

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/10/2026
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)		
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. Based on record review and interviews during a survey, the facility failed to ensure residents were free from abuse for one (Resident #1) of three residents reviewed. Specifically, Certified Nurse Aide #1 aggressively redirected Resident #1 on 05/30/2026. Findings include: The facility Policy titled, Resident Abuse last reviewed 1/2026 documented the residents of Palatine Nursing Home in accordance with Federal Regulation and New York State Title 10 Health Code have the right to be free from abuse, neglect, mistreatment and exploitation. Resident #1 was admitted to the facility with diagnoses of anxiety disorder (mental health conditions characterized by persistent, excessive, and irrational fear or worry that is disproportionate to the actual situation,) aphasia (a neurological language disorder caused by damage that affects a person's ability to speak) and non-traumatic subarachnoid hemorrhage (bleeding into the fluid-filled space between the brain and skull.) The Minimum Data Set (an assessment tool) dated 4/17/2026 documented that the resident could be understood and understand others and had moderate cognitive impairment. The facility Investigation Summary dated 6/01/2026 documented that the results of the investigation were inconclusive. Interviews with staff reported that the resident was agitated when Certified Nurse Aide #1 forcefully assisted Resident #1 into the chair and was verbally abusive. Certified Nurse Aide #1 was placed on investigative leave and the Sheriff's office was notified. During an interview on 06/08/2026 at 10:12 AM, Administrator #1 stated that they felt the staff's behavior was aggressive towards the resident and based on that the staff was terminated and facility wide education on abuse and de-escalation techniques was conducted. Attempts were made to interview Certified Nurse Aide #1 on 6/08/2026 and 6/09/2026 with no contact made. F-600 Past Non-Compliance Based on the following corrective action taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement at the time of this survey: The witnessed incident was reported to the Registered Nurse Supervisor, the accused staff was removed from the facility, and the resident was assessed with no injuries and no recollection of the incident. The incident was reported appropriately to the resident representative, State Survey Agency, and local law enforcement. A thorough investigation was completed, which resulted in the staff being terminated. Education was provided to all staff on Abuse Prevention, Dementia Behaviors, Redirection, and De-escalation. Education was completed on 6/02/2026. At the time of survey, there were no additional incidents of abuse identified since this incident. 10 New York Codes, Rules, and Regulations 415.4		

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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