STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335839	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, record reviews and interviews during survey, the facility failed to protect a resident from abuse, psychosocial harm, and to respond appropriately following an allegation of staff-to-resident sexual abuse for one of 16 sampled residents (Resident #1) reviewed for abuse. Specifically, on 06/20/2026 Resident #1 alleged Certified Nursing Assistant #1 raped them while providing incontinence care, and the facility failed to implement interventions to address Resident #1's physical and psychosocial needs. Resident #1 remained in the facility for five and a half hours following the allegation without documentation of a medical or psychosocial assessment. This resulted in actual harm to Resident #1 that was Immediate Jeopardy and likely placed other vulnerable residents at risk for serious harm, serious injury, serious impairment, or death. The Finding is: The facility policy titled Abuse and Neglect Policy reviewed on 06/20/2026, documented all alleged incidents of abuse and or neglect will be investigated. Injuries of unknown origin will be investigated to rule out abuse neglect or mistreatment. The administrator and director of nursing will be immediately notified of any alleged or suspected occurrence of abuse or neglect the administrator, or designee will provide a two-hour notification to the New York State Department of Health for any alleged or suspected or confirmed case of abuse or neglect. Abuse is defined by the willful infliction of injury, unreasonable confinement, intimidation or punishment which also result in physical harm pain or mental anguish. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault. If there are reasons to suspect abuse or neglect, the facility will report the ongoing investigation to the Department of Health within two hours whether the internal investigation is complete, the facility will take prompt action to protect the residents during the investigation. Resident#1 was admitted with diagnoses that include obstructive and reflux uropathy, hemiplegia and hemiparesis following cerebral infarction Resident #1's Minimum Data Set (a resident assessment tool) dated 06/02/2026 documented a Brief Interview for Mental Status score of 15 indicating intact cognition, bed mobility of one assist, toileting and transfer assist of two. Resident #1's Comprehensive Care Plan titled Psychosocial Well-Being dated 06/04/2026 documented interventions of orient resident to environment, staff and facility routines. Introduce to compatible peers. Provide opportunities to ventilate feelings, needs, and concerns. Address and validate concerns. Elicit family input as needed. The facility's Accident/Incident report dated 06/20/2026 at 6:30 AM, documented Resident #1 made an allegation to Licensed Practical Nurse #1 that they were raped by Certified Nursing Assistant #1. Assessment was done by Registered Nurse Supervisor #1 and there was redness in the perineal area. The facility concluded that abuse did not occur because of conflicting statements provided by Resident #1. A statement signed by Licensed Practical Nurse #1 dated 06/20/2026 documented that, Resident #1 stated I was raped. Licensed Practical Nurse #1 asked Are you sure? That's a serious allegation. Resident #1 responded with agitation. I know what it feels like. I want to call my sister. She is a cop. I then said, Let me get a supervisor. I called downstairs and spoke with a supervisor. When the supervisor arrived, we both entered the room and Resident #1 stated while they (Certified Nursing Assistant #1) were cleaning me, they were rough with me all up in the front, I even screamed. Resident #1 was eager to show their bottom at that time. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	They were composed but upset. A nursing progress note dated 06/20/2026, edited 06/21/2026, documented Resident #1 complained of burning sensation to the sacral and vaginal area after incontinence care. Resident #1 noted with confusion, and accusatory behavior towards care. Director of Nursing Services aware. No male caregiver, and two-person approach initiated this time. Video surveillance reviewed on 06/26/2026 at 9:44 AM with Administrator, revealed that on 06/20/2026 at 4:43 AM Certified Nursing Assistant #1, who was identified by Administrator, entered Resident#1's room and exited at 5:19 AM removing trash and linen. Certified Nursing Assistant #1 spent a total of thirty-six (36) minutes in Resident #1's room. During an interview on 06/25/2026 at 8:55 AM with Certified Nursing Assistant #1, they stated they provided incontinence care to Resident #1 at approximately 4:30 AM and recalled Resident #1 had scabs on their sacrum and complained of vaginal itching and burning. They applied ointment A and D to the Resident's pubis bone, crease of their groin and in their vagina. They stated they applied the ointment anywhere they observed pink skin. Certified Nursing Assistant #1 stated, I did not do anything more than she asked for. They stated they were in the room for over 30 minutes because the resident had multiple bowel movements. They stated that at approximately 6:30 AM, they were removed from shift due to an allegation made by Resident #1. Resident #1's bowel record was reviewed for 06/20/2026, and there was no documented evidence that multiple bowel movements were recorded. During an interview on 06/25/2026 at 1:33 PM with Family Member #1, they stated they received a call from Resident #1 at approximately 7:00 AM and returned Resident #1's call at 9:45 AM. Resident #1 was hysterically crying and stated, You need to come here now. Family Member #1 arrived at the facility and stated Resident #1 was still hysterically crying and stated that a staff member had raped them. Family Member #1 immediately contacted law enforcement and requested Resident #1 be sent to the hospital. They stated Resident #1 was sent to the hospital at 12:00 PM on 06/20/2026. They stated Resident #1 has remained tearful and is not eating. They stated that due to Resident #1's diagnosis, they require long term skilled nursing care and now are fearful and distrusting of facility staff. During an interview on 06/25/2026 at 2:55 PM with Resident #1, while they were in the hospital, they stated Certified Nursing Assistant #1 came in to change their brief because they were wet and had a small bowel movement. Resident #1 stated Certified Nursing Assistant #1 offered to apply cream to their skin tear on their hip. They stated Certified Nursing Assistant #1 began to apply the cream to their hip and then began to apply the cream to their anus and then applied the cream to their vaginal area. They stated they did not ask Certified Nursing Assistant #1 to apply the cream to the vaginal area, there was no pain or burning in their vagina or perineal area prior to the application. They stated they told Certified Nursing Assistant #1 that they were hurting them, and Certified Nursing Assistant #1 apologized and made a moaning sound. They stated they were positioned on their side and could not visualize Certified Nursing Assistant #1. Resident #1 stated they felt, something enters their anus and vagina, it felt soft but was unsure if it was Certified Nursing Assistant #1's finger or penis. They stated it has never taken 25 minutes to clean them after a bowel movement. They stated they asked them to stop. They stated that Certified Nursing Assistant #1 then went into Resident #1's bathroom and adjusted their pants and used tissues and then took the garbage out of the bathroom and took the linens and left the room. Resident #1 stated when they reported the incident to Licensed Practical Nurse #1, they replied, they (Certified Nursing Assistant #1) would not do such a thing like that. They stated when law enforcement arrived, they asked them what happened, but they were males and the nursing supervisor that was present was a male, and they felt embarrassed and ashamed, so they reported that Certified Nursing Assistant #1 was rough. Resident #1 stated they are not sleeping or eating well and felt afraid of returning to another healthcare facility. Throughout the interview with Resident #1, while they were describing the incident, Resident #1 became distressed and tearful with noticeable cracking and trembling in their voice. They paused several times throughout the interview to regain their composure. Resident #1 verbalized a growing fear and distrust of facility staff, loss of appetite, and being frightened to return to a healthcare facility. There is no documented evidence Resident #1 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was assessed for fear, anxiety, emotional trauma or other psychosocial effects following the alleged sexual abuse allegation. During an interview on 06/26/2026 at 11:39 AM with the Director of Nursing Services, they stated Family Member #1 called local law enforcement and alleged that Resident #1 was sexually assaulted by a staff member. Certified Nursing Assistant #1 was immediately removed from their shift. Resident #1 reported to local law enforcement that Certified Nursing Assistant #1 was rough during care. The Director of Nursing Services stated due to the change of the allegation, they did not feel that the incident rose to the threshold of reporting to the Department of Health or local law enforcement. The Director of Nursing Services stated rough care can cause psychosocial issues and fear of care. The Director of Nursing Services stated Resident #1 should have had a psychosocial assessment but there was no social worker available. During an interview on 06/25/2026 at 11:51 AM with Administrator, they stated they were made aware of the incident on 06/20/2026 at 9:35 AM. They stated Resident #1 told the Licensed Practical Nurse #1 on shift they were raped and then told the Nursing Supervisor #1 it was rough handling. They stated law enforcement was contacted by the resident's family. They stated it was not reported to the New York State Department of Health because Resident #1 stated it was rough handling during care, and that is subjective. They believe it could be that Resident #1's skin was sensitive because of the numerous bowel movements. They stated the allegation is subjective and Resident #1 retracted their statement which did not require an assessment. During an interview on 06/26/2026 at 2:28 PM with Primary Care Physician #1, they stated they were not informed of the allegation until Resident #1 was transferred to the hospital. They stated that initially, they were told that it was rough handling, then the family member called law enforcement. Primary Care Physician #1 stated the facility should have called law enforcement and the Department of Health if the allegation was rape. Primary Care Physician #1 stated that a psychosocial assessment should have been conducted after Resident #1 made the allegation to nursing staff. During an interview on 07/02/2026 at 9:36 AM with Social Worker #1, they stated they were the assigned social worker for Resident #1. They stated they were made aware of the incident after it occurred. They stated that since Resident #1 was alert and oriented, they would not have recommended a psychosocial assessment be completed. They stated they did not know if any interventions should be put in place following the allegation, because they lacked experience with this type of allegation. 10 NYCRR 415.4(a)(7)(b)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews during survey, the facility failed to ensure that alleged violations involving abuse, neglect, exploitation or mistreatment were reported to the Department of Health and local law enforcement no later than two hours after the allegations were made. This was identified for one resident (Resident#1) of 16 residents. Specifically, Resident#1 alleged that on 06/20/2026, Certified Nursing Assistant #1 sexually abused them while providing care. There is no documented evidence that the alleged sexual abuse was reported to local law enforcement or the New York State Department of Health as required. The facility's failure to report the incident to the New York State Department of Health posed the likelihood of harm to Resident #1 which was immediate Jeopardy and potential for harm to the other 16 residents.The findings are:The facility policy titled Abuse and Neglect, dated 04/22/2026 and reviewed June 2026, documented alleged incidents of abuse and neglect will be investigated and injuries of unknown origin will be investigated to rule out abuse, neglect, or mistreatment. The Administrator and Director of Nursing will be immediately notified of any alleged or suspected occurrence of abuse or neglect. The administrator or designee will provide a 2-hour notification to the New York State Department of Health for any alleged or suspected or confirmed case of abuse or neglect.Resident #1 was admitted to the facility with diagnosis that include obstructive and reflux uropathy (a structural or functional blockage of the urinary tract that prevents urine from flowing freely), hemiplegia (complete all partial paralysis on one side of the body) and hemiparesis (muscular weakness or partial paralysis affecting only one side of the body) following cerebral infarction(death of brain tissue caused by a prolonged lack of blood and oxygen supply) .The Minimum Data Set (a resident assessment tool) dated 05/22/2026 documented a Brief Interview for Mental Status score of 15, indicating intact cognition.A Comprehensive Care Plan titled Altered Health maintenance initiated 05/18/2026 documented the resident requires assistance with Activities of Daily Living. The Comprehensive Care Plan documented interventions that Resident #1 requires two staff members for transfers and toileting. Resident #1 also requires extensive assistance of one for dressing, bathing, grooming, and bed mobility.A facility's Accident/Incident report dated 06/20/2026 at 6:30 AM, documented Resident #1 made an allegation to Licensed Practical Nursing #1 that they were raped by Certified Nursing Assistant #1. A skin assessment was completed by Registered Nurse Supervisor #1. There is no documented evidence that the facility reported the allegation of sexual abuse to local law enforcement or the New York State Department of Health within two hours as required.During an interview on 06/25/2026 at 8:55 AM with Certified Nursing Assistant #1, they stated they provided incontinence care to Resident #1 at approximately 4:30 AM on 06/20/2026. Certified Nursing Assistant #1 stated that Resident #1 had scabs on their sacrum and complained of vaginal itching and burning and they applied A and D ointment to Resident #1's perianal area. Certified Nursing Assistant #1 stated I did not do anything more than Resident #1 asked for.During an interview on 06/25/2026 at 1:33 PM with Family Member #1, they stated they received a call from their family member (Resident #1) at approximately 7:00 AM and returned their family member's call at 9:45 AM. Resident #1 stated, You need to come here now. When Family Member #1 arrived at the facility approximately 11:00 AM, the resident was hysterically crying and stated that a staff member had raped her. Family member #1 immediately contacted law enforcement and requested that the resident be sent to the hospital.During an interview via telephone on 06/25/2026 at 2:55 PM, Resident #1 who was present with Family Member #1 at the hospital stated Certified Nursing Assistant #1 came into their room to change their brief because they were wet. Resident #1 stated Certified Nursing Assistant #1 began to apply cream to their hip and then begin to apply the cream to their anus and vaginal area. They stated they told Certified Nursing Assistant #1 that they were hurting them, and Certified Nursing Assistant #1 apologized and made a moaning sound. Resident #1 stated they felt, something enter their anus and vagina, it felt soft but was unsure (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	if it was Certified Nursing Assistant #1's finger or penis. Resident #1 stated Certified Nursing Assistant #1 took a very long time to provide care and then they felt burning in their vaginal area after the care. Resident #1 stated they asked Certified Nursing Assistant #1 to stop, but they did not stop. Resident #1 stated when law enforcement arrived, they (law enforcement) asked them what happened. Resident #1 stated they were male law enforcement officers, and the nursing supervisor was also present who was a male, so Resident #1stated they were embarrassed and ashamed and did not want to talk about the rape with them so Resident #1stated they only reported that Certified Nursing Assistant #1 was rough with them. Resident #1 stated they are not sleeping well because of this incident and were emotionally distraught and tearful with cracks in their voice during this interview.During an interview on 06/25/2026 at 9:00AM with the Director of Nursing Services, they stated Family Member #1 called Local Law Enforcement and alleged that their family member was sexually assaulted by a staff member. Director of Nursing Services stated they did not speak to Resident #1 about the incident, but that Resident #1 reported to local law enforcement that Certified Nursing Assistant #1 was rough with them during care nothing about the alleged rape. Director of Nursing Services stated due to the change in the allegation, they did not feel that the incident rose to the threshold of reporting to the New York State Department of Health.During an interview on 06/25/2026 at 11:51 AM with the Administrator, they stated they were aware of an incident on 06/20/2026 at 9:35 AM involving Certified Nursing Assistant #1 and Resident #1. They stated Resident #1 told a nurse they were raped, but then they told the (male) Nursing Supervisor #1 it was rough handling. The Director of Nursing suspended Certified Nursing Assistant #1 because Resident #1 alleged that Certified Nursing Assistant #1 raped them. The Administrator stated they did not report the alleged rape to the New York State Department of Health because they felt that rough handling was subjective and it was the perception of the resident (resident #1).During an interview on 06/25/2026 at 2:02 PM with Primary Care Physician #1, they stated they were contacted 06/20/2026 when Resident #1 was being transferred to the hospital. Primary Care Physician #1 stated Resident #1 made an allegation they were raped. They stated that initially they were told it was rough handling. Primary Care Physician #1 stated the facility should call law enforcement and the Department of Health if Resident #1 alleged they were raped.Video surveillance was reviewed on 06/26/2026 at 9:44 AM and revealed that on 06/20/26 at 4:43 AM, Certified Nursing Assistant #1 entered Resident #1's room and exited at 5:19 AM, removing trash and linen.During an interview on 07/03/2026 at 2:33 PM with Social Worker #1, they stated they were informed about the incident on 06/22/2026 by their supervisor and were under the impression that the incident had been reported to a higher authority, but they did not ask who it was reported to. Social Worker #1 stated they should have asked and if it was not reported appropriately, they should have spoken with Resident #1 and reported the incident of alleged rape to the Department of Health. 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. Based on observations, interviews, and record review during the abbreviated survey (Intake # 3052049) the facility failed to conduct a thorough investigation of an allegation of staff to resident abuse for 1 of 1 sampled resident reviewed for abuse. Specifically, Resident #1 alleged a Certified Nursing Assistant raped them while providing incontinence care. The facility's investigative report revealed no written or recorded statement from the resident detailing the allegation, which limited the facility's ability to objectively investigate the allegation. The facility's reported that Resident #1 changed their description of the allegation and the facility reached a conclusion rather than completing a comprehensive investigation of all evidence. Based on observations, interviews, and record review during the abbreviated survey (Intake # 3052049) the facility failed to conduct a thorough investigation of an allegation of staff to resident abuse for 1 of 1 sampled resident reviewed for abuse. Specifically, Resident #1 alleged a Certified Nursing Assistant raped them while providing incontinence care. The facility's investigative report revealed no written or recorded statement from the resident detailing the allegation, which limited the facility's ability to objectively investigate the allegation. The facility's reported that Resident #1 changed their description of the allegation and the facility reached a conclusion rather than completing a comprehensive investigation of all evidence. The findings are: The facility policy titled Abuse and Neglect Policy reviewed on 06/20/2026, documented all alleged incidents of abuse and or neglect will be investigated to rule out abuse neglect or mistreatment. The administrator and director of nursing will be immediately notified of any alleged or suspected occurrence of abuse or neglect, and the administrator or designee will provide a 2-hour notification to the New York State Department of Health for any alleged, suspected or confirmed case of abuse or neglect. Abuse is defined by the willful infliction of injury, unreasonable confinement, intimidation or punishment which also result in physical harm, pain or mental anguish. Sexual abuse is defined, which includes but is not limited to sexual harassment, sexual coercion, or sexual assault. If there are reasons to suspect abuse or neglect the facility will report the ongoing investigation to the Department of Health within two hours whether the internal investigation is complete, the facility will take prompt action to protect the residents during the investigation. Resident#1 was admitted with diagnoses that include obstructive and reflux uropathy, hemiplegia and hemiparesis following cerebral infarction and had intact cognition. There was no documented evidence related to the allegations made by the Resident #1 regarding the alleged rape. Resident #1 alleges that on 06/20/2026, Certified Nursing Assistant #1 raped them while providing care. They stated that while Certified Nursing Assistant #1 was changing their incontinence brief, they felt something soft enter their vagina and anus. Resident #1 stated they were unsure if it was Certified Nursing Assistant #1's finger or penis. Resident #1 alleged Certified Nursing Assistant #1 touched and rubbed their genital and anal area and that made them feel unsafe in the facility. Video surveillance revealed that on 06/20/2026 at 4:43 AM Certified Nursing Assistant #1 entered Resident#1's room and exited at 5:19 AM removing trash and linen. The facility's Accident /Incident report dated 06/20/2026 at 6:30 AM documented Resident #1 made an allegation to Licensed Practical Nurse #1 that they were raped by Certified Nursing Assistant #1. An assessment was completed by Registered Nurse Supervisor #1 and there was redness noted in the perineal area. The Accident /Incident report documented the facility concluded that abuse did not occur because of conflicting statements provided by Resident #1. A statement signed by Licensed Practical Nurse #1 dated 06/20/2026 documented that, Resident #1 stated to them I was raped. Licensed Practical Nurse #1 asked are you sure that's a serious allegation? Resident#1 responded with agitation. I know what it feels like, I want to call my sister, she is a cop. I then said to Resident #1 Let me get a supervisor, when the supervisor arrived, we both entered the resident's room and the residence stated while he was cleaning me Certified Nursing Assistant #1 was rough with me all up in the front. A telephone statement from Registered Nurse Supervisor #1 dated 06/23/2026 documented Resident #1 accused Certified Nursing Assistant #1 of rape. Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 stated that Certified Nursing Assistant #1 touched her vagina during application of cream in sacral area. Resident #1 complained that her vagina hurt and that while Certified Nursing Assistant #1 was cleaning her, he was very rough. Resident #1 complained of a burning sensation to their sacral and vaginal areas. Resident #1's skin noted to be intact, with no new skin alteration at this time. During an interview on 06/25/2026 at 8:55AM with Certified Nursing Assistant #1, they stated they provided incontinence care to Resident #1 at approximately 4:30 AM on 06/20/2026 and recalled Resident #1 had scabs on their sacrum and complained of vaginal itching and burning. Certified Nursing Assistant #1 stated they applied A and D ointment to the resident's perineal area. Certified Nursing Assistant #1 stated, I did not do anything more than they asked for. They stated that at approximately 6:30AM they were removed from shift due to an allegation made by Resident #1. During an interview on 06/25/2026 at 9:00AM with Family Member #1, they stated they received a call from Resident #1 at who stated, you need to come here now. Family member #1 arrived at the facility approximately 11:00 AM on 06/20/2026 and stated the resident was hysterically crying and stated that a staff member had raped them. Family Member #1 immediately contacted law enforcement and requested Resident #1 be sent to the hospital. During an interview on 06/25/2026 at 9:10 AM with Resident #1 they stated Certified Nursing Assistant #1 came in to change their brief because they were wet. Resident #1 stated Certified Nursing Assistant #1 began to apply cream to their hip and then began to apply the cream to their anus and then applied the cream to their vaginal area. They stated they told the Certified Nursing Assistant #1 that they were hurting them, and the Certified Nursing Assistant apologized and made a moaning sound. Resident #1 stated they felt, something enters their anus and vagina, it felt soft but was unsure if it was the Certified Nursing Assistant's finger or penis. They stated Certified Nursing Assistant #1 took a very long time to provide care and then they felt burning in their vaginal area. They stated they asked them to stop but they did not. The resident then informed Family Member #1 and when law enforcement arrived, they asked them what happened, but two male law enforcement offices came, and the (male) nursing supervisor was also present, so they felt embarrassed and ashamed, that is why they reported that the aide was rough instead of telling them they were allegedly raped. Resident #1 stated they are not sleeping well and feel afraid of returning to the facility. The resident requested to go to another healthcare facility. During an interview on 06/29/2026 at 1:55 PM with Nursing Supervisor#1 they stated they were notified by Licensed Practical Nurse #1 that Resident #1 reported that they were raped. Upon becoming aware of the allegation, they completed an assessment of the resident. Resident#1 stated that Certified Nursing Assistant #1 was applying cream during care, and the resident felt the cream went into their vagina, and they felt Certified Nursing Assistant #1's hand went into their vagina. Nursing Supervisor#1 stated they did not obtain or document any statements from Resident #1. During an interview on 06/26/2026 at 11:39AM with Director of Nursing Services they stated they were notified of the allegation in the morning on 06/20/2026 from Nursing Supervisor who told them Resident #1 made a complaint of roughness during care. The Director of Nursing Services stated the facility did obtain a statement from the Resident#1. 10 NYCRR 415.4(b)(3)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews during the abbreviated Survey the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for (1) (Resident #1), of sixteen residents. Specifically, the facility failed to ensure that alleged violations involving sexual abuse, neglect, exploitation or mistreating are reported immediately or not later than 2 hours to the Department of Health and Local Law Enforcement after the allegations are made. Additionally, the alleged incident Caused Resident #1 psychosocial harm. The facility failed to protect Resident #1 by allowing male Nursing Supervisor#1 to perform a nursing assessment with no other staff member with them after the alleged rape allegation incident. Additionally, the facility did not provide a social worker visit or psychosocial interventions to Resident #1.Refer to F600 and F609: Scope and Severity of J.Based on observations, record review and interviews during the abbreviated Survey the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for (1) (Resident #1), of sixteen residents. Specifically, the facility failed to ensure that alleged violations involving sexual abuse, neglect, exploitation or mistreating are reported immediately or not later than 2 hours to the Department of Health and Local Law Enforcement after the allegations are made. Additionally, the alleged incident Caused Resident #1 psychosocial harm. The facility failed to protect Resident #1 by allowing male Nursing Supervisor#1 to perform a nursing assessment with no other staff member with them after the alleged rape allegation incident. Additionally, the facility did not provide a social worker visit or psychosocial interventions to Resident #1.Refer to F600 and F609: Scope and Severity of J.The findings are: The facility policy titled Facility Abuse and Neglect policy dated 4/22/2026 and reviewed on 06/2026 documented alleged incidents of abuse and neglect will be investigated injuries of unknown origin will be investigated to rule out abuse neglect or mistreatment. The administrator and director of nursing will be immediately notified of any alleged or suspected occurrence of abuse or neglect. The administrator or designee will provide a 2-hour notification to the New York State Department of Health for any alleged or suspected or confirmed case of abuse or neglect.Resident #1 was admitted to the facility on [DATE] with diagnosis that include obstructive and reflux uropathy(a structural or functional blockage of the urinary tract that prevents urine from flowing freely), hemiplegia(complete all partial paralysis on one side of the body) and hemiparesis(muscular weakness or partial paralysis affecting only one side of the body) following cerebral infarction(death of brain tissue caused by a prolonged lack of blood and oxygen supply) .The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15 indicating intact cognition.A facility's Accident Incident report dated 06/20/2026 at 6:30 AM documented Resident #1 made an allegation to Licensed Practical Nursing #1 that they were raped by Certified Nursing Assistant #1. Assessment was done by Registered Nurse Supervisor #1.During an interview on 06/25/2026 at 1:33 PM with Family Member #1, they stated they received a call from their family member (Resident #1) at approximately 7:00 AM and returned their family member's call at 9:45 AM. Resident #1 stated, You need to come here now. When Family Member #1 arrived at the facility approximately 11:00 AM, the resident was hysterically crying and stated that a staff member had raped her. Family member #1 immediately contacted law enforcement and requested that the resident be sent to the hospital.During an interview via telephone on 06/25/2026 at 2:55 PM Resident #1 who was present with Family Member #1. Resident #1 stated Certified Nursing Assistant #1 came into their room to change their brief because they were wet. Resident #1 stated Certified Nursing Assistant #1 began to apply cream to their hip and then begin to apply the cream to their anus and vaginal area. They stated they told Certified Nursing Assistant #1 that they were hurting them, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335839	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #1 apologized and made a moaning sound. Resident #1 stated they felt, something enters their anus and vagina, it felt soft but was unsure if it was Certified Nursing Assistant #1's finger or penis. Resident #1 stated Certified Nursing Assistant#1 took a very long time to provide care and then they felt burning in their vaginal area after the care. Resident #1 stated they asked Certified Nursing Assistant #1 to stop but they did not stop. Resident #1 stated when law enforcement arrived, they (law enforcement) asked them what happened. Resident #1 stated they were male law enforcement officers, and the nursing supervisor was also present who was a male, so Resident #1stated they were embarrassed and ashamed and did not want to talk about the rape with them so Resident #1stated they only reported that Certified Nursing Assistant #1 was rough with them. Resident #1 stated they are not sleeping well because of this incident and were emotionally distraught and tearful with cracks in their voice during this interview. There was no documented evidence that the facility reported alleged violations involving abuse, neglect, exploitation or mistreating are reported immediately or not later than 2 hours to the Department of Health and Local Law Enforcement after the allegations are made. Additionally, the facility failed to ensure that resident #1s psychosocial needs were met after the allegation of rape.During an interview on 06/25/2026 at 11:51 AM with the Administrator, they stated they were aware of an incident on 06/20/2026 at 9:35 AM involving Certified Nursing Assistant #1 and Resident #1. They stated they were reported that Resident #1 informed a licensed practical nurse #1 they were raped but then changed their story and reported to the male nursing supervisor#1 the alleged incident was rough handling. The Administrator stated they did not report the alleged rape by Resident #1 to the New York State Department of Health because Resident #1 changed their story to rough handling. The Administrator stated they felt that rough handling was subjective, and the alleged rape was the perception of the resident (resident #1). The Administrator stated they did not think Resident #1 required Social Work or Psychosocial interventions.During an interview on 06/25/2026 at 2:02 PM with the Primary Care Physician they stated they were contacted 06/20/2026 when resident #1was being transferred to the hospital approximately 12:00 PM. The Primary Care Physician stated Resident #1 made an allegation they were raped but they were initially told it was rough handling. The Primary Care Physician stated the facility should call law enforcement and the Department of Health if Resident #1 alleged they were raped. 10NYCRR 415.26