, the resident had no acute distress and did not appear anxious. They were discharged back to the facility with no new orders. The 12/16/2024 at 10:21 PM Assistant Director of Nursing progress noted documented they assessed the resident at approximately 4:30 PM (follow-up assessment after the incident). The resident denied pain and stated they were tired. Their nose was a little swollen and there was slight bruising noted. The resident was being transferred to the hospital to see an Ear, Nose, and Throat (specialist) for evaluation per an order from Physician Assistant #8. The 12/16/2024 hospital record documented the resident presented in the emergency department earlier that day due to an assault at the nursing facility. They had an outpatient x-ray done and were found to have a non-displaced nasal bone fracture. No septal hematoma was identified, and the resident was requesting discharge. The 12/15/2024 facility Incident Report and Investigation Form signed and reviewed by the Director of Nursing, Administrator, and Assistant Director of Nursing on 12/17/2024 documented: - On 12/15/2024, Certified Nurse Aide #2 reported to the Director of Nursing, they observed Resident #1 was being pressed into a wall, face first, with their nose against the wall, by Licensed Practical Nurse #1. - Certified Nurse Aide #2 reported they heard Resident #1 tell Licensed Practical Nurse #1 the nurse was going to break the resident's nose as the nurse pressed their face to the wall. - Licensed Practical Nurse #1 was suspended immediately upon the reported incident. - Local police were notified and responded to initiate an investigation. - The medical provider was notified and ordered a nasal x-ray. - Resident #1 sustained a fracture to the tip of their nose. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Certified Nurse Aide #2's statement documented, at approximately 5:05 PM, they were in the hall when Resident #1 approached Licensed Practical Nurse #1 to ask about anxiety medication. As Certified Nurse Aide #2 approached to redirect Resident #1, Licensed Practical Nurse #1 grabbed both resident's arms, turned the resident around, and shoved them into the wall face first. The aide observed the resident's face hit the wall and the resident cried and said they thought they broke their nose. Certified Nurse Aide #2 took Resident #1 to the cafe to get them a drink and comfort them and notified the Director of Nursing via phone call to report the incident. - Resident #1's statement, taken by the Administrator on 12/15/2024 at 6:10 PM, documented Licensed Practical Nurse #1 pushed them down to the ground and made their nose bleed. It happened before dinner, and the resident was asking the nurse about medication. The resident reported no pain, they felt safe at the facility, and they did not want any care provided by Licensed Practical Nurse #1 going forward. - Resident #2's statement, taken by the Administrator on 12/15/2024 at 6:15 PM, documented they were by the oxygen room and saw Licensed Practical Nurse #1 push Resident #1 into the wall face first. - Certified Nurse Aide #3's statement documented they were in the hall and heard Licensed Practical Nurse #1 telling Resident #1 they were tired of it. The aide turned to go back up front and saw Resident #1 up against the wall with Licensed Practical Nurse #1 in front of the resident. - Licensed Practical Nurse #1's statement documented on 12/15/2024 they had multiple conversations with Resident #1 about the resident obtaining anxiety medications. The resident stood behind the medication cart to ask for something for anxiety and did so as the nurse kept the cart in front of themself, so their back was to the wall, to observe the unit end to end. - The investigation conclusion documented there was reasonable cause to believe abuse occurred by Licensed Practical Nurse #1 toward Resident #1. - Licensed Practical Nurse #1 was arrested following the police investigation, remained suspended from their duties, and was not allowed on the facility premises. The 12/17/2024 police report documented on 12/15/2024, Police Officers #12 and #13 were dispatched to the facility at 7:44 PM for a report of an assault. The resident's apparent condition was mentally disordered and appeared to be physically injured but not seriously. There was dried blood in the resident's nostrils and minor marks on both knees, which the resident stated were not there before the altercation. The officers interviewed Resident #1, who reported Licensed Practical Nurse #1 grabbed them and threw them to the ground and their nose started bleeding. The resident was not sure if they hit their head on the wall or floor. The same version of the altercation was repeated several times by the resident. Additional interviews included: - Resident #2 stated Licensed Practical Nurse #1 yelled at Resident #1 saying move get out of the way and grabbed the resident by the shoulders and pushed them toward the wall where they hit the right side of their head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Certified Nurse Aide #3, stated they saw the tail end of the altercation and saw Resident #1's head bounce off the wall. Licensed Practical Nurse #1 was in the resident's face yelling something like I'm sick of all this [expletive] or I'm sick of your [expletive]. The certified nurse aide stated they could see blood coming from the resident's nose. Certified Nurse Aide #3 turned away and walked in the opposite direction when Resident #2, who was fully alert and oriented, stopped them and asked why that licensed practical nurse pushed Resident #1 against the wall. Certified Nursing Aide #2 walked up to them, was crying and stated they saw Licensed Practical Nurse #1 push Resident #1 against the wall and yell at Resident #1. - On 12/16/2024, Police Officers #12 and #13 spoke to Licensed Practical Nurse #1 who stated there was never any altercation that took place and they never touched Resident #1. They stated the resident was always asking about their medication and they redirected them but had yelled at the resident in the past. They stated they did not see the resident fall to the ground or have a bloody nose. - Certified Nursing Aide #2 was interviewed and stated they saw Resident #1 asking Licensed Practical Nurse #1 about their medication. They walked towards the resident to redirect them from the nurse when they saw Licensed Practical Nurse #1 grab Resident #1 by the arms and turn them around. Licensed Practical Nurse #1 pushed Resident #1 from behind with both hands and the resident's face hit the wall. Certified Nursing Aide #2 was approximately two feet away from both the resident and the licensed practical nurse when the altercation took place. Certified Nurse Aide #2 took Resident #1 to the cafeteria to make sure they were okay and contacted the Director of Nursing. - The Administrator reported Resident #1's x-ray showed a fractured nose. - The Director of Nursing reported Certified Nurse Aide #2 notified them what they witnessed and heard Resident #1 say Licensed Practical Nurse #1 was going to break their nose when Licensed Practical Nurse #1 pushed them into the wall. The 12/16/2024 Arrest Report documented Licensed Practical Nurse #1 was charged with assault in the third degree and endangering the welfare of a vulnerable adult and physically disabled person in the second degree. They were taken to the Justice Center and held for arraignment. During an interview on 12/17/2024 at 4:40 PM Police Officer #12 stated witnesses and Resident #1 were interviewed with corroborating reports of the incident. The police officer observed dried blood in Resident #1's nose and redness to their knees on 12/15/2024. Licensed Practical Nurse #1 was arrested on 12/16/2024 and charged with endangering the welfare of an incompetent or physically disabled person (Class E felony) and assault in the 3rd degree (Class A misdemeanor). Upon a follow up visit on 12/17/2024, the officer learned the resident sustained a fracture to their nose. During an interview and observation on 12/18/2024 at 9:10 AM, Resident #1 stated Licensed Practical Nurse #1 was angry, touched their shoulders, grabbed them, and threw them on the ground in the hallway, and they hit their head. They had been asking for their medication. They stated that same nurse yelled at them before, and they had been pushed before in the facility but was not sure by who or when. They did not tell anyone in the facility, only their family. They continued to feel anxious and depressed as they had been for a while, but felt safe, and staff checked on them frequently. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/18/2024 at 10:50 AM, Resident #2 stated they saw Licensed Practical Nurse #1 abuse Resident #1 on 12/15/2024. The incident occurred at the end of the hallway by Resident #1's room, where the medication cart was. Resident #2 stated they went down that way to get a new oxygen tank before going to the dining room. Resident #1 asked for medications all the time but on that day, Licensed Practical Nurse #1 responded angrily and told the resident they did not have medication. Resident #2 got their oxygen and Resident #1 was still there asking for their medications. The nurse said, I told you it is not time, and I am sick of this [expletive]. The nurse then grabbed Resident #1 by the shirt and threw them to the wall. Resident #1 hit their head stating they were hurt. Certified Nurse Aide #2 started to cry. The Administrator was there to talk to the residents as well as the police. During an interview on 12/18/2024 at 11:31 AM, the Administrator stated Licensed Practical Nurse #1 had no prior disciplines and there were no reported resident or family complaints about care or abuse regarding Licensed Practical Nurse #1 prior to this incident. On 12/15/2024, they were notified by the Director of Nursing before 6:00 PM related to an allegation of abuse. They arrived at the facility within 15 minutes and Registered Nurse Supervisor #4 was walking Licensed Practical Nurse #1 around the corner. Licensed Practical Nurse #1 provided a written statement and then left the facility. Licensed Practical Nurse #1 denied the incident. Certified Nurse Aide #2 left the facility at 6:00 PM when their shift ended. Resident #1 and Resident #2 were interviewed first. Witnesses stated the resident went face first into the wall. The Police Department was called, and they arrived at the facility between 7:00 PM and 7:30 PM. They spent a couple of hours interviewing residents and staff. Education on abuse and neglect was started that night around 10:00 PM for 12 or 13 staff that were working. The Administrator stated they left the facility after midnight. On 12/16/2024, the Administrator completed a full house education on abuse and neglect (all staff were educated). During an interview on 12/17/2024 at 12:05 PM the Director of Nursing stated Certified Nurse Aide #2 called them on 12/15/2024 at 5:37 PM and reported Licensed Practical Nurse #1 pushed Resident #1 against the wall with the resident's nose to the wall and the resident said to that nurse you are going to break my nose. Certified Nurse Aide #2 said they immediately took the resident to the cafeteria and the resident had coffee and cookies. The Director of Nursing immediately called Registered Nurse Supervisor #4 to get a statement and then suspended Licensed Practical Nurse #1. They notified the Administrator who went into the facility to conduct the investigation at approximately 6:00 PM. The on-call physician was notified and ordered an x-ray of the nose and the resident was sent to the emergency room for evaluation on 12/16/2024. During an interview on 12/18/2024 at 1:21 PM Social Worker #5 stated they saw Resident #1 on 12/16/2024 and each day since the incident. The resident frequently and repeatedly asked for their medications as their baseline behavior. The social worker did not see any change in their psychosocial behaviors and the resident was seen by the psychiatric provider. The resident continued to participate in their daily routine with no noted changes. Following the incident, they interviewed 19 residents who were oriented, all felt safe at the facility and had no concerns related to abuse or mistreatment by staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/18/2024 at 1:35 PM, Certified Nurse Aide #2 stated on 12/15/2024, they worked from 6:00 AM to 6:00 PM. The incident happened at approximately 5:05 PM when they were going down the hall to redirect Resident #1 because they were asking for medications. They thought they would give the resident their meal tray to distract them. As they approached the resident, Licensed Practical Nurse #1 put their hands on the resident's shoulders, turned them and pushed them. They heard the resident say, I broke my nose again and the resident's eyes teared up. There was a lot of commotion at that time with other residents in the hallway and a lot of them were eating. They took the resident, who was shaken up, to the dining room for coffee and cookies to calm them down. They calmed down and the aide walked the resident back to their room where they stayed. Certified Nurse Aide #2 then contacted the Director of Nursing on the telephone and reported the incident. During an interview on 12/18/2024 at 2:09 PM Certified Nurse Aide #3 stated on 12/15/2024, before dinner, they looked down the hallway and saw Licensed Practical Nurse #1 push the resident into the wall. They could not hear well what was being said, but when the nurse pushed Resident #1, the resident hit the wall like a basketball. They could see the resident's nose bleeding from down the hallway. They thought they heard Licensed Practical Nurse #1 say I am tired of your [expletive] and the resident said, [they] hurt me. Certified Nurse Aide #2 and Resident #2 were near the resident. Certified Nurse Aide #3 thought the resident slid to the floor but was not sure. Certified Nurse Aide #2 was crying, and Certified Nurse Aide #3 was initially shocked at what they saw and did not immediately move. Certified Nurse Aide #2 approached Certified Nurse Aide #3, very upset and asked what to do. Certified Nurse Aide #3 told Certified Nurse Aide #2 they must report it. Certified Nurse Aide #2 was scared and took the resident with them to get a drink and cookies. When they returned, Certified Nurse Aide #2 notified the Director of Nursing. Both aides were afraid of retaliation and did not know who the supervisor was or where they were only that they were busy, so Certified Nurse Aide #2 called the Director of Nursing. During a phone interview on 12/18/2024 at 5:20 PM, Licensed Practical Nurse #1 stated they were unaware of what happened and was told they tripped or pushed Resident #1. They wrote a statement for the Administrator on 12/15/2024. Resident #1 asked for medication all day long, even after they receive their medications. Licensed Practical Nurse #1 stated they got along well with all the staff and had never had a problem with staff or other residents. A certified nurse aide went to a registered nurse on another unit, and no one approached Licensed Practical Nurse #1 about a nosebleed, and they never saw Resident #1 with a nosebleed. Registered Nurse Supervisor #4 went to the unit and told them they had to leave. As they were walking off the unit, the Administrator arrived, and Licensed Practical Nurse #1 went to their office to write a statement before leaving. During a phone interview on 1/03/2025 at 11:42 AM, Physician Assistant #8 stated they were notified in the evening of 12/15/2024 about Resident #1 and they saw the resident the morning of 12/17/2024 for follow up of their injury. The resident was seen by the Medical Director on 12/16/2024 and they shared with them the abuse of this resident. The physician assistant ordered an x-ray of the resident's nose and ordered the resident to go to the emergency room for an evaluation on 12/16/2024. The resident returned without paperwork, so they did not know what the hospital had done. After the x-ray results showed a fractured nasal bone, they wanted the resident to go back to the emergency room for further evaluation to see an Ears, Nose, and Throat specialist, as there may have been cosmetic concerns. When they examined the resident's nose, there was minor bruising and swelling across the bridge of the nose. The resident expressed no pain, and their injury was not severe. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/7/2025 at 10:49 AM the Medical Director stated they were advised of the incident and saw Resident #1 on 12/16/2024. The resident reported no pain and had no observed swelling or bruising. The Medical Director stated they were made aware the resident's nasal bone was fractured and there was some bleeding the day it occurred. 10NYCRR 415.4(b)(1)(i) Deficient practice was identified in the area of abuse that resulted in harm to Resident #1 during the Abbreviated Survey on 12/18/2024. The facility provided verification the following corrective actions were completed by 12/17/2024: - On 12/15/2024, following notification of abuse, Licensed Practical Nurse #1 was suspended from their duties and exited the facility. They were subsequently terminated. - On 12/15/2024, the Administrator responded to the facility immediately following notification of abuse and initiated a comprehensive investigation. They completed interviews with witnesses and staff who were working at the time of the incident, as well as Resident #1. - Law Enforcement was notified on 12/15/2024 and responded to the facility for an investigation. - On 12/15/2024, the facility initiated a whole house education on abuse prevention and reporting of abuse. The education was mandatory for all staff, to be completed by the directors of each department, with oversight of the Administrator, Director of Nursing, and Assistant Director of Nursing. - All staff completed education by 12/17/2024, except for staff out on leave or who had not been scheduled. Any staff who had not completed the abuse training by 12/17/2024 would not be permitted to work until completion. - On 12/17/2024, 19 residents who reside in the facility were interviewed by the social worker and reported no concerns with instances of abuse from any staff, or being fearful of any staff, including Licensed Practical Nurse #1. - Resident #1 was monitored by the social worker and continues to meet with their psychiatric provider. No changes in the resident's baseline mood or behavior have been noted. - A QAPI meeting was held on 12/16/2024 and the incident was reviewed. Random auditing of 5 vulnerable residents was initiated and will be completed weekly for 4 weeks, then monthly for 3 months, with review at the Quality Assurance and Performance Improvement meetings.