STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335704	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnsville Rehabilitation and Nursing Center	7 Timmerman Avenue Saint Johnsville, NY 13452

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification and abbreviated survey (Case # 684171), the facility did not ensure the residents' right to be free from abuse and neglect for two (2) (Resident #s 89 and 109) of two (2) residents reviewed for abuse and neglect. Specifically, (a.) on 6/10/2025, Resident #89 who was care planned to be observed closely when not in their room, was left unattended and struck Resident #109 with their walker; and (b.) on 6/22/2025, Resident #89 was sprayed in the face with hot sauce by Resident #63. This is evidenced by: The Facility's Policy titled; Resident Abuse Prevention, dated 05/2025, documented that the purpose was to provide residents, families, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. The policy documented that the facility shall identify, correct, and intervene in situations in which abuse, neglect, mistreatment, or misappropriation of property may be more likely to occur. Procedures documented included, but were not limited to, supervision of staff, which shall include identification of inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, or directing residents in need of toileting to urinate or defecate in their beds or briefs, and counseled when performance is not acceptable.Resident #89Resident #89 was admitted to the facility with Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and behavior), dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), and hypertension (a condition where the force of your blood against the walls of your arteries is too high). The Minimum Data Set, dated [DATE], documented that Resident #89 rarely or never made themselves understood, rarely or never understand others, and had severe cognitive impairment. The Comprehensive Care Plan for behaviors, dated 06/02/2025, documented on 11/08/2021 that Resident #89 had behavior issues as evidenced by screaming, yelling, and causing distress to self and others related to their Alzheimer's Disease, Dementia, and was hard to redirect at times. On 2/15/2022, Resident #89 was care planned to be closely observed when not in their room. The facility's Investigative Report dated 6/22/2025 documented that Resident #89 was standing next to Resident #63, whom they were not supposed to be near due to a prior incident in December of 2024. Staff noticed that Resident #89 was nearby and went to separate them. Before the staff person was able to reach them, the Resident #63 sprayed hot sauce into Resident #89's eyes. During the investigation, the staff asked the resident why they had sprayed the sauce in Resident #89's eyes, and Resident #63 stated it was because the resident wanted hot sauce. Staff assessed the resident, flushed their eyes, and moved them back to their own unit. During an interview on 08/27/2025 at 3:35 PM, Certified Nurse Aide #1 stated that they were feeding another resident in their room when they heard the incident and did not see the actual act. They came out of the room and noticed the resident with a red substance on their face being escorted by the nurse. They stated that Resident #89 resided on the A unit and wandered the facility a lot and was supposed to be closely watched, as there have been multiple incidents with them and other residents.During an interview on 08/29/2025 at 3:15 PM, Certified Nurse Aide #2 stated they were not working that day of the incident but knew the residents well. They stated that Resident #89 wandered a lot throughout the facility and should have been observed when not on the unit. They stated they were unsure whether or not they were being observed. uring an interview on 8/29/2025 at 10:25 AM, Licensed Practical Nurse #3 stated that they remembered the incident. They stated that Resident #89 was next to the other resident when they attempted to move them and separate them. They stated that they did not get to them in time, and Resident #89 was sprayed in the face with hot sauce. They stated that they removed the resident, rinsed the patient's face, and flushed their eye. They stated that they reported the incident to their supervisor. Attempted phone interview on 09/02/2025 at 12:35 PM with Registered Nurse #2, who was the Director of Nursing at the time of the incident, was unsuccessful. Resident #109Resident #109 was admitted to the facility with dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), chronic obstructive pulmonary disease (a group of lung diseases that cause airflow obstruction and breathing difficulties), and hypertension (a condition where the force of your blood against the walls of your arteries is too high). The Minimum Data Set, dated [DATE], documented that Resident #109 sometimes made themselves understood, sometimes understand others, and had severe cognitive impairment.The facility's Investigative Report dated 6/10/2025 documented that Resident #109 was walking