STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335555	A. Building B. Wing	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cold Spring Hills Center for Nursing and Rehab	378 Syosset Woodbury Road Woodbury, NY 11797

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** 49247 Based on observations, record reviews and interviews conducted during a complaint investigation, Complaint # NY00332067 initiated on 2/8/2024 and completed on 2/12/2024, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately to the New York State Department of Health. This was identified for one (Resident #1) of three residents reviewed for Abuse. Specifically, the facility did not report an allegation of physical abuse to the New York State Department of Health within 24 hours when Resident #1 complained that Certified Nursing Aide #1 handled the resident roughly during care and it was reported to the nursing supervisor. The resident stated Certified Nursing Assistant #1 grabbed the resident's left arm, twisted, and pushed to turn the resident. The findings are: The facility's policy titled, Abuse Prohibition and Prevention Accident Investigation Report dated 11/16/2023 documented that if there is belief or suspicion of abuse, neglect, mistreatment, or any other reportable incidents, notification will be given to the Director of Nursing and/or Administrator to report immediately to the New York State Department of Health. The facility's policy titled Conducting an Investigation, dated 2/18/2022, documented that when there is an allegation of abuse, neglect, or mistreatment, a thorough investigation should be started immediately by the Registered nurse (Charge Nurse/Manager/Supervisor). Resident #1 was admitted with diagnoses including Fibromyalgia, Depression and Anxiety. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15 which indicated the resident had intact cognition. A Comprehensive Care Plan for Abuse dated 2/8/2024 documented the resident was at risk for abuse. The interventions included to maintain a safe environment, provide emotional support, and inform the medical doctor and family of occurrence. Grievance log dated 1/22/2024 documented that the resident complained that Certified Nursing Assistant #1 handled the resident roughly during care. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Accident and Incident report dated 1/29/2024 documented that on 1/23/2024 at 9:30 AM, the nursing leadership was informed of an alleged incident happened on 1/21/2024 at 3:00 AM. Resident #1 reported to the charge nurse that Certified Nursing Assistant #1 grabbed their left hand and pushed forward to the front of the resident's body during care when turning the resident to their right side. Resident #1 reported the incident to Registered Nurse #2, Registered #2 called Certified Nursing Assistant #1 into the resident's room and asked Certified Nursing Assistant #1 Did you grab the resident and Certified Nursing Assistant #1 denied the allegation. Registered #2 immediately notified the incident to the nursing supervisor. The facility concluded that it was believed that when Resident #1 was being turned to their right side by Certified Nursing Assistant #1 with the bed sheet Resident #1 hand and Certified Nursing Assistant #1 hand were entangled. With the Certified Nursing Assistant #1's strength used in turning Resident #1, it was believed that Resident#1 experienced discomfort at the left hand/wrist area. The facility concluded that there was no reasonable cause to believe that any alleged abuse or mistreatment had occurred. During an interview conducted with Resident #1 on 2/8/2024 at 1:35 PM and 4 PM, they stated that Certified Nursing Assistant #1 entered their room without knocking. The resident requested assistance from Certified Nursing Assistant #1 to change because they were wet. According to Resident #1, Certified Nursing Assistant #1, standing on the left side, grabbed the resident's left arm to turn, twisted their arm, and pushed forward to reposition the resident onto their right side. The resident reported the incident to the nurse (Registered Nurse #2), and the nurse returned with Certified Nursing Assistant #1. The Certified Nursing Assistant #1 denied the allegations despite the resident's account. During an interview conducted with the 11-7 PM shift Registered Nurse #2 (Sea Cliff 2-unit charge nurse) on 2/9/2024 at 5:07 PM and stated on 1/21/2024 around 3:30 AM Resident #1 complained about Certified Nursing Assistant #1 using excessive force to turn the resident and asked to stop. Registered Nurse #2 then spoke to Certified Nursing Assistant #1, who denied the allegation. When returning to the resident's room with Certified Nursing Assistant #1, Resident #1 reiterated their complaint, and Certified Nursing Assistant#1 continued to deny it. Registered #2 promptly reported the incident to the nursing supervisor. During an interview conducted with the 11-7 PM shift Nurse Supervisor on 2/9/2024 at 11 AM and stated they visited Resident #1 at around 8 AM, following complaints from the resident regarding rough handling by Certified Nursing Assistant#1 and grabbing of their left arm. They admitted they should have reported the incident immediately but forgot because a lot was happening that day. On 1/23/2024, they were told by the Assistant Director of Nursing to submit a statement and incident report. They affirmed receiving prevention and reporting in-service training. During an interview conducted with the Social Worker on 2/8/2024 at 10 AM who stated Resident #1 contacted the social worker on 1/22/2024 to report the incident. Resident #1 stated they reported the incident to the nursing supervisor on the day of the event, who should have notified the nursing leadership and initiated an investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with the Assistant Director of Nursing (Facility Investigator) on 2/8/2024 at 2:25 PM they stated the incident was initially reported to the overnight nursing supervisor on 1/21/2024. The social worker reported to nursing leadership on 1/23/2024 during the morning report. The Assistant Director of Nursing admitted that this incident should have been reported to the nursing leadership and should have initiated an investigation immediately. During an interview conducted with the Director of Nursing Service was on 2/8/2024 at 2:50 PM and stated they were informed of the incident on 1/23/2024 around 9:30 AM. The overnight nursing supervisor should have reported the incident immediately on 1/21/2024 and initiated an investigation. Furthermore, the social worker should have reported to the nursing leadership when made aware on 1/22/2024 to initiate an investigation and implement effective measures and reported to New York State Department of Health. 10 NYCRR 415.4(b)(2)