STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335587	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Nursing and Rehabilitation Center, Inc	232 Academy Street Boonville, NY 13309

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility policy Resident Rights and Responsibilities, dated 01/13/2025, documented the facility services provided to the resident demonstrated the belief in dignity and worth of every individual. The facility provided the resident with optimal nursing and psychosocial care. Every effort is made by the staff to meet the resident's individual needs and requirements. The facility policy Facility Incident/Abuse Investigation and Reporting, dated 09/2025, documented personnel must report any resident incident or suspected incident immediately to the Supervisor/Administrator. The facility would investigate instances of alleged resident abuse to ensure the physical and mental well-being of the resident. The facility would conduct an immediate and thorough investigation, upon discovery of sexual abuse. Sexual abuse was defined as non-consensual sexual contact of any type with a resident. Conduction of an investigation included rendering aid to protect the residents, removing them from harm; and ensuring an appropriate individualized care plan. 1) Resident #4 had diagnoses including depression, anxiety, and Alzheimer's disease. The 09/03/2025 Minimum Data Set assessment (a resident assessment tool) documented the resident had severely impaired cognition; did not exhibit wandering behaviors; was independent with ambulation; and did not require a walker or wheelchair. The 10/05/2025 at 8:22 PM Licensed Practical Nurse #7 progress note documented on 10/05/2025 at 6:45 PM, staff notified them another resident's family member found Resident #4 with Resident #1 on top of them in bed and both residents did not have on pants or under garments. Staff immediately intervened and removed the residents from the room. The writer made the supervisor (unnamed) aware immediately. Both residents were educated on appropriate behaviors. Resident #4 complained of stomach pain following the incident. There was no bruising or vaginal bleeding (to Resident #4) noted at the time. The supervisor was made aware, and an incident report was filled out and given to the supervisor. There was no documented evidence of a registered nurse assessment of Resident #4 following the inappropriate sexual contact and complaint of stomach pain on 10/05/2025, and no documented evidence of notification to the resident's family regarding the incident. The 10/06/2025 at 7:11 AM Licensed Practical Nurse #8 progress note documented they followed up from the previous incident, 15-minute checks continued (for Resident #4) and there was no interaction with the other resident throughout the night. Resident #4's Comprehensive Care Plan, initiated 09/11/2024 and revised 09/23/2025, documented the resident had the potential to wander into other residents' rooms and sit/lie down on the beds. Interventions included redirect as able. There was no documented evidence the care plan was revised to include potential/actual abuse. The 10/08/2025 at 10:41 PM Nurse Practitioner #13 progress note documented Resident #4 was seen at the request of nursing staff for a 30-day review. There was no documentation regarding the 10/05/2025 incident. The 10/24/2025 at 4:23 AM Licensed Practical Nurse #8 progress noted documented at 11:00 PM (on 10/23/2025) while doing rounds, Resident #4 was not in their bed. Resident #4 was found in Resident #1's bed with their shirt raised and their breast exposed. They immediately assisted Resident #4 out of the bed and out of the room. Resident #1 stated they played with the resident's breast when Resident #4 got in their bed. The supervisor (unnamed) was made aware. Resident #4 had no complaints and no signs of fear. The 10/24/2025 at 4:23 AM Licensed Practical Nurse Supervisor #9 progress note documented on 10/23/2025 at 11:10 PM, Resident #4 was found in Resident #1's bed by Licensed Practical Nurse #8. Resident #4 was escorted of out the room and put on 15-minute checks. The Director of Nursing was notified. There was no documented evidence of a registered nurse assessment of Resident #4 following the 10/23/2025 incident, and no documented notification of the resident's family regarding the incident. The Comprehensive Care Plan for potential to wander into other residents' rooms and sit/lie down on the bed was updated on 10/23/2025 to include an intervention to maintain 15-minute visual checks. There was no documented evidence the care plan was revised to include potential/actual abuse or potential for victimization. There was no documented evidence of social worker progress notes from 10/1/2025 -10/31/2025 that included psychosocial assessments of Resident #4 after the incidents on 10/05/2025 and 10/23/2025.The 10/27/2025 at 10:30 AM Registered Nurse #4 progress note documented Resident #4 continued to wander during the night. This was discussed with the provider and a new order was obtained to increase Trazadone (antidepressant with sedative effects) to 50 milligrams daily. There was no documentation the medical provider was notified about the 10/23/2025 incident. The 10/29/2025 at 7:09 PM Nurse Practitioner #13 progress noted documented the resident was seen for insomnia. The plan was to increase Trazadone to 50 milligrams nightly, monitor the resident's sleep, and update the provider as

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Based on record review and interviews during the abbreviated (#2639795) survey, the facility failed to ensure allegations of abuse, are reported immediately, but not later than two (2) hours after the allegation is made, to the Administrator of the facility and the New York State Department of Health in accordance with State law for three (3) of three (3) incidents of alleged abuse (10/05/2025, 10/09/2025 and 10/23/2025) involving Resident #1. Specifically, Resident #1 was witnessed engaging in sexually inappropriate behavior with Residents #3 and #4 who did not have capacity to consent on 10/05/2025, 10/09/2025, and 10/23/2025 and the incidents were not reported by the facility to the New York State Department of Health or local law enforcement. Additionally, the incident on 10/09/2025 was not reported to the Administrator until 10/24/2025. The facility's failure to report abuse to Administration, law enforcement, and the State Agency resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Residents #3 and #4 and placed all 111 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death. Refer to F 600 Free from Abuse and Neglect and F 610 Investigate/Prevent/Correct Alleged Violations. Findings include:The facility policy Facility Incident/Abuse Investigation and Reporting, revised 09/2025, documented staff were to report any resident incident or suspected incident immediately to Supervisor/Administrator. All applicable incidents were to be reported to the state agency, adult protective services and to all other required agencies including law enforcement within specified timeframes. For allegations of abuse, the Director of Nursing was to notify the Department of Health and other appropriate Law Enforcement Agencies immediately and not to exceed two (2) hours.10/05/2025 Incident The 10/05/2025 at 8:24 PM, Licensed Practical Nurse #7 progress note documented on 10/05/2025 at 6:45 PM, another resident's family member found Resident #1 on top of Resident #4 in bed and neither resident had pants or undergarments on. Staff immediately intervened and removed the residents from the room. Licensed Practical Nurse #7 made the supervisor (unnamed) aware immediately. Both residents were educated on appropriate behaviors, an incident report was filled out and given to the supervisor. The 10/05/2025 Investigation Summary report completed by the Director of Nursing documented Resident #5's family member observed Resident #1 and Resident #4 lying down in Resident #1's bed sleeping. When nursing staff arrived at the room, there was no physical contact noted, and Resident #1 was in the corner of the room with their incontinent brief intact, and not near Resident #4. Staff intervened and Resident #4 was redirected from the room. The documented immediate response was to separate the residents, a Registered Nurse (no name indicated) skin assessment was performed on Resident #4 and there was no injury, fear, pain or mental anguish noted. Resident #4 was evaluated by a medical provider (no name indicated) and Trazadone (antidepressant with sedative effects) was implemented to improve Resident #4's wandering into other residents' rooms. Resident #1 had an alarming floor mat, and an alarming stop sign. The incident was not witnessed by staff and was reported by a family member. The incident was not reported to the New York State Department of Health because there was no pain, injury or mental anguish noted at the time of the incident with Residents #1 and #4. There was no documented evidence of notification to the New York State Department of Health or local law enforcement regarding the incident. 10/09/2025 Incident A 10/09/2025 at 12:07 AM Licensed Practical Nurse #8 progress note (in Resident #3's medical record) documented they and the supervisor (unidentified) found Resident #3 in another resident's bed (unidentified) with their shirt pulled up and their breasts exposed. The other resident was not in bed at the time. Resident #3 was placed on 15-minute checks per the supervisor. The 10/09/2025 Investigation Summary completed by the Director of Nursing documented:- Staff were performing 15-minute checks on Resident #1 on 10/09/2025, Resident #3 was found lying in Resident #1's bed with their shirt slightly pulled up and Resident #1 was not in the room. - Investigative findings were that Resident #3 had a history of wandering and was independent with ambulation. - Resident #3 was placed on 15-minute checks for wandering and started on 50 milligrams of Trazodone for sleep. - The incident was not reported to the New York State Department of Health due to there being no pain, injury, or mental anguish noted at the time of the incident with Resident #3. There was no documented evidence of notification to the New York State Department of Health or local law enforcement regarding the incident.10/23/2025 Incident The 10/23/2025 at 11:15 PM incident report initiated by Licensed Practical Nurse Supervisor #9 documented an inappropriate behavior incident with no injury. Licensed Practical Nurse #8 witnessed Resident #4 in Resident #1's bed while Resident #4 had their shirt pulled up and their breasts exposed. Resident #4 was moved to the opposite hallway (a room change) and

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Based on record review and interviews during the abbreviated (#2639795) survey, the facility failed to ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for three (3) of eight (8) residents reviewed (Residents #1, #3, and #4). Specifically, on 10/05/2025, 10/09/2025, and 10/23/2025, Resident #1 was witnessed by visitors and/or staff engaging in sexually inappropriate behavior with Residents #3 and #4, who did not have capacity to consent. There was no documented evidence the incidents were thoroughly investigated to determine abuse and to protect residents from further abuse during the investigation. The facility's failure to investigate abuse thoroughly resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Residents #3 and #4 and placed all 111 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death.Refer to F 600 Free from Abuse and Neglect. Findings include: The facility policy Facility Incident/Abuse Investigation and Reporting, revised 09/2025, documented staff were to report any resident incident or suspected incident immediately to Supervisor/Administrator. The facility would conduct an immediate and thorough investigation, upon discovery of an incident including abuse. Should there be an allegation or suspected abuse, the employee was to notify the nursing supervisor who would assess the resident. The nursing supervisor would initiate an Accident/Injury report in the electronic program and notify the Director of Nursing immediately. The Director of Nursing would initiate the investigation which included witness statements and notify the Administrator. For residents who were cognitively impaired who may be unable to self-report abuse, the staff observed for verbal and non-verbal indications of changes in behavior, body language that may indicate physical discomfort or distress, unusual bruising, unexplained outbursts, and sudden negative responses to staff, family, visitor, or other residents.On 10/29/2025, Accident and Incident reports from 09/01/2025 to 10/29/2025 were requested. There was no documented evidence of a completed accident and investigation form for a 10/09/2025 incident between Resident #1 and Resident #3. The investigations provided for 10/05/2025 and 10/23/2025 only included the investigative summary and unsigned witness statements. The Administrator provided a copy of the 10/09/2025 investigation on 10/31/2025.10/05/2025 and 10/23/2025 Incidents: Resident #1 had diagnoses including stroke, unspecified dementia without behavioral disturbance, and depression. The 09/24/2025 Minimum Data Set documented the resident had severe cognitive impairment, no behavioral symptoms, and was independent with mobility and transfers. Resident #4 had diagnoses including Alzheimer's disease, cognitive communication deficit, and insomnia. The 09/03/2025 Minimum Data Set documented the resident had severely impaired cognition, had no behaviors, and was independent with mobility and transfers. The 10/05/2025 Licensed Practical Nurse #7 progress note for Resident #4 documented another resident's family member found Resident #4 with Resident #1 on top of them with no pants or undergarments. Staff intervened immediately and removed the residents from the room. The supervisor (unidentified) was made aware, and both residents were educated on appropriate behaviors. Resident #4 complained of stomach pain following the incident. There was no bruising or vaginal bleeding at the time. An incident report was filled out and given to the supervisor. The 10/05/2025 investigation summary completed by Director of Nursing #3 documented: - A visiting family member reported Resident #4 was lying down in Resident #1's bed asleep. No physical contact was noted by the staff (unidentified) when they arrived at the room. Resident #1 was noted to be in the corner of the room with their brief intact. Resident #4 was redirected from the room.- There was no fear, pain, or distress noted from Resident #1 or Resident #4. - Resident #4 complained about residents entering their room. Resident #1 had an alarming floor mat and alarming stop sign.- Both Resident #1 and Resident #4 were noted to only like to sleep in a brief on their lower half at night. - A Registered Nurse skin assessment was performed on Resident #4 with no findings. - Resident #4 was evaluated by the provider and Trazodone was started to help improve wandering into other resident rooms.- The incident was not reported to the New York State Department of Health as there was no pain, injury, or mental anguish noted at the time of the incident. - A witness statement by Licensed Practical Nurse #7 documented on 10/05/2025 at 6:45 PM, they were counting narcotics in the C Wing medication room when Certified Nurse Aide's #5 and #6 came to tell them a resident's family member found Resident #1 and Resident #4 in bed with no pants or briefs on. Resident #1 was lying on top of Resident #4. The two (2) residents were moved away from each other and placed on 15-minute checks.- A witness statement by Certified Nurse Aide #5 documented they were informed by Certified Nurse Aide #6 that Resident #1 and Resident #4 were lying in bed together. When they entered the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record review, and interviews during the abbreviated (2639795) survey, the facility did not ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain and or maintain their highest practicable physical, mental, and psychosocial well-being for three (3) of seven (7) residents (Residents #1, #8, and #9) reviewed. Specifically, Residents #1, #8, and #9 had behavioral symptoms related to diagnoses of dementia and were not cared for in a dementia-informed manner with a personalized plan of care and interventions. Refer to F 600 Findings include:The facility policy Behavior Monitoring, revised 2/2025, documented behavior monitoring was utilized to identify specific behaviors, the frequency of behaviors, non-pharmacological interventions, and outcomes of prescribed psychological medications. The facility policy Social Worker-Services and Responsibilities, revised 8/2024, documented the facility provided a social service program that met the psychosocial needs of individual residents and provided services, based upon a comprehensive assessment, which assured the maximum attainable quality of life for the residents, the residents' emotional and physical well-being, self-determination, self-respect and dignity. Social Services was responsible for interpreting residents' needs and behaviors and extending professional intervention to all levels of staff suggesting positive approaches, such as alternatives to the use of restraints and psychotropic medications, and for assisting in providing corrective action for the residents' needs by developing and maintaining individualized social care plan.The facility did not provide a policy regarding dementia or their dementia care unit when requested.The dementia education for dealing with Dementia with Difficult behaviors provided by the facility included:- what dementia was and understand why difficult behaviors occur.- New Approaches for Dealing with Difficult Dementia documented someone dealing with dementia was not being deliberately difficult and being aware could keep the staff member safe. Strategies included to validate the person's feelings, avoid topics you think will upset them, not to argue, maintain a sense of calm, be accepting instead of contradicting, introduce pleasant stimuli into the situation, use familiar music, scents, and other items, try to engage the resident in their favorite hobby or interest, and use a cooling off period if needed.- Strategies on how to help a resident with dementia with difficulty behaviors were by knowing what causes the agitation, worry or frustration for the resident, speak in a calming soothing voice, and to step away if it was safe to do so.1) Resident #1 had diagnoses including stroke, unspecified dementia without behavioral disturbance, and depression. The 9/24/2025 Minimum Data Set documented the resident had severely impaired cognition with continuously present inattention, had no behavioral symptoms, was independent with mobility and transfers, and did not receive psychotropic medication. Resident 31's Comprehensive documented the following;-initiated 12/24/2024 and revised 1/7/2025, the resident had potential for alteration in socialization/leisure time activities related to preferring privacy and in room/unit activities. The resident was registered to vote and was a veteran. Interventions included provide an activity calendar, inform and invite to scheduled activities, provide verbal direction to leisure time activities, facilitate participation as desired, and promote program participation and praise efforts. Blank template interventions for resident's family history, life history, special interests, and room visits were on the care plan but were not updated with the resident's information.-initiated 12/27/2024 the resident had a problem related to neurological/memory deficits. The resident was alert and oriented to person and had memory loss/deficit related to a stroke. Interventions included to monitor for cognitive changes daily with care and their cognitive status necessitated frequent reminders.-Initiated 12/27/2024 and revised 10/30/2025, the resident had no alteration in their psychosocial well-being but had an alteration in mood and behavior pattern related to episodes of verbal aggression and a stroke. They had the potential to refuse care, hold hands with a resident on the memory care unit, to become physically aggressive toward caregivers when offered assistance with care. Interventions included an alarming floor mat for the resident's room door, encourage activities, encourage hobbies of interest, they preferred to wear only a brief on their bottom half to bed, provide a quiet environment and redirect from crowded areas, offer choices when assisting with personal care, monitor for sleep pattern and changes in mood/behavior and respond to behaviors by reapproaching during episodes of refusals. Nursing progress notes for Resident #1 documented:- on 10/5/2025 by Licensed Practical Nurse #7 it was reported a family member of another resident found Resident #1 on top of Resident #4 with no pants or undergarments. Staff immediately intervened and removed the residents from the room. They informed the supervisor immediately and both residents were educated on appropriate behaviors - on 10/24/2025 by Licensed Practical Nurse #8 they were

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on record review and interviews during the abbreviated survey (#2639795) the facility did not ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, administration failed to ensure residents were free from abuse, neglect and exploitation; and failed to ensure policies and procedures were properly identified, communicated, and consistently implemented. This failure resulted in Immediate Jeopardy in the areas of F600 Free from Abuse and Neglect, F609 Reporting of Alleged Violations, and F610 Investigation/Prevent/Correct Alleged Violation.Findings include: The undated Administrator job description documented they would set an example for all staff members, consultants and others affiliated with the facility which recognized the facility existed to serve the interest and the needs of the residents. They emphasized the importance of a resident's right to independence regarding all aspects of facility life and encouraged residents to participate together with staff in resolving conflict and problems which may arise. The Administrator notified the New York State Department of Health Office of Health Systems Management as required (including but not limited to); any changes in personnel as required by code; disaster/disruption of service events; facility alteration and all other issues required by code.The facility Quality Assurance Performance Improvement (QAPI) Plan, dated 10/2025, documented the purposed of quality assurance performance improvement was to take a proactive approach to continually improve the way the facility cared for and engaged with residents, caregivers, staff and other partners, to realize the vision to improve the lives of nursing home residents. The facility provided a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and positive outcomes could be reinforced and expanded to improve care. Resident's Free from Abuse and Neglect, Refer to the citation text under F600.The facility failed to ensure residents were free from abuse and failed to protect residents from further abuse for two (2) of four (4) residents reviewed.Reporting of Alleged Violations, Refer to the citation text under F609.The facility failed to ensure an incident of resident-to-resident abuse was reported to the State Agency, law enforcement, and the Administrator for three (3) of eight (8) residents reviewed. Investigate/Prevent/Correct Alleged Violation, Refer to the citation text under F610.The facility failed to ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for three (3) of eight (8) residents reviewed. During an interview on 10/29/2025 at 12:49 PM, the Administrator stated the abuse incident files were with the Director of Nursing. At 12:55 PM, they provided a file for a 10/05/2025 incident and stated the Director of Nursing was wrapping up another investigation. At 2:12 PM, an incident report for 10/23/2025 was provided but they stated it was not complete. During an interview on 11/03/2025 at 12:45 PM, the Administrator stated they were informed of incidents of residents wandering into Resident #1's room and lying in Resident #1's bed. As far as they knew the residents were clothed. Resident #3's and #4's shirts were only slightly lifted. All three residents were deemed to not have decision making capacity for consent. Either they or the Director of Nursing reported incidents to New York State. Reporting depended on the investigation and witness statements to determine if the situation met reporting guidelines. They could not confirm any intimate contact between the residents for any of the incidents, so they did not feel it was reportable. During an interview on 11/06/2025 at 3:24 PM, the Administrator stated they did not previously have abuse on their list for quality performance improvement. They stated if a resident had inappropriate behaviors this was brought up in the staff morning meetings and they would evaluate if the interventions in place were working. They recently lost their social worker, but the unit managers should be assisting with interventions with the support of the certified nurse aides with managing residents with inappropriate behaviors.During a follow up interview on 11/07/2025 at 11:48 AM, the Administrator stated they were made aware of the 10/5/2025 the next day on 10/6/2025 but were not aware of the 10/09/2025 incident until 10/24/2025 after they were informed of the 10/23/2025 incident when the resident was moved off the unit. They were informed of all the incidents by the Director of Nursing. A thorough investigation included interviewing all staff, assessing the resident, following proper reporting guidelines, and implementing interventions depending on the investigation or situation. The Director of Nursing was responsible for investigations and verbally updated them on their investigative findings. 10 NYCRR 483.70(i)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Nursing and Rehabilitation Center, Inc	232 Academy Street Boonville, NY 13309

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on record review and interviews during the abbreviated survey (#2639795), the facility did not comply with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standard and principles that apply to professionals providing services in such a facility. Specifically, the facility did not provide requested accident and incident reports including abuse incident documentation when requested by the New York State Department of Health surveyor in a timely manner.Findings include:Refer to F609 - Reporting of Alleged ViolationsRefer to F610 - Investigate/Prevent/Correct Alleged ViolationsOn 10/29/2025 at 8:45 AM, the surveyor provided the Administrator a request for documents including their accident and incident reports for September 2025 and October 2025.On 10/29/205 at 9:45 AM, the Administrator provided copies of accident and incident reports for September 2025 and October 2025.On 10/29/205 at 10:45 AM, after review of the files provided, the surveyor clarified with Administrator the accident and incidents should include all abuse or injuries of unknown origin. The Administrator stated those were separate files and they would provide them for September 2025 and October 2025. On 10/29/2025 at 11:55 AM, the surveyor requested from the Administrator a second time the abuse incidents and files for September 2025 and October 2025.On 10/29/205 at 12:49 PM, the surveyor requested from the Administrator a third time the abuse incidents and files from September 2025 and October 2025. The Administrator stated the Director of Nursing had the files and they would bring them to the conference room. On 10/29/2025 at 12:55 PM, the Administrator brought in one file dated 10/5/2025 and stated the Director of Nursing had one more report they were finishing. The surveyor requested to review the unfinished file as it was.On 10/29/2025 at 2:12 PM, the Director of Nursing provided an incident report for an incident dated 10/23/2025 and stated the report was not completed. On 10/29/2025 at 4:18 PM, the surveyor requested additional accident and incident reports from April 2025 to date. On 10/31/2025 at 8:53 AM, the Administrator had not provided the requested accident and incident reports from April 2025 to date. On 10/31/2025 at 9:50 AM, the surveyor notified the Director of Nursing the 10/30/2025 at 4:18 PM requested accident and incident reports were not received.On 10/31/2025 at 9:53 AM, the Administrator provided hard copies of accidents and incidents since April 2025.10NYCRR 400.2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335587	A. Building B. Wing	11/12/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on record review and interviews during the abbreviated survey (#2639795) the facility's governing body did not establish and implement policies regarding the management and operation of the facility. Specifically, there was not consistent communication between the governing body and the facility Administrator to ensure regulatory compliance. Deficiencies identified during the abbreviated survey included three Immediate Jeopardies in Free from Abuse and Neglect (F600), Reporting of Alleged Violations (F609), and Investigate/Prevent/Correct Alleged Violations (F610). Findings include:The 10/2025 facility policy Quality Assurance Performance Improvement (QAPI) Plan, documented:-The facility maintains a planned, systematic, organization-wide approach to design process that will measure, assess and improve the organization's performance and focus on indicators of quality.-The purpose of quality assurance performance improvement in the organization is to take a proactive approach to continually improve the way they care for and engage with residents, care givers, staff and other partners, to realize their vision to improve the lives of the nursing home residents. -The facility will provide a means whereby negative outcomes related to resident care and safety can be identified and resolved through an interdisciplinary approach and positive outcome can be reinforced and expanded to improve care. Refer to F 600 Free from Abuse and NeglectRefer to F 609 Reporting of Alleged ViolationsRefer to F 610 Investigate/Prevent/Correct Alleged ViolationsDuring an interview on 11/3/2025 at 12:46 PM, the Director of Nursing stated the 10/5/2025, 10/9/2025, and 10/23/2025 incidents were investigated by interviewing staff and reviewing the care plans for proper interventions. They ruled out abuse for the 10/5/2025 incident based on the interview of Resident #5's family member who stated there was no physical contact between Resident #1 and Resident #4. The 10/9/2025 incident they thought it was just Resident #3 wandering into Resident #1's bed and lying down in the bed. The 10/23/2025 incident, abuse was ruled out because Licensed Practical Nurse #8 stated there was no physical contact made, and no one witnessed any physical contact. For all three incidents, they ruled out abuse based on witness statements. They did not report the potential abuse to the New York Stated Department of Health because they did not think abuse happened. During an interview on 11/6/2025 at 3:24 PM, the Administrator stated they did a performance improvement plan for abuse prevention and detection. They stated they recently had been filling in as the social worker while being the Administrator. They did not assess the involved resident's mental health on 10/5/2025, because that would have been the prior social workers responsibility. They did not assess the resident's mental health on 10/9/2025 and 10/23/2025 because they were the Administrator. During an additional interview on 11/7/2025 at 11:48 AM, the Administrator stated they were made aware of the 10/5/2025 incident between Resident #1 and Resident #4 the day after the incident, when the Director of Nursing called them. They were not notified about the 10/9/2025 incident until 10/24/2025 when they moved Resident #1 to another unit after the 10/23/2025 incident. They stated they previously did not sign off on incident investigations, but the Director of Nursing notified them verbally about incidents. 10NYCRR 415. 26(b)(3)(1)