

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a recertification and abbreviated survey (Case #s777608, 777666, and 777668), the facility did not ensure that alleged violations involving abuse, were reported immediately, but not later than two (2) hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to officials (including to the State Agency). Additionally, the facility did not ensure a report of the results of all investigations were submitted to the State Agency, within five (5) working days of the incident, in accordance with State law for four (4) (Residents # 58, 76, 78, and 80) of five (5) residents reviewed for abuse. Specifically, (a.) for Resident #58 and 76, a resident-to-resident abuse incident occurred on 02/09/2025 at 18:15 PM and was not reported to the New York State Department of Health until 02/10/2025 at 15:53 PM and the investigation report was not submitted until 02/20/2025; (b.) Resident #78 and 80 allegations of physical abuse were investigated by facility staff and not reported to the New York State Department of Health. This is evidenced by: The Facility Policy titled, Resident Abuse was last reviewed 1/2026 and documented, it is the responsibility of any employee of this facility to report any case of suspected abuse, neglect, mistreatment and exploitation, including injuries of unknown origin, immediately to the facility Administrator and/or Director of Nursing or to the abuse hotline number. If you have reasonable suspicion that a crime that involved serious bodily injury including criminal sexual abuse, you must report it immediately but no later than 2 hours after forming suspicion. 1. Resident #58 was admitted to the facility with diagnoses including dementia (symptoms associated with a decline in cognitive function), anxiety disorder (an overwhelming sense of fear), and depression (persistent feeling of sadness). The Minimum Data Set (an assessment tool) dated 1/16/2025, documented the resident could be understood, could understand others, and had moderate cognitive impairment. Resident #76 was admitted to the facility with diagnoses including dementia, hypoxia (low levels of oxygen), and depression. The Minimum Data Set, dated [DATE], documented the resident could be understood, could understand others, and had severe cognitive impairment. A facility document titled, Incident and Accident Report documented an unwitnessed resident-to-resident altercation took place on 2/09/2025 at 6:15 PM that resulted in Resident #76 having a small cut on their nose, possibly caused by being struck with a broken table by Resident #58. A Nursing Home Incident Submission Report documented the facility submitted a report of the resident-to-resident abuse to the New York State Department of Health on 2/10/2025 at 15:53. The New York State Department of Health Nursing Home Investigative Report Submission form documented the investigation report was submitted on 02/20/2025 at 13:11. 2. Resident #78 was admitted to the facility with diagnoses of anxiety disorder, dementia, and atrial fibrillation (irregular heart rhythm). The Minimum Data Set, dated [DATE], documented the resident could usually be understood, could usually understand others and had severely impaired cognition for decisions of daily living. A Progress Note dated 08/17/2024, documented Resident</p> <p>(continued on next page)</p>		

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	78's family member reported the resident had been hit by an aide. The Director of Nursing was called for direction; the Administrator and Social Worker were e-mailed. A facility document titled, Internal Investigation, documented that on 08/17/2024 Resident #78 reported an aide was mean and struck them in the stomach. The investigation was completed, and abuse was ruled out. Review of the Internet Quality Improvement & Evaluation System (iQIES) revealed no facility submission related to this incident. 3. Resident #80 was admitted to the facility with diagnoses of dementia, aortic stenosis (narrowing of heart valve opening), and congestive heart failure (heart is unable to pump blood efficiently). The Minimum Data Set, dated [DATE], documented the resident could be understood, could understand others and had intact cognition for decisions of daily living. A Facility Investigative Report dated 08/09/2022 documented that on 08/08/2022 Resident #80 reported a nurse hit them. The investigation was completed with no evidence of abuse found. Review of the Internet Quality Improvement & Evaluation System (iQIES) revealed no facility submission related to this incident. During an interview on 1/22/2026 at 10:50 AM, Administrator #1 stated the previous Director of Nursing was responsible for submitting the reports of abuse, neglect, or mistreatment but they were responsible now. They stated they would first ensure the resident's safety, remove the accused staff and begin an investigation. If it looked like it may be found, then it would be reported to the Department of Health. Administrator #1 stated they were not aware it had to be reported within 2 hours even if it was unfounded or that the complete investigation had to be submitted within 5 days of the allegation. 10 New York Codes, Rules, and Regulations 483.12(c)(1)(4)		