STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335598	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton County Nursing Home	16 Flynn Avenue Plattsburgh, NY 12901

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 - Minimal harm or potential for 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. 33538 Based on record review and interviews during an abbreviated survey (Case # NY00369226), the facility did not ensure the resident's right to be free from abuse for 1 (Resident # 1) of 3 residents reviewed for abuse. Specifically, Resident #1 was not protected from verbal and physical abuse when Certified Nurse Aide #1 was witnessed by Activity Aide #1 and Licensed Practical Nurse #1 forcefully grabbing Resident #1's arm and being verbally aggressive. This is evidenced by: The facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, last revised on 10/20/2022 documented, it was essential for facilities to prohibit and prevent abuse, neglect, exploitation of residents. The facility would have systems in place to encourage and support reporting of suspected abuse. Resident #1 was admitted to the facility with the diagnoses of Alzheimer's disease, hypertension, and anxiety disorder. The Minimum Data Set (an assessment tool) dated 11/21/2024 documented the resident was rarely/never understood, rarely/never understood others, and had severe cognitive deficits. An undated Facility Investigation Summary documented that, on 01/16/2025 Certified Nurse Aide #1 was witnessed by two staff to speak and act in an inappropriate manner that was noted to be aggressive toward Resident #1. It further documented that Certified Nurse Aide #1 had been terminated effective 01/23/2025. A written statement in the facility investigation folder dated 01/16/2025 and signed by Activity Aide #1 documented they witnessed Certified Nurse Aide #1 being verbally abusive toward Resident #1, swearing and yelling at them while grabbing their wrists and dragging them to a chair. An undated written statement in the facility investigation folder for this incident signed by Licensed Practical Nurse #1 documented they witnessed Certified Nurse Aide #1 grab Resident #1's wrists and forcefully pull them to their feet. While forcefully undressing, Certified Nurse Aide #1 was swearing at the resident and stating, you have to be rough with them. A written statement in the facility investigation folder dated 01/17/2025 and signed by Certified Nurse Aide #1 documented they held the resident 's hand and were joking with the resident to distract them so the nurse could provide care. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/2025 at 10:40 AM, Administrator #1 stated the facility investigation concluded Certified Nurse Aide #1 spoke inappropriately to the resident and used profanity. They confirmed that Certified Nurse Aide #1, behaved inappropriately toward the resident but could not confirm physical abuse because there was no physical evidence. During an interview on 01/24/2025 at 10:59 AM, Director of Nursing #1 stated that on 1/16/2025 at around 2:00 PM, a statement was provided by an Activities Aide that indicated verbal and physical abuse to a resident by an aide. Certified Nurse Aide #1 was interviewed and stated the incident did not occur as reported, they were joking with the resident and took the resident gently by the hands. The resident was assessed, and no injuries were discovered. During an interview on 01/24/2025 at 1:03 PM, Activity Aide #1 stated they were assisting Licensed Practical Nurse #1 with Resident #1 when Certified Nurse Aide #1 opened the door to the resident's room in an aggressive manner and told Resident #1 they were a grown woman and stop acting that way. Activities Aide #1 stated they witnessed Certified Nurse Aide #1 strip off Resident #1's shirt while the resident said no, no. Certified Nurse Aide #1 told Resident #1 to stop that. Licensed Practical Nurse #1 asked Certified Nurse Aide to leave the room, but Certified Nurse Aide #1 refused. When Activities Aide #1 left the room after assuring the resident was safe, they informed their supervisor. Attempts to interview Certified Nurse Aide #1 via telephone on 01/24/2025 were unsuccessful. Call and message left did not elicit a response. 10 New York Code, Rules, and Regulations 415.4(b)(1)(i)

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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 - 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. 33538 Based on record review and interviews during an abbreviated survey (Case # NY00369226), the facility did not ensure that all alleged violations involving abuse were reported immediately, or no later than 2 hours after the allegation was made. If the events that caused the allegation involved abuse, they needed to be reported to the Administrator of the facility and to the State Survey Agency for 1 (Resident #1) of 3 residents reviewed. Specifically, an allegation of physical and verbal abuse was observed by staff on 01/16/2025 at approximately 11:00 AM. The allegation was reported to the New York State Department of Health on 01/17/2025 at 8:13 AM. This is evidenced by: The facility Policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, revised 10/2022 documented the following: All alleged violations involving abuse are reported immediately to the Administrator. For all allegations of abuse, the Administrator or designee will notify officials, to include the State Survey Agency immediately but no later than 2 hours if the alleged violation involves abuse. Resident #1 Resident #1 was admitted to the facility with the diagnoses of Alzheimer's disease, hypertension, and anxiety disorder. The Minimum Data Set (an assessment tool) dated 11/21/2024 documented the resident was rarely/never understood, rarely/never understood others, and had severe cognitive deficits. An undated Facility Investigation Summary documented, on 01/16/2025 Certified Nurse Aide #1 was witnessed by two staff members, to speak and act in an inappropriate manner that was noted to be aggressive toward Resident #1. Certified Nurse Aide #1 has been terminated effective 01/23/2025. A Webform Submission Email documented the incident was reported to the New York State Department of Health on 01/17/2025 at 8:13 AM. During an interview on 01/24/2025 at 10:39 AM, Administrator #1 stated they were made aware of the incident a few hours after it had happened. Administrator #1 stated the incident should have been reported to the Department of Health within 2 hours, however it was reported the next morning (01/17/2025) because they wanted to submit as complete of a preliminary investigation as possible. During an interview on 01/24/2025 at 10:59 AM, Director of Nursing #1 stated they were assisting residents in the dining room on 01/16/2025 a little before noon when Activities Director #1 reported there had been an incident and their staff would be writing a statement. Around 2:00 PM, Director of Nursing #1 stated they asked about the statement and were told it wasn't written yet. Around 2:20 PM the statement was handed to Director of Nursing #1 and they realized this could be abuse. 10 New York Codes, Rules, and Regulations 483.12 (c) (1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 33538 Based on record review and interviews during an abbreviated survey (Case # NY00369226), the facility did not ensure the resident's right to be free from further potential abuse, neglect, exploitation, or mistreatment while an investigation was in progress for 1 (Resident #1) of 3 residents reviewed for abuse and neglect. Specifically, Certified Nurse Aide #1 was not removed immediately from resident's care when there was an allegation of physical and verbal abuse to prevent further abuse from occurring. Certified Nurse Aide #1 was allowed to work until the end of their shift. This is evidenced by: The facility Policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, revised 10/2022 documented the following: Immediately upon receiving a report of alleged abuse the Administrator or designee will immediately protect the resident, ensuring safety and well-being for the vulnerable individual are of the utmost priority. Safety security and support of the resident and other residents with the potential to be affected will be provided. Employees accused of alleged abuse will be immediately removed from the facility. Resident #1 Resident #1 was admitted to the facility with the diagnoses of Alzheimer's disease, hypertension, and anxiety disorder. The Minimum Data Set (an assessment tool) dated 11/21/2024 documented the resident was rarely/never understood, rarely/never understood others, and had severe cognitive deficits. An undated Facility Investigation Summary documented, on 01/16/2025 Certified Nurse Aide #1 was witnessed by two staff to speak and act in an inappropriate manner that was noted to be aggressive toward Resident #1. Certified Nurse Aide #1 has been terminated effective 01/23/2025. During an interview on 01/24/2025 at 10:40 AM Administrator #1 stated the accused staff finished the shift because the gravity of the situation was not relayed to the Director of Nursing by the staff reporting it. The accused Aide was allowed to continue to work as the witnesses were writing their statements, which was not done as timely as it should have been. The alleged abuse should have been stopped by the witnessing staff and the accused removed from the building immediately. During an interview on 01/24/2025 at 10:59 AM, Director of Nursing #1 stated they were assisting residents in the dining room on 1/16/2025 when Activities Director #1 stated their staff would be writing a statement. Around 2:00 PM, Director of Nursing #1 stated they asked about the statement and was told it wasn't written yet. Around 2:20 PM the statement was handed to Director of Nursing #1 and they realized this could be abuse. Director of Nursing #1 stated they called Administrator #1 to discuss the incident, and it was decided the employee would be placed on administrative leave immediately. At that time, Certified Nurse Aide #1 had completed their shift and left the facility. They were not allowed entrance to the facility when they returned the next day. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/2025 at 12:36 PM, Activities Director #1 stated Activities Aide #1 had come to them during lunch with concerns about what had happened. They informed Director of Nursing #1 that Activities Aide #1 would be writing a statement but did not tell the Director of Nursing what the statement would entail. Activities Aide #1 went on their lunch break. When they returned, Activities Director #1 instructed Activities Aide #1 to write the statement and give it to the Director of Nursing. Activities Director #1 stated they did not see an urgency to the situation as the resident was unharmed and they made sure the resident stayed in the activity room where they were safe from further abuse by the accused staff. During an interview on 01/24/2025 at 1:03 PM, Activities Aide #1 stated they were assisting Licensed Practical Nurse #1 with Resident #1 when Certified Nurse Aide #1 opened the door to the resident ' s room in an aggressive manner and told Resident #1 they were a grown adult and stop acting that way. Activities Aide #1 stated they witnessed Certified Nurse Aide #1 pull off Resident #1's shirt while the resident repeatedly said no. Certified Nurse Aide #1 told Resident #1 to stop that. The resident attempted to get away from Certified Nurse Aide #1, when they were holding their wrists and Certified Nurse Aide #1 said I can twist too and twisted the resident's wrists. Licensed Practical Nurse #1 asked Certified Nurse Aide #1 to leave the room, but they refused, saying you know this is how we have to do it, I know what I'm doing. When Activities Aide #1 left the room after assuring the resident was safe, they informed their supervisor. Activity Aide #1 reported they were with Resident #1 in the dining room after the incident, Certified Nurse Aide #1 was feeding another resident and looked over at Resident #1 and said don' t start with me. Attempts to interview Certified Nurse Aide #1 and Licensed Practical Nurse #1 via telephone on 01/24/2025 were unsuccessful. Calls and messages left did not elicit a response. 10 New York Codes, Rules, and Regulations 483.12(c)(3)