STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335845	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Ctr for Rehabilitation and Brain Injury	300 Grant Avenue Lake Katrine, NY 12449

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49372 Based on record review and interviews conducted during an abbreviated survey (NY00336137) from 3/22/2024 to 3/25/2024 the facility did not ensure residents rights to be free from physical abuse for 1 (Resident #1) out of 3 residents reviewed for abuse. Specifically, on 3/15/2024, Certified Nursing Assistant(staff #2) and Licensed Practical Nurse(staff #1) witnessed Resident # 1 being hit in the face by a Community Support Specialist(staff #3), after Resident #1 threw their food on them. The community support staff's job description and tasks did not include assisting/passing of trays to residents. Findings include: Review of the Abuse policy and procedure dated 11/1/2013 last revised 11/2023 documented it is the policy that neighbors will be protected from abuse in accordance with State and Federal regulations. Abuse means the willful infliction of injury with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching and kicking. All alleged or suspected incidents of abuse of neighbors will be thoroughly investigated and finings documented in a report format. Resident #1 was admitted to the facility with diagnosis that included dementia, cognitive communication deficit, unspecified mood [affective] disorder, anxiety and depression. The Comprehensive Admission Minimum Data Set (an assessment tool) dated 2/1/2024 documented the resident had a brief mental interview (BIMS) score of 0. No delirium noted or social isolation. Resident #1 exhibited physical behavioral symptoms towards others and rejected care. Resident #1 required set-up assistance with meals and is dependent for bed mobility and transfers. They required maximal assistance with toileting and was occasionally incontinent of bladder and always incontinent of bowel. A review of the behavior care plan dated 2/5/2024 documented Resident #1 had potential for behavior problems, verbal aggression, physical aggression, socially interruptive behaviors and disruptive behaviors, resistant to care and had impulsiveness related to dementia. A review of the potential victim of abuse care plan revealed it was not initiated until 3/15/2024, the day of the incident, despite the knowledge of a mood disorder diagnosis and a Minimum Data Set finding of exhibiting physical behavioral symptoms towards others. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's major investigative summary concluded abuse could not be substantiated due to the reactive nature, lack of injury and the lack of willful intent. During an interview on 3/22/2024 at 11:45 AM Staff #2 (certified nurse aide-witness) stated Resident #1 was on the dementia unit, in the dining room and Staff #3 raised their right hand and hit Resident#1 across the face hard it echoed the room. Staff #3 struck the resident above their right eye, stated they were in shock. Stated Resident #1 can be combative at times. They asked Staff #1 (Licensed practical nurse) did the resident just hit Staff #3, Staff #1 stated no. Staff #3 then stated the resident just threw food at them, they saw Staff #3 had a small amount of food on their collar. Staff #3 then repeated Resident #1 threw food at them and they just reacted. During an interview on 3/22/2024 at 11:58 AM the Administrator stated the incident happened around 2pm, they were informed at 2:10 PM the Social Worker came and informed them Resident #1 had been hit by Community Support Specialist(staff #3). The Administrator stated the Community Support Specialist(staff #3) stated Resident #1 scooped up a handful of food and threw it on them and the food went on their chest and down their blouse and got on their nameplate. The administrator stated Community Support Specialist(staff #3) reported they got startled and their hand left the tray and that's when it jerked inwards, and they hit Resident #1 in the head. The Administartor stated the Community Support Specialist(staff #3) told them it was a reaction and they(the administrator) would have done the same thing in that situation. The Administartor stated the Community Support Specialist(staff #3)'s intent was not to hit Resident #1, but their reaction was not appropriate. During an interview on 3/22/2024 at 4:20 PM, Licensed Practical Nurse-witness(staff #1) stated they were serving lunch on 3/15/2024(the day of the incident), and they together with (Certified nurse Assistant(staff #2 and Community Support Specialist-staff # 3) were all in the dining room and the Community Support Specialist(staff #3) was setting up Resident # 1's tray. Resident #1 took a spoonful of their food and threw it at Staff #3 and they in turn hit Resident #1. Licensed Practical Nurse-witness(staff #1) stated the Community Support Specialist(staff # 3) smacked Resident #1 on the right side of their face. During an interview on 3/22/2024 at 3:55 PM the Director of Nursing stated the incident was reported to them at the same time as the Administrator. Stated they ensured the situation was addressed immediately and that Resident #1 was not in any harm's way. Stated they got Staff #3 off the unit right away. Stated the safety of the resident is definitely a priority in the facility. During an interview on 3/25/2024 at 10:22 AM the Director of the Community Support Specialists stated Staff #3 should not have been dealing with Resident #1 because they were on close visual observation with another resident. Stated Staff #3 was aware of the neighbor's behaviors, on the dementia unit all the neighbors are unpredictable. Stated Staff #3, should have stepped back and tried to reapproach, redirect and prompt the neighbor. They should have let the neighbor know what they were doing was wrong and that would have a better outcome for the neighbor, the situation could have been avoided. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/2024 at 11:39 AM, the Community support Specialist(Staff #3) stated they gave Resident#1 their tray and the began eating. Out of nowhere they felt something hot hit their face and go down their shirt. The Community Support Specialist(staff #3) They stated when they felt the heat their initial reaction was that they swung their hand and they hit Resident #1. They stated usually Resident #1 is aggressive, verbally not physically. There was only one person in the dining room at the time besides them. The Community Support Specialist stated that Certified Nurse Assistant(staff #2) was not in the dining room, but outside in the hallway passing the trays to residents in the rooms. During an interview on 3/25/2024 at 4:00 PM, Registered Nurse Unit Manager(staff #4 stated they were informed by the Administrator that Staff #3 had smacked Resident #1 in the face. Stated Staff #3 informed them that Resident #1 threw food on them, and they hit the resident. Stated the resident is challenging and combative almost every day. Stated some interventions in place for the resident are, keeping other residents away from them. Also stated Resident #1 is resistant to everything. Once the resident is left alone and reapproached, then they are fine. Stated when Resident #1 is in those moments they should just be left alone. 415.4(b)(1)(i)

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49372 Based on record review and interviews conducted during an abbreviated survey (NY00336137), the facility did not report the results of the investigation of a physical abuse allegation to the New York State Department of Health in accordance with State law within 5 working days of the incident for 1 (Resident #1) of 3 residents reviewed for abuse. Specifically, the facility did not submit the 5-day investigative report until 3/26/2024 for an incident that occurred on 3/15/2024. Finding include: The Facility Policy and Procedure on abuse and reporting dated 11/1/2013 last revised 11/2023 documented the reporting requirements include notification to the New York State Department of Health will occur based on the reporting requirement identified by the Nursing Home Incident Repoorting Manual. If it is determined that there is sufficient evidence for a prudent person to believe that abuse, neglect or mistreatment occurred, the administartor or designeee will report the findings of the investigation to the New York State Department of Health based upon the reporting requirements identified in the Nursing Home Incident Reporting Manual. Resident #1 had diagnoses that included dementia, cognitive communication deficit, unspecified mood [affective] disorder, anxiety, and depression. The Admission Minimum Data Set (an assessment tool) dated 2/1/2024 documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). No delirium noted or social isolation. The resident exhibited physical behavioral symptoms towards others and rejected care. The resident required set-up assistance with meals and is dependent for bed mobility and transfers. The resident required maximal assistance with toileting and was occasionally incontinent of bladder and always incontinent of bowel. The Facility submitted a report to the New York State Department of Health for a witnessed staff to resident abuse allegation on 3/15/2024. A review of the Facility investigative summary documented a Community Support Specialist Staff # 3, was witnessed by Licensed Practical Nurse-witness(Staff #1) and Certified Nurse assistant(Staff #2), hitting Resident #1 in the face in the dining room after Resident #1 threw their food on them. The investigation concluded abuse was unsubstantiated due to the reactive nature, lack of injury and lack of willful intent. A review of the investigation report dated 3/21/2024 submitted to the New York State Department of Health documented the details of the incident that occurred on 3/15/2024, however the case number and the date of the incident were incorrect. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/22/2024 at 4:10 PM, the Administrator delivered the 5-day investigative summary report with the document details of the incident that occurred on the 3/15/2024 but with a different case number. The administrator stated the case number is for another case they reported, and they were unaware why the details from the incident on 3/15/20 24 was documented under a wrong case. Review of the Aspen Complaint Tracking System documented a 5-day report submission from the facility on 3/26/2024, which is 2 days after the required date of submission. 415.4(b)(1)(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews conducted during an abbreviated survey (NY00336137), the facility did not ensure a comprehensive person-centered care plan was developed or implemented for 1 (Resident #1) out of 3 residents reviewed for care plans. Specifically, Resident # 1 who was assessed for mood and behaviors indicating they were at risk for abuse by staff and other residents but there was no comprehensive care plan developed with interventions to prevent the resident from being abused. Findings include: A review of the comprehensive care plan policy dated 6/10/2013 and last revised 11/1/2013 documented each resident will have a comprehensive care plan. Comprehensive care plans include residents strengths and weaknesses, measurable objectives, and timetables to meet the resident's medical, nursing and psychological needs that are identified in the Minimum Data Set (an assessment tool). The comprehensive care plan is initiated by the nurse on admission and is a reflection of the resident's needs, strengths and plan of care. Resident #1 had diagnoses of dementia, cognitive communication deficit, unspecified mood [affective] disorder, anxiety, and depression. The Admission Minimum Data Set (an assessment tool) dated 2/1/2024 documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). No delirium noted or social isolation. The resident exhibits physical behavioral symptoms towards others and reject care. The resident required set-up assistance with meals and is dependent for bed mobility and transfers. They required maximal assistance with toileting and was occasionally incontinent of bladder and always incontinent of bowel. A review of the behavior care plan dated 2/5/2024 documented the resident had a potential for behavior problems, verbal aggression and physical aggression, socially interruptive behaviors and disruptive behaviors, resistance to care and impulsiveness related to dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the behavior care plan documented the following notations: On 2/3/2024. Resident #1 repeatedly attempted to go in peer's rooms and put on their clothes. Resident #1 became combative with staff when they attempted to redirect them; On 2/5/2024 Resident #1 was combative with cares, punching and hitting staff. Resident #1 refused cares multiple times and was mocking the certified nurse aide when asked Can I change you? Resident #1's family came to visit and were also unsuccessful in getting the resident to accept cares. On 2/10/2024 Resident #1 was combative during toileting. Staff stayed outside for safety to give Resident #1 time to deescalate. Resident #1 allowed cares after 30 minutes of encouragement. On 2/14/2024 Resident #1 was combative and verbally aggressive with staff. On 2/15/2024 Resident #1 was combative with cares and redirected. Resident #1 was hitting staff with objects and entering peers' rooms, difficult for staff to redirect. On 2/21/2024, Resident #1 was tapping peers to get their attention in the common area. On 2/26/2024 Resident #1 was combative when the nurse attempted to redirect them out of their peers room. A review of the potential victim of abuse care plan revealed it was not initiated until 3/15/2024, the day of the abuse allegation incident, despite the knowledge of a mood disorder diagnosis and a Minimum Data Set finding of exhibiting physical behavioral symptoms towards others. A review of the potential to abuse care plan revealed it was not initiated until 3/15/2024, despite Resident #1 having exhibited physical and verbal aggression towards staff and other residents on numerous occasions per the behavior care plan. During an interview on 3/22/2024 at 3:55 PM, the Director of Nursing stated the nurse manager on the unit is responsible for updating and initiating the care plans.The Director of Nursing stated upon admission the Nursing supervisor would initiate them. During a follow up interview on 3/25/2024 at 9:45 AM, the Director of Nursing stated the unit manager checks the care plans to ensure they are all initiated, the day after admission. The Director of Nursing stated if the unit manager finds that a care plan was not initiated, they should be taking care of it and initiating the care plan. During an interview on 3/25/2024 at 3:15 PM, the Assistant Director of Nursing #1 stated the admitting nurse should be initiating the care plans for the residents and the unit manager should follow up. The Assistant Director of Nursing #1 stated there is a list of care plans that are to be initiated upon admission as a reference. All care plans [NAME] to be initiaited upon admission. During an interview on 3/25/2024 at 4:00 PM, Registered Nurse Unit Manager(staff #4) stated when a new admission comes in during the day shift, if a Registered Nurse does the assessment, then they will initiate the care plans. Registered Nurse Unit Manager(staff #4) stated the Licensed Practical Nurses enter the medication orders. Registered Nurse Unit Manager(staff #4) stated if there is no Registered Nurse on the unit, then the nursing supervisor initiates the care plans. Care plans should be reviewed the day after admission to be sure all care plans are completed. Registered Nurse Unit Manager(staff #4) stated there is a checklist that indicates which care plans need to be initiated on admission. The list needs to be reviewed to be sure all care plans are in place. 415.11(c)(1)