STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335610	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Allegany L L C	2178 North Fifth Street Allegany, NY 14706

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. (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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(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	Based on interviews and record review conducted during the Abbreviated survey (Complaint #NY00385514) the facility did not ensure that residents were free from abuse and mistreatment for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Certified Nurse Aide #3 was witnessed to slap Resident #1's head during care.The finding is:The policy Abuse Prohibition revised 2/2023, documented residents have the right to be free from physical abuse and mistreatment. The facility will not condone any form of resident abuse. The policy and procedure Facility Incident/Abuse Investigation and Reporting revised 6/7/23, documented mistreatment means inappropriate treatment of a resident. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. The New York State Department of Health document titled Your Rights as a Nursing Home Resident in New York State revised 10/2022, documented as a resident you have the right to be free from abuse including verbal, sexual, mental and physical abuse.1.Resident #1 had diagnoses including dementia with severe agitation, polyosteoarthritis (multiple joints are affected by osteoarthritis (degenerative joint disease) and history of falls. The Minimum Data Set (a resident assessment tool) dated 6/5/25 documented Resident #1 rarely/never understood, rarely/never understands. No behaviors were exhibited. The comprehensive care plan revised on 6/24/25, documented Resident #1 had an alteration in their psychosocial well-being and cognitive loss. They had a potential for alteration in mood and behavior pattern/communication, at times had physical behaviors during care. Interventions included to establish trust with resident, monitor mood/behavior for changes, respond to behaviors with the following diversions/approaches: reassurance, staff supervision outside of room, family support, utilize mechanical support animal, sensory boards. The resident was care planned for 2 staff assist as needed if the resident was not cooperating during dressing. The facility incident report Physical Aggression Received, prepared by the Director of Nursing, dated 7/1/25 at 10:20 PM, documented Resident #1 was in bed being rolled to change clothing when Resident #1 bit the aide's right arm, not letting go. The aide reactively slapped Resident #1 on the top of their head. Predisposing physiological factors included: agitation, confusion, incontinence, and impaired memory. Review of the Facility Reported Incident received 7/2/25 at 11:23 AM, documented there was reasonable cause to believe that abuse, neglect or mistreatment occurred on 7/1/25 at 10:20 PM. Investigation findings documented the incident was witnessed, with reason to believe an aide slapped Resident #1 in the head while the aide was being bit. An investigation statement dated 7/1/25 at 10:30 PM, signed by Certified Nurse Aide #3, documented when they (Certified Nurse Aide #3 and #4) rolled Resident #1 towards the wall Resident #1 lifted their head to bite Certified Nurse Aide #3 on their right arm, as they had rolled Resident #1 to the wall. Certified Nurse Aide #3 documented they tapped Resident #3 on the head without realizing it because Resident #1 was not letting go.An investigation statement dated 7/1/25 at 10:20 PM, signed by Certified Nurse Aide #4 documented that after they (Certified Nurse Aide #3 and #4) started to roll Resident #1, Resident #1 started to get a little bit agitated. Certified Nurse Aide #3 was standing at Resident #1's head when Resident #1 bit Certified Nurse Aide #3's arm. Certified Nurse Aide #4 documented Certified Nurse Aide #3 stated I'm sorry, I'm sorry I shouldn't have hit you. The investigation summary dated 7/2/25 and signed by the Director of Nursing on 7/3/25, documented it was determined that no abuse occurred and there was no intent in harming Resident #1. The Director of Nursing documented the staff member (Certified Nurse Aide #3) had physical contact with Resident #1; however, it was not willful and was reactionary to the situation with no intent to injure Resident #1. During an interview on 7/8/25 at 1:06 PM, Resident #1's family member stated they were told that Resident #1 was tapped on the head. They stated they did not know if it was a hard tap or a soft tap, but that stuff should not happen in a nursing home. They stated if Resident #1 did bite, that they could not help it. Resident #1's family member stated they were not happy about the situation and whether it was meant or not, Resident #1 should not have been tapped on the head. During a telephone interview on 7/8/25 at 1:19 PM, Certified Nurse Aide #4 stated they assisted Certified Nurse Aide #3 with getting Resident #1 ready for bed. They stated Certified Nurse Aide #3 was at the head of the bed removing Resident #1's shirt and they were at the foot of the bed removing Resident #1's pants. They stated they heard Certified Nurse Aide #3 yell and witnessed, and heard Certified Nurse Aide #3 slap the left corner part of Resident #1's forehead and top head with their hand. They stated Certified Nurse Aide #3 knew what they did was wrong and immediately stated they should not have hit Resident #1. Certified Nurse Aide #4 stated they saw Certified Nurse Aide #3's arm in Resident #1's mouth. Certified