STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335821	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine of Siena Nrsg and Rehab Care Center	52 Route 25a Smithtown, NY 11787

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49457 Based on record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00335331) initiated on 3/14/2024 and completed on 3/22/2024 the facility did not ensure each resident was free from abuse. This was identified for two (Resident # 9 and Resident #157) of four residents reviewed for abuse. Specifically, on 3/07/2024 Certified Nursing Assistant #2 witnessed Certified Nursing Assistant #1 slap Resident #9 on their leg with an open hand and held Resident #9's wrist to the resident's mouth to prevent the resident from biting Certified Nursing Assistant #1. Immediately following this incident with Resident #9, Certified Nursing Assistant #2 witnessed Resident #157 being roughly pushed and pulled by their arms and legs by Certified Nursing Assistant #1 during care. Resident #157 complained of pain and asked Certified Nursing Assistant #1 to stop; however, Certified Nursing Assistant #1 continued to provide care to Resident #157. This resulted in actual harm to Resident #157 that was not Immediate Jeopardy. The finding is: The facility's Abuse Prohibition policy dated 3/11/2023 documented that each resident has the right to be free from abuse (verbal, sexual, physical, and mental), neglect, corporal punishment, involuntary seclusion, chemical and/or physical restraints unless required to treat a medical condition, and misappropriation of personal funds or property. Acts of resident abuse, neglect, or mistreatment are not tolerated. Residents may not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The Abuse Prohibition policy also included that as per the Elder Justice Act, if a reasonable suspicion of a crime has been determined either through investigation or witnessed by a covered individual, the suspicion shall be immediately reported to the Administrator, and Director of Nursing Services, Local Law enforcement, and the State Survey Agency (SA)/Department of Health. Resident # 9 has diagnoses that include Dementia, Stroke, and Anxiety. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 2 which indicated the resident's cognitive skills for daily decision-making skills were severely impaired. The Minimum Data Set documented that Resident # 9 exhibited no behaviors of hitting, kicking, pushing scratching, or abusing others; and did not reject care. The Minimum Data Set documented the resident required maximum assistance of one staff member for bed mobility and transfers and moderate assistance of one person to ambulate with a rolling walker for 10 feet. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER St Catherine of Siena Nrsg and Rehab Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 52 Route 25a Smithtown, NY 11787	

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Comprehensive Care Plan for Behavior dated 2/28/2024 documented Resident # 9 had a history of refusing treatments such as TED (compression stocking) stockings. Interventions included that staff would explain the importance of medications, meals, treatments, and care, and re-approach the resident after refusal of care. The Incident/Accident report dated 3/07/2024 documented that at approximately 5:30 AM Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 slap Resident #9 with an open hand on Resident #9's left lower calf. Certified Nursing Assistant #2 told Certified Nursing Assistant #1, Do not do that. Certified Nursing Assistant #1 responded to Certified Nursing Assistant #2, Do not tell anyone. Certified Nursing Assistant #2 reported this incident to Licensed Practical Nurse #1. Licensed Practical Nurse #1 then reported the incident to Registered Nurse Supervisor #1. Registered Nurse Supervisor #1 interviewed and assessed Resident #9. Registered Nurse Supervisor #1 documented there was no injury, bruising, redness or swelling and that Resident #9 had no recollection of the event. The Accident/Incident report documented the Nurse Practitioner was made aware. The Nursing Progress Notes for Resident #9 were reviewed from 3/06/2024 through 3/09/2024. There was no documentation of an assessment related to the 3/07/2024 incident. The Medical progress notes for Resident #9 were reviewed from 3/06/2024 through 3/09/2024. There was no documentation of an assessment related to the 3/07/2024 incident. The Social Work Progress notes for Resident #9 were reviewed from 3/06/2024 through 3/09/2024. There was no documentation of the incident or an assessment of the resident. During an interview on 3/18/2024 at 1:30 PM Certified Nursing Assistant #1 stated that on 3/07/2024, between 4:00 AM and 5:00 AM, they were asked by Certified Nursing Assistant #2 to assist with care of Resident #9. Certified Nursing Assistant #1 stated Resident #9 was fighting them. Certified Nursing Assistant #1 stated that Resident #9 raised their knee as if to kick Certified Nursing Assistant #1 near their head. Certified Nursing Assistant #1 stated on instinct they then took their hand and slapped Resident #9's knee down. Certified Nursing Assistant #1 stated that Resident #9 was then hitting them (Certified Nursing Assistant #1) on the arms so they took Resident #9's wrists and held them up to Resident #9's mouth, so Resident #9 would not try to bite them. Certified Nursing Assistant #1 stated that Resident #9 was going for a fight and was not a calm person during brief changes. Certified Nursing Assistant #1 stated, I barely hit [them (Resident #9)], it was the softest thing in the whole wide world. Certified Nursing Assistant #1 stated that they and Certified Nursing Assistant #2 continued providing care for the rest of their assigned residents. Certified Nursing Assistant #1 stated they then finished their documentation and went home. Certified Nursing Assistant #1 stated they were contacted by the Director of Nursing later that same day (3/07/2024), but they were busy and could not have a conversation. Certified Nursing Assistant #1 further stated they did not return to work at the facility because they were not happy working there and just assumed they were not on the schedule. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine of Siena Nrsg and Rehab Care Center	52 Route 25a Smithtown, NY 11787

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 - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

During an interview on 3/19/2024 at 10:30 AM Certified Nursing Assistant #2 stated they were assigned to Resident #9 and asked Certified Nursing Assistant #1 to assist them with Resident #9 because the resident can become combative during care. Certified Nursing Assistant #2 stated that they observed Certified Nursing Assistant #1 slap Resident #9 on their left leg. Certified Nursing Assistant #2 stated they yelled at Certified Nursing Assistant #1 not to do that, and Certified Nursing Assistant #1 said, do not say anything. Certified Nursing Assistant #2 stated that they looked for a nurse to report the incident upon leaving Resident #9's room but did not see a nurse. Certified Nursing Assistant #1 then asked Certified Nursing Assistant #2 to assist them with Resident #157, who was assigned to Certified Nursing Assistant #1. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 did not knock on Resident #157's door and did not inform Resident #157 that they were going to change them. Certified Nursing Assistant #2 stated they turned on the light in Resident # 157's room and observed Certified Nursing Assistant #1 yanking blankets off of Resident #157 without warning. Certified Nursing Assistant #2 stated they observed Certified Nursing Assistant #1 using the resident's arms and legs to move them and did not use the lift pad or draw sheet. Certified Nursing Assistant #2 stated they observed Certified Nursing Assistant #1 pushing and pulling Resident #157's arms and legs roughly when they were moving Resident #157 in their bed. Certified Nursing Assistant #2 stated that Resident #157 said to Certified Nursing Assistant #1 you're hurting me and Certified Nursing Assistant #1 then said to Resident #157, well, you don't want to turn over, with an attitude and Certified Nursing Assistant #1 was pulling roughly on Resident 157's arms. Certified Nursing Assistant # 2 stated they then told Certified Nursing Assistant #1 that they would finish providing care for Resident #157. Certified Nursing Assistant #2 stated they then left Resident #157's room and told Licensed Practical Nurse #1 about what took place with both Resident #9 and Resident #157. Certified Nursing Assistant #2 stated that the next day (3/08/2024) they received a text from Certified Nursing Assistant #1 that read, [curse word] you for reporting me. Certified Nursing Assistant #2 stated they reported this to the Director of Nursing who advised Certified Nursing Assistant #2 to save the text and block Certified Nursing Assistant #1 in their phone.

Resident # 9 was not interviewed regarding the incident due to their severely impaired cognitive skills.

Review of the Accident/Incident report dated 3/07/2024 regarding Resident #9 was reviewed again on 3/19/2024 at 11:00 AM. There was no documentation in Certified Nursing Assistant #2's statements regarding Certified Nursing Assistant #1's actions that were witnessed during care to Resident #157.

Resident # 157 has diagnoses that include Morbid Obesity, Hypertension, and Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 11 which indicated the resident had moderate cognitive impairment. The Minimum Data Set Assessment documented the resident had mood symptoms of depression several (2-6) days, in a fourteen day look back period, and had no behavioral symptoms. The Minimum Data Set Assessment documented Resident #157 required maximum assistance of one person for bed mobility, maximum assistance of 2 for transfers, and ambulated with maximum assistance of one person up to 50 feet with a rolling walker.

A Comprehensive Care Plan for Mood dated 1/12/2024 documented Resident #157 had a history of Depression. Interventions included to provide emotional support, encourage the resident to express feelings, and to engage in social group activities. There were no Comprehensive Care Plan developed for behaviors or resistance to care.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine of Siena Nrsg and Rehab Care Center	52 Route 25a Smithtown, NY 11787

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 - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

The Nursing Progress Notes for Resident #157 were reviewed from 3/06/2024 through 3/09/2024. There was no documentation that an assessment of Resident #157 was conducted.

The Social Work Progress notes for Resident #157 were reviewed from 3/06/2024 through 3/09/2024. There was no documented evidence of the incident or an assessment of the resident.

During an interview on 3/19/2024 at 11:30 AM, Resident #157 stated they remember something took place, a couple of weeks ago, in the middle of the night. Resident #157 stated that two staff members came into their room, like gang busters to change their brief. Resident #157 stated one of them grabbed hold of their arm roughly to move them, and they told them, you're hurting me. Resident #157 stated Certified Nursing Assistant #1 did not care because they continued to do what they had to do. Resident #157 stated they asked Certified Nursing Assistant #2, why are they [Certified Nursing Assistant #1] doing this to me? Resident #157 stated to the surveyor, I guess they (Certified Nursing Assistant #1) were trying to tell me who was the boss. Resident #157 stated they did not tell anyone about this incident because they were afraid of retaliation. Resident #157 stated they, would be afraid if they (Certified Nursing Assistant #1) walked through that door right now.

During an interview on 3/18/2024 at 2:09 PM Licensed Practical Nurse #1 stated that on 3/07/2024 at approximately 5:00 AM - 6:00 AM, Certified Nursing Assistant #2 approached them and stated that Certified Nursing Assistant #1 was rough, and they did not want to work with Certified Nursing Assistant #1 anymore. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 turn Resident #157 too fast and was rough. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #2 told them that Certified Nursing Assistant #1, rushes the residents and did not give Resident #157 time to turn. Licensed Practical Nurse #1 stated that as they were walking away, Certified Nursing Assistant #2 stated, I didn't want to say anything but, [Resident #9] kicked [Certified Nursing Assistant #1] and [Certified Nursing Assistant #1] then slapped [Resident #9] on their leg. Certified Nursing Assistant #2 reported that Certified Nursing Assistant #1 told them, Not to say anything to the nurse. Licensed Practical Nurse #1 stated they then went to assess Resident #9 and then went to the nursing office to find and report the incidents to Registered Nursing Supervisor #1. Licensed Practical Nurse #1 stated that Registered Nursing Supervisor #1 came to the unit to assess both Resident #9 and Resident #157 between 5:30 AM and 6:00 AM.

Registered Nursing Supervisor #1 was interviewed on 3/19/2024 at 4:32 PM and stated they were working the 10:30 PM to 6:30 AM nursing shift on 3/06/2024 - 3/07/2024. Registered Nursing Supervisor #1 stated that at approximately 6:00 AM Licensed Practical Nurse #1 reported to them that Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 slap Resident # 9 and abruptly pulled the blankets off Resident #157 then roughly treated Resident #157 by pulling the resident's arms and legs while turning and positioning them. Registered Nursing Supervisor #1 stated they went to the unit and performed a clinical assessment on both Resident #9 and Resident # 157.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER St Catherine of Siena Nrsg and Rehab Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 52 Route 25a Smithtown, NY 11787	

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Director of Nursing was interviewed on 3/18/2024 at 11:30 AM and stated they received a call on the morning of 3/07/2024 from the Assistant Director of Nursing. The Assistant Director of Nursing informed the Director of Nursing that an incident had occurred that morning where Certified Nursing Assistant #1 slapped Resident #9. The Director of Nursing stated they arrived at the facility shortly after the call and immediately began to conduct an investigation. Certified Nursing Assistant #1 was placed on immediate suspension pending further investigation. The facility's security department was made aware, and a report was filed with the local Police Department. At approximately 9:00 AM - 9 :30 AM on 3/07/2024 the Director of Nursing and Assistant Director of Nursing spoke with Certified Nursing Assistant #1 over the phone to get a statement. Certified Nursing Assistant #1 stated they were busy, unable to talk, ended the call, and has been unreachable since. The Director of Nursing and the Assistant Director of Nursing were interviewed concurrently on 3/19/2024 at 1:22 PM. Certified Nursing Assistant #2 reported that Resident #9 started to kick Certified Nursing Assistant #1 and that is when Certified Nursing Assistant #1 slapped Resident #9 on the left leg with an open hand. Certified Nursing Assistant #2 stated that they told Certified Nursing Assistant #1 not to do that and that Certified Nursing Assistant #1 told Certified Nursing Assistant #2 not to tell anyone. Certified Nursing Assistant #2 told the Director of Nursing that Certified Nursing Assistant #1 was hanging around and that they were looking for the nurse to report the incident but did not see the nurse. After the incident with Resident #9, Certified Nursing Assistant #1 was witnessed by Certified Nursing Assistant #2 roughly handling Resident #157 during care by pulling the resident's arms and legs to turn the resident. Resident #157 verbalized to Certified Nursing Assistant #1 why are you treating me like this and Certified Nursing Assistant #1 responded to Resident #157, because you won't turn. The Director of Nursing stated that Certified Nursing Assistant #2 attempted to locate a nurse after leaving Resident #9's room but did not see the nurse and was then immediately called into Resident #157's room by Certified Nursing Assistant #1. When Certified Nursing Assistant #2 left Resident #157's room they were able to locate Licensed Practical Nurse #1 and reported both incidents. The Director of Nursing stated that all staff should report any concerns related to abuse, neglect, or mistreatment immediately. The Director of Nursing stated that both residents (Resident #9 and Resident #157) were abused by Certified Nursing Assistant #1. The Administrator was interviewed on 3/19/2024 at 3:00 PM. The Administrator stated they were made aware of alleged incidents involving Certified Nursing Assistant #1 and Residents # 9 and #157 the morning of 3/07/2024 by the Director of Nursing, and that they are involved in the Accident/Incident Investigation process. The Administrator stated it is expected that all witnessed instances of abuse must be reported immediately by all staff members. The Administrator stated that after learning further details of what occurred with Resident #157, abuse had occurred. The Medical Director was interviewed on 3/22/2024 at 4:00 PM. The Medical Director stated they do not recall being made aware of the incidents; however, they expect that the facility would notify them or their partner of any instances where a resident may have been physically injured, in order to ensure the resident was medically assessed. 10 NYCRR 415.4(b)(1)(i)

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NAME OF PROVIDER OR SUPPLIER St Catherine of Siena Nrsg and Rehab Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 52 Route 25a Smithtown, NY 11787	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49457 Based on record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00335331) initiated on 3/14/2024 and completed on 3/22/2024 the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than two hours to the New York State Department of Health. This was identified for one (Resident #157) of four residents reviewed for Abuse. Specifically, Certified Nursing Assistant #2 witnessed Certified Nursing Assistant #1 roughly handling Resident #157 during care by abruptly removing Resident #157's blanket and pulling the resident by their arms and legs while turning the resident in bed. Resident #157 complained of pain, yet Certified Nursing Assistant #1 continued to provide care. The facility did not report the allegation of abuse related to Resident #157 to the New York State Department of Health. Cross References: F600 - Free from Abuse and Neglect F610 - Investigate/Prevent/Correct Alleged Violation The finding is: The Abuse Prohibition policy dated 3/11/2023 documented that investigative policies are in place for accidents, incidents, grievances, and complaints and immediate reporting of suspected or actual evidence of abuse to the Administrator, Director of Nursing Services, and Medical Director. All alleged cases of abuse, neglect, or mistreatment will be reported to the Department of Health or any other agency as appropriate by the Administrator and the Director of Nursing Services. The Abuse Prohibition policy also included that as per the Elder Justice Act, if a reasonable suspicion of a crime has been determined either through investigation or witnessed by a covered individual, the suspicion shall be immediately reported to the Administrator, and Director of Nursing Services, Local Law enforcement, and the State Survey Agency (SA)/Department of Health. The Accident/Incident report dated 3/07/2024 documented that at approximately 5:30 AM Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 slap Resident #9 with an open hand on Resident #9's left lower calf. Certified Nursing Assistant #2 told CNA #1, Do not do that. Certified Nursing Assistant #1 responded to Certified Nursing Assistant #2, Do not tell anyone. Certified Nursing Assistant #1 reported this incident to Licensed Practical Nurse #1. Licensed Practical Nurse #1 then reported the incident to Registered Nurse Supervisor #1. Registered Nurse Supervisor #1 interviewed and assessed Resident # 9. Registered Nurse Supervisor #1 documented there was no injury, bruising, redness, or swelling and that Resident #9 had no recollection of the event. The Accident/Incident report documented the Nurse Practitioner was made aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2024 at 10:30 AM Certified Nursing Assistant #2 stated they were assigned to Resident #9 and asked Certified Nursing Assistant #1 to assist them with Resident #9 because the resident can become combative during care. Certified Nursing Assistant #2 stated that they observed Certified Nursing Assistant #1 slap Resident #9 on their left leg. Certified Nursing Assistant #2 stated they yelled at Certified Nursing Assistant #1 not to do that, and Certified Nursing Assistant #1 said, do not say anything. Certified Nursing Assistant #2 stated that they looked for a nurse to report the incident upon leaving Resident #9's room but did not see a nurse. Certified Nursing Assistant #1 then asked Certified Nursing Assistant #2 to assist them with Resident #157, who was assigned to Certified Nursing Assistant #1. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 did not knock on Resident #157's door and did not inform Resident #157 that they were going to change them. Certified Nursing Assistant #2 stated they turned on the light in Resident # 157's room and observed Certified Nursing Assistant #1 yanking blankets off of Resident #157 without warning. Certified Nursing Assistant #2 stated they observed Certified Nursing Assistant #1 using the resident's arms and legs to move them and did not use the lift pad or draw sheet. Certified Nursing Assistant #2 stated they observed Certified Nursing Assistant #1 pushing and pulling Resident #157's arms and legs roughly when they were moving Resident #157 in their bed. Certified Nursing Assistant #2 stated that Resident # 157 said to Certified Nursing Assistant #1 you're hurting me and Certified Nursing Assistant #1 then said to Resident #157, well, you don't want to turn over with an attitude and Certified Nursing Assistant #1 was pulling roughly on Resident 157's arms. Certified Nursing Assistant # 2 stated they then told Certified Nursing Assistant #1 that they would finish providing care for Resident #157. Certified Nursing Assistant #2 stated they then left Resident #157's room and told Licensed Practical Nurse #1 about what took place with both Resident #9 and Resident #157. Certified Nursing Assistant #2 stated that the next day (3/08/2024) they received a text from Certified Nursing Assistant #1 that read, [curse word] you for reporting me. Certified Nursing Assistant #2 stated they reported this to the Director of Nursing who advised Certified Nursing Assistant #2 to save the text and block Certified Nursing Assistant #1 in their phone. Review of the Accident/Incident report dated 3/07/2024 regarding Resident #9 was reviewed again on 3/19/2024 at 11:00 AM. There was no documentation in Certified Nursing Assistant #2's statements regarding Certified Nursing Assistant #1's actions that were witnessed during care to Resident #157. Resident # 157 has diagnoses that include Morbid Obesity, Hypertension, and Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 11 which indicated the resident had moderate cognitive impairment. The Minimum Data Set Assessment documented the resident had mood symptoms of depression several (2-6) days, in a fourteen day look back period, and had no behavioral symptoms. The Minimum Data Set Assessment documented Resident #157 required maximum assistance of one person for bed mobility, maximum assistance of 2 for transfers, and ambulated with maximum assistance of one person up to 50 feet with a rolling walker. A Comprehensive Care Plan for Mood dated 1/12/2024 documented Resident #157 had a history of Depression. Interventions included to provide emotional support, encourage the resident to express feelings, and to engage in social group activities. There were no Comprehensive Care Plan developed for behaviors or resistance to care. The Nursing Progress Notes for Resident #157 were reviewed from 3/06/2024 through 3/09/2024. There was no documentation that an assessment of Resident #157 was conducted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Catherine of Siena Nrsg and Rehab Care Center	52 Route 25a Smithtown, NY 11787

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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The Social Work Progress notes for Resident #157 were reviewed from 3/06/2024 through 3/09/2024. There was no documented evidence of the incident or an assessment of the resident.

During an interview on 3/19/2024 at 11:30 AM, Resident #157 stated they remember something took place, a couple of weeks ago, in the middle of the night. Resident #157 stated that two staff members came into their room, like gang busters to change their brief. Resident #157 stated one of them grabbed hold of their arm roughly to move them, and they told them, you're hurting me. Resident #157 stated Certified Nursing Assistant #1 did not care because they continued to do what they had to do. Resident #157 stated they asked Certified Nursing Assistant #2, why are they [Certified Nursing Assistant #1] doing this to me? Resident #157 stated to the surveyor, I guess they (Certified Nursing Assistant #1) were trying to tell me who was the boss. Resident #157 stated they did not tell anyone about this incident because they were afraid of retaliation. Resident #157 stated they, would be afraid if they (Certified Nursing Assistant #1) walked through that door right now.

During an interview on 3/18/2024 at 2:09 PM Licensed Practical Nurse #1 stated that on 3/07/2024 at approximately 5:00 AM - 6:00 AM, Certified Nursing Assistant #2 approached them and stated that Certified Nursing Assistant #1 was rough, and they did not want to work with Certified Nursing Assistant #1 anymore. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 turn Resident #157 too fast and was rough. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #2 told them that Certified Nursing Assistant #1, rushes the residents and did not give Resident #157 time to turn. Licensed Practical Nurse #1 stated that as they were walking away, Certified Nursing Assistant #2 stated, I didn't want to say anything but, [Resident #9] kicked [Certified Nursing Assistant #1] and [Certified Nursing Assistant #1] then slapped [Resident #9] on their leg. Certified Nursing Assistant #2 reported that Certified Nursing Assistant #1 told them, Not to say anything to the nurse. Licensed Practical Nurse #1 stated they went to the nursing office to find and report the incidents to Registered Nursing Supervisor #1. Licensed Practical Nurse #1 stated that Registered Nursing Supervisor #1 came to the unit to assess both Resident #9 and Resident #157 between 5:30 AM and 6:00 AM.

Registered Nursing Supervisor #1 was interviewed on 3/19/2024 at 4:32 PM and stated they were working the 10:30 PM to 6:30 AM nursing shift on 3/06/2024 - 3/07/2024. Registered Nursing Supervisor #1 stated that at approximately 6:00 AM Licensed Practical Nurse #1 reported to them that Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 slap Resident # 9 and abruptly pulled the blankets off Resident #157 then roughly treated Resident #157 by pulling the resident's arms and legs while turning and positioning them. Registered Nursing Supervisor #1 stated they went to the unit and performed a clinical assessment on both Resident #9 and Resident # 157. Registered Nurse Supervisor #1 stated they reported the incident to the Nursing Administration and did not initiate an investigation for Resident #157.

The Director of Nursing and the Assistant Director of Nursing were interviewed concurrently on 3/19/2024 at 1:22 PM. Certified Nursing Assistant #1 was witnessed by Certified Nursing Assistant #2 roughly handling Resident #157 during care by pulling the resident's arms and legs to turn the resident. Resident #157 verbalized to Certified Nursing Assistant #1 why are you treating me like this and Certified Nursing Assistant #1 responded to Resident #157, because you won't turn. The Director of Nursing stated they did not report the incident related to Resident #157 to the New York State Department of Health because they were not told of the arm pulling and resident's verbalization of pain.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER St Catherine of Siena Nrsg and Rehab Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 52 Route 25a Smithtown, NY 11787	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 3/19/2024 at 3:00 PM. The Administrator stated they were made aware of alleged incidents involving Certified Nursing Assistant #1 and Residents # 9 and #157 the morning of 3/07/2024 by the Director of Nursing, and that they are involved in the Accident/Incident Investigation process. The Administrator stated it is expected that all witnessed instances of abuse must be reported immediately by all staff members. The Administrator stated that after learning further details of what occurred with Resident #157, abuse had occurred. The Administrator stated they did not report the incident related to Resident #157 to the New York State Department of Health because they were not told of the arm pulling and resident's verbalization of pain. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49457 Based on record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00335331) initiated on 3/14/2024 and completed on 3/22/2024 the facility did not initiate and complete an investigation of an alleged violation of abuse. This was identified for one (Resident #157) of four residents reviewed for Abuse. Specifically, on 3/07/2024 at approximately 6:00 AM Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 abruptly removing the blanket from Resident #157 and startled the resident. Certified Nursing Assistant #1 then roughly pulled Resident # 157's arms and legs during care. The facility did not investigate the incident related to Resident #157. Cross References: F600 - Free from Abuse and Neglect F609 - Reporting of Alleged Violations The finding is: The Abuse Prohibition policy dated 3/11/2023 documented the facility has policies and procedures in place to ensure that all accidents/incidents are fully investigated. The investigative process includes review of all accidents and incidents by designated managerial and administrative personnel. Accidents/incidents, complaints, grievances, and data collection are tracked within the facility to identify patterns and trends that may require further review and investigation, especially if they reveal potential issues of abuse. Investigative policies are in place for accidents, incidents, grievances, and complaints and immediate reporting of suspected or actual evidence of abuse to the Administrator, Director of Nursing Services, and Medical Director. Additional notifications will occur as deemed necessary through the investigative process. Resident # 157 has diagnoses that include Morbid Obesity, Hypertension, and Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 11 which indicated the resident had moderate cognitive impairment. The Minimum Data Set Assessment documented the resident had mood symptoms of depression several (2-6) days, in a fourteen-day look back period, and had no behavioral symptoms. The Minimum Data Set Assessment documented Resident #157 required maximum assistance of one person for bed mobility, maximum assistance of 2 for transfers, and ambulated with maximum assistance of one person up to 50 feet with a rolling walker. A Comprehensive Care Plan for Mood dated 1/12/2024 documented Resident #157 had a history of Depression. Interventions included to provide emotional support, encourage the resident to express feelings, and to engage in social group activities. There were no Comprehensive Care Plan developed for behaviors or resistance to care. The Nursing Progress Notes for Resident #157 were reviewed from 3/06/2024 through 3/09/2024. There was no documentation that an assessment of Resident #157 was conducted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Work Progress notes for Resident #157 were reviewed from 3/06/2024 through 3/09/2024. There was no documented evidence of the incident or an assessment of the resident. During an interview on 3/19/2024 at 10:30 AM Certified Nursing Assistant #2 stated Certified Nursing Assistant #1 asked Certified Nursing Assistant #2 to assist them with Resident #157, who was assigned to Certified Nursing Assistant #1. Certified Nursing Assistant #2 stated that Certified Nursing Assistant #1 did not knock on Resident #157's door and did not inform Resident #157 that they were going to change them. Certified Nursing Assistant #2 stated they turned on the light in Resident # 157's room and observed Certified Nursing Assistant #1 yanking blankets off of Resident #157 without warning. Certified Nursing Assistant #2 stated they observed Certified Nursing Assistant #1 using the resident's arms and legs to move them and did not use the lift pad or draw sheet. Certified Nursing Assistant #2 stated they observed Certified Nursing Assistant #1 pushing and pulling Resident #157's arms and legs roughly when they were moving Resident #157 in their bed. Certified Nursing Assistant #2 stated that Resident #157 said to Certified Nursing Assistant #1 you're hurting me and Certified Nursing Assistant #1 then said to Resident #157, well, you don't want to turn over, with an attitude and Certified Nursing Assistant #1 was pulling roughly on Resident 157's arms. Certified Nursing Assistant # 2 stated they then told Certified Nursing Assistant #1 that they would finish providing care for Resident #157. Certified Nursing Assistant #2 stated they then left Resident #157's room and told Licensed Practical Nurse #1 about what took place with both Resident #9 and Resident #157. During an interview on 3/18/2024 at 2:09 PM Licensed Practical Nurse #1 stated that on 3/07/2024 at approximately 5:00 AM - 6:00 AM, Certified Nursing Assistant #2 approached them and stated that Certified Nursing Assistant #1 was rough, and they did not want to work with Certified Nursing Assistant #1 anymore. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 turn Resident #157 too fast and was rough. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #2 told them that Certified Nursing Assistant #1, rushes the residents and did not give Resident #157 time to turn. Licensed Practical Nurse #1 stated that as they were walking away, Certified Nursing Assistant #2 stated, I didn't want to say anything but, [Resident #9] kicked [Certified Nursing Assistant #1] and [Certified Nursing Assistant #1] then slapped [Resident #9] on their leg. Certified Nursing Assistant #2 reported that Certified Nursing Assistant #1 told them, Not to say anything to the nurse. Licensed Practical Nurse #1 stated they then went to assess Resident #9 and then went to the nursing office to find and report the incidents to Registered Nursing Supervisor #1. Licensed Practical Nurse #1 stated they returned to the unit with the Accident/Incident paperwork but tried to hide the paperwork because they did not want Certified Nursing Assistant #1 to see it. Licensed Practical Nurse #1 stated they asked Certified Nursing Assistant #2 to write a statement. Licensed Practical Nurse #1 stated that Registered Nursing Supervisor #1 came to the unit to assess both Resident #9 and Resident #157 between 5:30 AM and 6:00 AM. Review of the Accident/Incident report dated 3/07/2024 regarding Resident #9 was reviewed again on 3/19/2024 at 11:00 AM. There was no documentation in Certified Nursing Assistant #2's statements regarding Certified Nursing Assistant #1's actions that were witnessed during care to Resident #157. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2024 at 11:30 AM, Resident #157 stated they remember something took place, a couple of weeks ago, in the middle of the night. Resident #157 stated that two staff members came into their room, like gang busters to change their brief. Resident #157 stated one of them grabbed hold of their arm roughly to move them, and they told them, you're hurting me. Resident #157 stated Certified Nursing Assistant #1 did not care because they continued to do what they had to do. Resident #157 stated they asked Certified Nursing Assistant #2, why are they [Certified Nursing Assistant #1] doing this to me? Resident #157 stated to the surveyor, I guess they (Certified Nursing Assistant #1) were trying to tell me who was the boss. Resident #157 stated they did not tell anyone about this incident because they were afraid of retaliation. Resident #157 stated they, would be afraid if they (Certified Nursing Assistant #1) walked through that door right now. Registered Nursing Supervisor #1 was interviewed on 3/19/2024 at 4:32 PM and stated they were working the 10:30 PM to 6:30 AM nursing shift on 3/06/2024 - 3/07/2024. Registered Nursing Supervisor #1 stated that at approximately 6:00 AM Licensed Practical Nurse #1 reported to them that Certified Nursing Assistant #2 observed Certified Nursing Assistant #1 slap Resident # 9 and abruptly pulled the blankets off Resident #157 then roughly treated Resident #157 by pulling the resident's arms and legs while turning and positioning them. Registered Nursing Supervisor #1 stated they went to the unit and performed a clinical assessment on both Resident #9 and Resident # 157. Registered Nursing Supervisor #1 further stated that they did not initiate an investigation related to the incident with Resident #157. The Director of Nursing and the Assistant Director of Nursing were interviewed concurrently on 3/19/2024 at 1:22 PM. Certified Nursing Assistant #2 reported that Resident #9 started to kick Certified Nursing Assistant #1 and that is when Certified Nursing Assistant #1 slapped Resident #9 on the left leg with an open hand. Certified Nursing Assistant #2 stated that they told Certified Nursing Assistant #1 not to do that and that Certified Nursing Assistant #1 told Certified Nursing Assistant #2 not to tell anyone. After the incident with Resident #9, Certified Nursing Assistant #1 was witnessed by Certified Nursing Assistant #2 roughly handling Resident #157 during care by pulling the resident's arms and legs to turn the resident. Resident #157 verbalized to Certified Nursing Assistant #1 why are you treating me like this and Certified Nursing Assistant #1 responded to Resident #157, because you won't turn. When Certified Nursing Assistant #2 left Resident #157's room they were able to locate Licensed Practical Nurse #1 and reported both incidents. The Director of Nursing stated that both residents (Resident #9 and Resident #157) were abused by Certified Nursing Assistant #1 and an investigation should have been completed for Resident #157. 10 NYCRR 415.4(b)(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observation, record review, and interviews during Recertification Survey initiated on [DATE] and completed on [DATE] the facility did not ensure each resident's Comprehensive Care Plan was reviewed and revised to reflect the current needs of the resident. This was identified for one (Resident #178) of five residents reviewed for care planning care area. Specifically, Resident #178's Comprehensive Care Plan was not updated to reflect a change in the resident's Advance Directives from a Full Code status (Cardio Pulmonary Resuscitation-CPR) to a Do Not Resuscitate (DNR) status. The finding is: The facility's policy titled, Clinical Records: Comprehensive Care Planning effective [DATE] documented the interdisciplinary care plans will be individualized to meet resident-specific needs. Resident #178 was admitted with diagnoses that included Atrial Fibrillation, Syncope and Collapse. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #178's Brief Interview for Mental Status score was 12 which indicated the resident had moderately impaired cognition. Resident #178 was observed in the dining room sitting in their (Resident#178) wheelchair on [DATE] at 2:40 PM participating in a recreational activity. The physician's order dated [DATE] documented the resident's Code Status: Do Not Resuscitate (DNR- is a legal document a person has decided not to have Cardiopulmonary Resuscitation attempted on them if their heart or breathing stops). The Comprehensive Care Plan for Advanced Directives dated [DATE] documented that Resident #178 was a Full code (Cardio Pulmonary Resuscitation). The care plan was updated on [DATE] to indicate the resident's Advance Directive was now Do Not Resuscitate, 21 days after the physician's order was obtained. Registered Nurse Manager #3 was interviewed on [DATE] at 2:03 PM and stated that Resident #178's Advanced Directive status was changed to Do Not Resuscitate on [DATE]. Registered Nurse Manager #3 stated that they put the physician's order for Do Not Resuscitate in the resident's Electronic Medical Record on [DATE] and notified Social Worker #1 of the changes in the resident's Advance Directives on [DATE]. Registered Nurse Manager #3 stated Social Worker #1 was responsible for updating the Advanced Directive Care Plan. Social Worker #1 was interviewed on [DATE] at 2:23 PM and stated that they were informed by Registered Nurse Manager #3 on [DATE] regarding Resident #178's Advanced Directive status change to Do Not Resuscitate and they (Social Worker #1) forgot to update the resident's care plan. The Director of Nursing Services was interviewed on [DATE] at 3:44 PM and stated that the social workers were responsible for initiating and updating the Advanced Directive care plans and that Social Worker #1 should have updated Resident #178's care plan on [DATE] to reflect the accurate Advance Directive status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.11(c)(2)(i-iii)