

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335810	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Lutheran Center at Poughkeepsie Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  965 Dutchess Turnpike Poughkeepsie, NY 12603	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</b></p> <p>Based on observations and interviews during an abbreviated survey (NY00333580), the facility did not ensure that each residents had the right to a dignified existence and each resident was cared for in a manner and environment that promoted maintenance or enhancement of their quality of life. This was evident for 1 of 3 residents (Resident #4) reviewed for dignity. Specifically, during an observation on Unit 1 South on 1/6/2025 Certified Nurse Assistant #2 was standing over Resident #4 while assisting them with their meal in the alcove in the hallway.</p> <p>The findings are:</p> <p>The facility Resident Rights policy last revised 9/2024 documented the facility strives to make sure that each resident is afforded a dignified existence, is treated with respect and dignity, and receives care in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life.</p> <p>Resident #4 admitted to the facility on [DATE] with diagnoses including but not limited to Schizoaffective Disorder, Unspecified Intellectual Disabilities and Hypothyroidism.</p> <p>A Quarterly Minimum Data Set (an assessment tool that measures health status) dated 12/16/2024 documented the resident had severe cognitive impairment. The resident required a wheelchair for locomotion. The resident was dependent for eating, toileting and independent with bed mobility and moderate assistance with transfers.</p> <p>Review of a preference care plan last revised 7/12/2024 documented to respect Resident #4's wishes to have meals in the hallway or their room fed by staff. Interventions listed included the resident will consume meals in a dignified manner.</p> <p>Review of an activities of daily living care plan last revised 7/27/2023 documented Resident #4 had a self-performance deficit related to intellectual deficit. Interventions listed included for eating the resident is totally dependent on 1 staff and requires 1 staff assistance.</p> <p>During rounds on the unit on 1/6/2024 from 12:20 PM to 1:00PM, Certified Nurse Assistant #2 was observed in the alcove by a room standing while assisting Resident #4 with their meal.</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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/6/2024 at 12:50 AM, Licensed Practical Nurse #1 stated the staff should be sitting when they are assisting a resident with a meal. Licensed Practical Nurse #1 stated they did not see the staff standing.</p> <p>During an interview on 1/6/2024 at 1:02 PM, Certified Nurse Assistant #2 stated they are aware that they should not be standing while assisting residents during meals. Certified Nurse Assistant #2 stated they have been a certified nurse assistant for a long time, and they received the right training and know they should be seated when assisting a resident with their meal.</p> <p>During an interview on 1/7/2024 at 11:42 AM, the Director of Nursing stated that staff should be seated when they are assisting residents with their meals, and they are aware of this. The Director of Nursing stated staff receive training on this and they will speak with Certified Nurse Assistant #2.</p> <p>10 NYCRR 415.3(d)(1)(i)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>49372</p> <p>Based on observation, record reviews, and interviews during an abbreviated survey (NY00345910, NY00358013), the facility did not ensure the residents right to be free from abuse for 2 out of 3 residents (Residents #1 &amp; #3) reviewed for abuse. Specifically, (1) on 6/19/2024, Certified Nurse Assistant #1 was observed on video surveillance engaging in a verbal altercation with Resident #1 and taunting them in the dining room. Certified Nurse Assistant #1 was also observed engaging in a shoving match at a table in the dining room with Resident #1. Resident #1 and Certified Nurse Assistant #1 later engaged in a physical altercation at the nurse's station where Resident #1 was seen grabbing Certified Nurse Assistant #1 by their shirt and Certified Nurse #1 and Resident #1 began tussling; (2) on 10/4/2024, Resident #3 reported Physical Therapy Assistant #2 was verbally aggressive with them causing them to lose sleep and endure psychological distress requiring antianxiety medication intervention.</p> <p>The findings are:</p> <p>The facility Abuse Prohibition Protocol last revised 3/2024 documented each resident has the right to be free from abuse, neglect, and mistreatment. The facility will do everything in its control to prevent occurrences, and will conduct prompt, thorough investigations for all cases of any type of alleged abuse in compliance with state laws and regulations.</p> <p>1) Resident #1 was admitted with diagnoses including but not limited to Dementia, Alzheimer's disease, and Difficulty in Walking.</p> <p>An Annual Minimum Data Set (an assessment tool that measures health status) dated 4/17/2024 documented the resident had severe cognitive impairment. The resident had impairment to the upper extremities on both sides and required a wheelchair for ambulation. The resident required set up assistance for eating, maximal assistance with toileting and supervision with bed mobility and transfers.</p> <p>There was no evidence of an abuse, victim, or potential victim care plan in place for Resident #1 prior to the incident on 6/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the surveillance video from 6/19/2024 revealed at 16:08 Resident #1 was observed rolling their self over to the table where the other resident was working on a puzzle with Certified Nurse Assistant #1 at their side. Resident #1 proceeded to push the table the other residents were sitting at. Certified Nurse Assistant #1 then attempted to grab the table and pulled it back into place. At 16:15:20, Resident #1 is seen attempting to go for Certified Nurse Assistant #1. Certified Nurse Assistant #1 moved the resident's doll and Resident #1 attempted to chase them. Certified Nurse Assistant #1 was observed taunting Resident #1. Resident #1 was visibly agitated trying to get around the table to Certified Nurse Assistant #1, Resident #1 then reached out and threw the puzzle (which was been completed by another resident) on the floor. At 16:26, Certified Nurse Assistant #1 was seen seated at the nurse's station on the computer and Resident #1 is observed wheeling into the nurse's station and grabbing the Certified Nurse Assistant by the shirt lifting them off the chair. Certified Nurse Assistant #1 and Resident #1 begin tussling. Certified Nurse Assistant #1 stood up and pushed Resident #1 to get them off of their shirt and continued to tussle with Resident #1 as they held Certified Nurse Assistant #1's shirt. Certified Nurse Assistant #1 then grabbed Resident #1 by their hands and Resident #1 kicked at Certified Nurse Assistant #1. Other staff members are seen entering the nurses station trying to release Resident #1's hands from Certified Nurse Assistant #1. Staff is seen rolling Resident #1 out of the nurse's station. Certified Nurse Assistant #1 then kicked Resident #1's baby doll on the floor and proceeded to sit back at the computer.</p> <p>Review of the investigative findings submitted to the New York State Department of Health on 6/20/2024 documented on 6/19/2024 Certified Nurse Assistant #1 was witnessed by other staff teasing, provoking and making faces at Resident #1. At about 4:10pm Certified Nurse Assistant is witnessed holding on to a table in the dining room while Resident #1 was trying to pull the table away and the resident was visibly agitated and upset. Certified Nurse Assistant #1 was asked by registered nurse Supervisor to relocate the other resident on the table to another area but Certified Nurse Assistant #1 disregarded the instruction stating, he has to learn. At approximately 4:15 PM, Resident #1 was observed asking Certified Nurse Assistant #1 for something, but Certified Nurse Assistant #1 kept on arguing with Resident #1 and provoking them. Resident #1 got up from their wheelchair trying to get it from Certified Nurse Assistant #1, but they would not give it to them. Certified Nurse Assistant #1 kept antagonizing Resident #1 for approximately 10 minutes as a result Resident #1 got aggressive and tried to hit Certified Nurse Assistant #1. As per staff statements, Certified Nurse Assistant #1 kicked Resident #1's doll (who they think is their baby daughter) on the table. Resident #1 got aggressive and started following Certified Nurse Assistant #1 speaking in their language as they were very upset.</p> <p>During an interview on 1/6/2025 at 11:20 AM, the Director of Nursing stated there is video footage of the incident that occurred with Resident #1, and that the family have reviewed the footage, and they were very upset by it. The Director of Nursing stated Certified Nurse Assistant #1 was terminated, and they are fighting the termination with the union.</p> <p>During an interview on 1/8/2025 at 4:42 PM, the Director of Nursing stated they tried to get Certified Nurse Assistant #1 out of the facility, but the union fought with them to keep the staff in the building.</p> <p>2) Resident #3 admitted to the facility 9/20/2024 with diagnoses including and not limited to Pneumonia, Obsessive Compulsive Disorder and Heart Failure.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A 5 -day Admission Minimum Data Set (an assessment tool that measures health assessment) dated 9/26/2024 documented the resident was cognitively intact. The resident required a walker for ambulation. The resident required set up assistance with meals, moderate assistance with toileting, supervision with bed mobility and transferring.</p> <p>Review of a grievance form dated 10/10/2024 documented Resident #3 reported that on 10/4/2024 they went to the therapy gym for therapy at around 4:20 PM and it was a Friday. Resident #3 stated they asked Physical Therapy Assistant #2 when they would be able to go home and Physical Therapy Assistant #2 in a stern manner responded they had 2 options: Assisted Living Facility or 24 hour care with supervision. Resident #3 stated the answer made them very upset because it was never mentioned during the care plan meeting that was held on 10/2/2024 where Physical Therapist #2 was present. Resident #3 stated after they told Physical Therapist #2 that they could not do 24 hour care with supervision, Physical Therapist #2 responded then they will call Adult Protective Service if the resident left without 24 hour care with supervision in place. Resident #3 stated as they tried to continue to speak to Physical Therapist #2, they were trying to get them out of the gym stating it was 5 PM and time to go. Resident #3 stated Physical Therapist #2 got them to the door and then closed the door in their face. Resident #3 reported this interaction caused them to be unable to sleep the entire weekend as they tried to reach out to 411 to find 24 hour care. The grievance form also revealed that it was also reported by nursing staff and a family member of the resident that Resident #3 was worried all weekend and was psychologically affected by the incident. Resident #3 reported that on Sunday 10/6/2024 Physical Therapy Assistant #2 came to them for therapy, and they refused because they did not want to work with them.</p> <p>During an interview on 1/8/2025 at 11:35 AM, the Certified Occupational Therapy Aide stated it was the end of the day on a Friday, and Resident #3 came into the therapy room to speak with Physical Therapy Assistant #2 and was asking about their discharge planning in which they had a conversation about previously. The Certified Occupational Therapy Aide stated Physical Therapy Assistant #2 did not want to talk about Resident #3's discharge. The Certified Occupational Therapy Aide stated Resident #3 began to get frustrated and upset and Physical Therapy Assistant #2 stated they would figure it out on Monday but Resident #3 wanted to talk about it, and Physical Therapy Assistant #2 was trying to leave and told the resident it was the end of the day on Friday, and they needed to leave and they did not want to talk about.</p> <p>During an interview on 1/8/2025 at 11:50 AM, Physical Therapy Assistant #1 stated was late on a Friday and Resident #3 came into the therapy room to speak with Physical Therapy Assistant #2, and that Resident #3 wanted to discuss their discharge with the therapist. Physical Therapy Assistant #1 stated Resident #3 and Physical Therapy Assistant #2 were arguing back and forth and the resident was upset. Physical Therapy Assistant #1 stated Resident #3 was talking loud and Physical Therapy Assistant #2 got louder. Physical Therapy Assistant #1 stated Resident #3 did have some difficulty hearing and they had asked Physical Therapy Assistant #2 what their name was several times, but they did not tell them and stated they knew what their name was. Physical Therapy Assistant #1 stated Physical Therapy Assistant #2 told Resident #3 it was late in the day, and they needed to go and then pushed the resident's wheelchair out of the therapy room and closed the door and the resident was still upset.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 1/8/2025 at 1:20 PM, Physical Therapy Assistant #2 stated Resident #3 was very difficult and narcissistic with a history of verbal aggression. Physical Therapy Assistant #3 stated they had multiple discussions with Resident #3 regarding their discharge. Physical Therapy Assistant #2 stated they had a care plan meeting with Resident #3 and their family over the phone and discussed placement for the resident as they had 14 stairs in their home. Physical Therapy Assistant #3 stated they spoke with Resident #3 during their therapy session, and they stated they were going home and there was nothing they could do about it. Physical Therapy Assistant #2 stated they in a stern voice, told Resident #3 that they had not discussed them going home, and the resident continued stating they are going to do what they want. Physical Therapy Assistant #2 stated they told Resident #3 they did not feel they were safe to go up and down their stairs. Physical Therapy Assistant #2 stated Resident #3 stated they were going to go home if they want to, and they could not stop them. Physical Therapy Assistant #2 stated they told Resident #3 they were correct, and they could not stop them from going home, but that it would not be a safe discharge and in that case, they would have to inform Adult Protective Services. Physical Therapy Assistant #2 stated that was the breaking point and Resident #3 started screaming, and they walked away and got a drink of water and then Resident #3 became more upset. Physical Therapy Assistant #2 stated they did not interact with Resident #3 the rest of the day.</p> <p>During an interview on 1/8/2025 at 12:03 PM, the Director of Rehabilitation stated they were informed on Tuesday by the other therapists of the incident, and they then informed the Human Resource Director, who requested the therapists write statements, so the staff wrote their statements the next morning. The Director of Rehabilitation stated Physical Therapy Assistant #2 happened to be on paid time off the next day and the following day after the incident and usually the alleged staff would be suspended immediately pending an investigation. The Director of Rehabilitation stated Physical Therapy Assistant #2 was suspended over the telephone and they did not provide them with much detail, but they informed them it had to do with a resident's grievance.</p> <p>During a telephone interview on 1/23/2025 at 10:43 AM, Licensed Practical Nurse #3 stated the incident with Resident #3 happened on Sunday with Physical Therapy Assistant #2 and they were informed on Monday 12/9/2024 and they wrote a statement. Licensed Practical Nurse #3 stated they were informed by the staff nurse and informed that Resident #3 was upset because Physical Therapy Assistant #2 made a comment that they were not going to go home if there was no 24-hour supervision for them at home. Licensed Practical Nurse #3 stated Resident #3 stated they were told by Physical Therapy Assistant #2 if they insist on going home, then they are going to call the lawyer and tell Adult Protective Services. Licensed Practical Nurse #3 stated they spoke with Resident #3, and they stated they did not want Physical Therapy Assistant #2 to get in trouble, but they just want to leave the facility and go to their apartment. Licensed Practical Nurse #3 stated when they spoke with Resident #3, they were no longer upset, and they usually were able to calm them down by sitting and talking with them. Licensed Practical Nurse #3 stated Resident #3 kept saying they were upset about the situation with Physical Therapy Assistant #3, and they just want to go home.</p> <p>10NYCRR 415.4(b)(1)(i)</p>		

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<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>49372</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00345910, NY00333580, NY00358013) the facility did not ensure the report of the results of an investigation to the New York State Department of Health in accordance with State law within 5 working days of the incident or report an allegation of abuse within the regulatory timeframe for 3 of 4 residents (Resident #1, #2, #3) reviewed for abuse. Specifically, (1) On 6/19/2024 Certified Nurse Assistant #1 was observed on video surveillance engaging in a verbal altercation and the pushing and pulling of a table back and forth with Resident #1. Review of the 5-day investigative conclusion submission revealed it was not submitted to the New York State Department of Health until 7/25/2024; (2) On 2/13/2024 Resident #2 reported alleged inappropriate contact by Certified Nurse Assistant #3. Review of the 5-day investigative conclusion submission revealed it was not submitted until 3/6/2024; (3) On 10/6/2024 Resident #3 reported to the social worker that Physical Therapy Assistant #2 spoke to them in a manner that made them upset and experience mental anguish. Review of the 5-day investigative conclusion submission revealed it was not submitted until 10/22/2024.</p> <p>The findings are:</p> <p>The facility Abuse Prohibition Protocol last reviewed 3/2024 documented all alleged incidents of abuse, neglect and mistreatment must be reported to your immediate supervisor investigated and reported to the Administrator who is the abuse prevention coordinator or designee. When required by law or regulation, the Administrator/Designee shall ensure timely notification of the incident to the Department of Health.</p> <p>1) Resident #1 had diagnoses including but not limited to Dementia, Alzheimer's disease, and Difficulty in Walking.</p> <p>An Annual Minimum Data Set (an assessment tool that measures health status) dated 4/17/2024 documented the resident had severe cognitive impairment. The resident had impairment to the upper extremities on both sides and required a wheelchair for ambulation. The resident required set up assistance for eating, maximal assistance with toileting and supervision with bed mobility and transfers.</p> <p>Review of the investigative findings submitted to the New York State Department of Health on 6/20/2024 documented on 6/19/2024 at approximately 4:10 PM Resident #1 tried to pull one of the tables when Certified Nurse Assistant #1 tried to pull it back and kept on arguing with the resident. At approximately 4:15 PM Resident #1 was observed asking Certified Nurse Assistant #1 for something but they kept on arguing with Resident #1 trying to provoke them. Resident #1 gets up from their wheelchair trying to get it from Certified Nurse Assistant #1, but they would not give it to them. Certified Nurse Assistant #1 kept antagonizing Resident #1 for approximately 10 minutes as a result Resident #1 got aggressive and tried to hit Certified Nurse Assistant #1. As per staff statements Certified Nurse Assistant #1 threw Resident #1's doll on the table, who they think was their daughter. Resident #1 got so aggressive and started following Certified Nurse Assistant #1 speaking in their language as they were very upset.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 5-day investigative conclusion submission revealed it was not submitted to the New York State Department of Health until 7/25/2024.</p> <p>2) Resident #2 had diagnoses including but not limited to Macular Degeneration, Hypertensive Heart Disease without Heart Failure and Unspecified Fall.</p> <p>An Admission Minimum Data Set (an assessment tool that measures health status) dated 2/5/2024 documented Resident #2 had moderate cognitive impairment. No behaviors noted. The resident used a walker and a wheelchair for locomotion and had impairment to the lower extremity on one side. The required set up assistance with eating, moderate assistance with bed mobility and dependent for toileting and transfers.</p> <p>Review of the investigative summary of the incident documented Resident #2 on 2/13/2024, reported that on 2/2/2024 they were lying in bed and saw 2 male figures. Resident #2 stated they thought it was their vision due to their history of macular degeneration. Resident #2 stated while they were lying down Certified Nurse Assistant #3 was on the side of them. Resident #2 stated Certified Nurse Assistant #3 started pecking them on their cheek, but not aggressively. Resident #2 stated that Certified Nurse Assistant #3 realized they were growing suspicious but continued to peck them on their cheek. Resident #2 stated they informed Certified Nurse Assistant #3 that this was not them, they are above this and do not do this to their self. Resident #3 then stated they can put this in the past and in the morning, they will look at it as it was the past. Resident #2 stated while saying this to Certified Nurse Assistant #3 they continued to peck them on the cheek but could tell Certified Nurse Assistant #3 was giving up. Resident #2 stated Certified Nurse Assistant #3 eventually pulled away from them and stopped.</p> <p>The investigative conclusion dated 2/16/2024 documented after reviewing the incident, staff changes and Resident #2's health condition, it is concluded that there was no evidence of sexual abuse, mistreatment, or neglect.</p> <p>Review of the investigation file revealed the 5-day conclusion was submitted on 3/6/2024.</p> <p>3) Resident #3 had diagnoses including and not limited to Pneumonia, Obsessive Compulsive Disorder and Heart Failure.</p> <p>A 5 -day Admission Minimum Data Set (an assessment tool that measures health assessment) dated 9/26/2024 documented the resident was cognitively intact. The resident required a walker for ambulation. The resident required set up assistance with meals, moderate assistance with toileting, supervision with bed mobility and transferring.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a grievance form dated 10/10/2024 documented Resident #3 reported on Friday 10/4/2024 they went to the therapy gym for therapy at around 4:20 PM and they were talking to Physical Therapy Assistant #2. Resident #3 stated they were asking when they were going to be going home and Physical Therapy Assistant #2 in a stern manner responded to them, they had 2 options, 24-hour care with supervision or go to an assisted living facility. Resident #3 stated they were very upset with this answer and responded they cannot do that with the 24-hour care and supervision. Resident #3 reported Physical Therapist Assistant #2 responded if they did not choose one of the options then they would have to get the law on them. Resident #3 reported they were trying to talk to Physical Therapist Assistant #2 and they were trying to get them out of the gym stating it is 5 PM and time to go. Resident #3 stated Physical Therapist #2 got them to the door and then closed the door in their face. Resident #3 reported this interaction caused them to not be able to sleep because they kept thinking about it. Resident #3 reported that on Sunday 10/6/2024 Physical Therapy Assistant #2 came to them for therapy, and they refused because they did not want to work with them.</p> <p>Review of the investigation file revealed the 5-day conclusion was submitted on 10/22/2024.</p> <p>During an interview on 1/6/2025 at 11:20 AM, the Director of Nursing stated they submit the reports to the Department of Health, and they also submit the 5-day conclusion.</p> <p>During an interview on 1/8/2025 at 4:42 PM, the Director of Nursing stated they are responsible for the submission of the reportable. The Director of Nursing stated if there is an injury then they call the hotline for an incident and if there is no injury and someone reports an incident, they complete the submission online within 24 hours. After submission, they will usually receive the second follow up email from the Department of Health and then they would submit the 5-day investigative conclusion. The 5-day report is submitted once they receive the email informing them to submit. The Director of Nursing stated they were not aware that they had 5 working days to submit the 5-day investigative summary and therefore they were waiting for the email from Department of Health before submitting the conclusion.</p> <p>10NYCRR 415.4(b)(1)(ii)</p>		

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NAME OF PROVIDER OR SUPPLIER  Lutheran Center at Poughkeepsie Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  965 Dutchess Turnpike Poughkeepsie, NY 12603	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49372</p> <p>Based on record review and interview during an abbreviated survey (NY00345910, NY00358013), the facility did not ensure that a comprehensive person-centered care plan was developed and implemented to ensure services were provided to maintain the residents' highest practicable physical, mental, and psychosocial well-being for 2 out of 3 residents (Resident #1, #3) reviewed for care planning. Specifically, (1) On 6/19/2024 Certified Nurse Assistant #1 was observed on surveillance footage engaging in a verbal altercation and taunting Resident #1. Certified Nurse Assistant #1 and Resident #1 then engaged in a physical tussle at the nurse's station. Review of Resident #1's care plans revealed they did not have an abuse, victim, or potential victim care plan initiated until after the incident on 6/19/2024; (2) Resident #3 reported that on 10/4/2024 they had a verbal altercation with Physical Therapy Assistant #2 which led them to become angry and suffer mental anguish. Review of Resident #3 care plans revealed they did not have a risk to be victimized care plan before and after the verbal altercation incident occurred.</p> <p>The findings are:</p> <p>The Facility Policy titled Baseline care Plan and Summary, last revised 11/2023 documented the facility ensures that a baseline care plan is completed for all residents within 48 hours of admission. The is intended to focus on the resident as the center of control. The baseline care plan promotes continuity of care and communication among staff , and increases resident safety and safeguards against adverse events that are most likely to occur after admission.</p> <p>1) Resident #1 had diagnoses including but not limited to Dementia, Alzheimer's disease and Difficulty in Walking.</p> <p>An Annual Minimum Data Set (an assessment tool that measures health status) dated 4/17/2024 documented the resident had severe cognitive impairment. The resident exhibited wandering behaviors. The resident had impairment to the upper extremities on both sides and required a wheelchair for ambulation. The resident required set up assistance for eating, maximal assistance with toileting and supervision with bed mobility and transfers.</p> <p>There was no evidence of an abuse, victim, or potential victim care plan in place for Resident #1 prior to the incident that occurred on 6/19/2024.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the surveillance video from 6/19/2024 revealed at 16:08 Resident #1 was observed rolling themselves over to the table where another resident was working on a puzzle with Certified Nurse Assistant #1. Resident #1 proceeded to push the table the other residents were sitting at, and Certified Nurse Assistant #1 is seen grabbing the table and pulling it back into place. At 16:15:20, Resident #1 is seen going towards Certified Nurse Assistant #1. Certified Nurse Assistant #1 is seen moving a doll and Resident #1 attempted to chase behind them. Certified Nurse Assistant #1 was observed taunting Resident #1. Resident #1 was visibly agitated trying to get around the table to Certified Nurse Assistant #. Resident #1 reached out and threw the puzzle (been worked on by another resident) on the floor. At 16:26, Certified Nurse Assistant #1 was seen seated at the nurse's station on the computer. Resident #1 wheeled into the nurse's station and grabbed Certified Nurse Assistant #1 by the shirt lifting them off the chair. Certified Nurse Assistant #1 and Resident #1 began tussling. Certified Nurse Assistant #1 then stood up and pushed Resident #1 to get them off of their shirt and continued to tussle with Resident #1 as they were still holding onto them. Certified Nurse Assistant #1 grabbed Resident #1 by their hands and Resident #1 kicked at Certified Nurse Assistant #1. Other staff members are seen entering the nurses station trying to release Resident #1's hands from Certified Nurse Assistant #1. Resident #1 is seen being rolled out of the nurse's station. Certified Nurse Assistant #1 then kicked Resident #1's baby doll to the floor and proceeded to go back and sit at the computer.</p> <p>2) Resident #3 admitted to the facility 9/20/2024 with diagnoses including and not limited to Pneumonia, Obsessive Compulsive Disorder and Heart Failure.</p> <p>A 5 -day Admission Minimum Data Set (an assessment tool that measures health assessment) dated 9/26/2024 documented the resident was cognitively intact. The resident required a walker for ambulation. The resident required set up assistance with meals, moderate assistance with toileting, supervision with bed mobility and transferring.</p> <p>Review of a needs care plan last revised 12/11/2024 documented Resident #3 was dependent on staff for meeting their emotional, intellectual, physical, and social needs related to their physical limitations. Interventions listed included provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression, and responsibility.</p> <p>There was no documented evidence of Resident #3 having a risk to be victimized care plan in place. There was no documentation of the incident that occurred being reflected in any of the resident's care plans.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a grievance form dated 10/10/2024 documented Resident #3 reported that on 10/4/2024 they went to the therapy gym for therapy at around 4:20 PM and it was a Friday. Resident #3 stated they asked Physical Therapy Assistant #2 when they would be able to go home and Physical Therapy Assistant #2 in a stern manner responded they had 2 options: Assisted Living Facility or 24 hour care with supervision. Resident #3 stated the answer made them very upset because it was never mentioned during the care plan meeting that was held on 10/2/2024 where Physical Therapist #2 was present. Resident #3 stated after they told Physical Therapist #2 that they could not do 24 hour care with supervision, Physical Therapist #2 responded, then they will call Adult Protective Service if the resident left without 24 hour care with supervision in place. Resident #3 stated as they tried to continue to speak to Physical Therapist #2, they were trying to get them out of the gym stating it was 5 PM and time to go. Resident #3 stated Physical Therapist #2 got them to the door and then closed the door in their face. Resident #3 reported this interaction caused them to be unable to sleep the entire weekend as they tried to reach out to 411 to find 24 hour care. The grievance form also revealed that it was also reported by nursing staff and a family member of the resident that Resident #3 was worried all weekend and was psychologically affected by the incident. Resident #3 reported that on Sunday 10/6/2024 Physical Therapy Assistant #2 came to them for therapy, and they refused because they did not want to work with them.</p> <p>During an interview on 1/8/2025 at 4:42 PM, the Director of Nursing stated for Resident #3's care plan for risk to be victimized should have been initiated after the incident with Physical Therapy Assistant #2. The Director of Nursing stated the unit manager would have been the one to initiate this care plan.</p> <p>During a telephone interview on 1/23/2025 at 10:43 AM, Licensed Practical Nurse #3 stated they update the care plans most of the time for the residents on their unit, but for this incident with Resident #3, they spoke with the social worker. Licensed Practical Nurse #3 stated they did not initiate an abuse care plan because Resident #3 was alert and oriented with a high Brief Interview of Mental Status score. Licensed Practical Nurse #3 stated they spoke about this with the social worker, and they stated an abuse care plan was not needed because the issue was more related to the staff. Licensed Practical Nurse #3 stated the social worker usually updates the behavior and abuse care plans, unless it is otherwise determined in a meeting. Licensed Practical Nurse #3 stated they meet with the social worker and decide together if an abuse care plan is needed for a resident. Licensed Practical Nurse #3 stated they remember a surveyor told them a victim care plan is only initiated for residents with dementia diagnosis or issues with cognition. Licensed Practical Nurse #3 stated when Resident #3 was discharged and returned to the facility after another hospitalization, they initiated a high risk to be victimized care plan due to their impulsivity.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/23/2025 at 12:48 PM, the Director of Nursing stated the baseline care plan policy is the only care plan policy they have, they do not have a policy for updating and reviewing care plans. The Director of Nursing stated it is the responsibility of the unit managers to complete the comprehensive care plan and the social worker completes the abuse/risk to be a victim care plans, however if the social worker was not available, the unit managers would be expected to complete the abuse care plans. The Director of Nursing stated the unit manager is the oversight for the social worker completing the abuse care plans and the unit manager should be checking to be sure the care plans are initiated. The Director of Nursing stated they do not check the unit managers to ensure they are doing their job. The Director of Nursing stated they spoke with the social worker and were told the care plans were completed. Based on the residents Brief Interview of Mental Status score there was no need for a risk to be a victim care plan because the residents can speak up when something happens. The Director of Nursing stated care plans are updated for a change in condition. If there are changes during the morning meetings, issues are discussed, then a care plan meeting is set up. The Director of Nursing stated they did speak with the interdisciplinary team about Resident #3 during morning report and reported the incident to the Department of Health, but because the resident was alert and oriented an at risk for abuse and victim care plan were not initiated. The Director of Nursing stated they will be initiating the potential victim care plan for all residents going forward. The Director of Nursing stated they try to check that everything is in place following an incident but if it was missed then it was missed.</p> <p>10 NYCRR 415.11(c)(1)</p>		