

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847</p> <p>Based on observations, record review, and interviews conducted during the abbreviated survey (NY00368528), the facility did not ensure 1 (Resident #1) of 3 residents reviewed for abuse, had the right to be free from abuse, neglect, or mistreatment. Specifically, Resident #1 was heard yelling from behind their closed room door and when multiple staff entered the room, they observed Certified Nursing Assistant #1 pushing Resident #1, holding their arms down, and preventing Resident #1 from leaving their room. Staff attempted to intervene with no success. Certified Nursing Assistant #1 did not let go of Resident #1 until Licensed Practical Nurse #1 arrived and told them to let go.</p> <p>The facility policy titled Abuse Prevention Policy and Procedure last revised on 11/2024 documented it is the policy of the facility to promote and support each resident's rights to be free from abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>Resident #1 was admitted on [DATE] with the following diagnoses including, but not limited to, adjustment insomnia, diffuse traumatic brain injury with loss of consciousness, persistent mood disorder, post-traumatic stress disorder, and schizophrenia.</p> <p>The 10/28/24 Comprehensive Minimum Data Set documented Resident #1 was cognitively impaired, required supervision with eating, moderate assist with toileting, transfers, and bathing, and was independent with bed mobility. The 10/28/24 Comprehensive Minimum Data Set documented that Resident #1 had physical and verbal behaviors towards others, rejection of care, and wandering that all occurred daily. Resident #1 received antipsychotics, antianxiety, and antidepressant medications.</p> <p>The Social Worker assessment dated [DATE] documented that Resident #1 was assessed to be cognitively intact.</p> <p>The Potential for Victim of Abuse Care Plan dated 11/20/24 documented that Resident #1 is at high risk for abuse, has been a victim of abuse previously, is vulnerable due to physical disabilities, is vulnerable due to cognitive disabilities, and due to inability to communicate needs effectively. Interventions included redirecting away from persons of concern, encourage attendance at supervised activities, encourage the resident to spend leisure time in supervised areas, assessing for behavior used as communication for symptoms of pain, move room closer to nurses' station.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Potential to Abuse Others Care Plan dated 10/22/24 documented that Resident #1 is abusive to caregivers/staff, has poor impulse control, and exhibits threatening or intimidating behaviors. Interventions included: 10/22/24-to observe for signs of agitation in overly stimulated areas, redirect them, remove other residents from area. Psychiatry and/or psychologist consults prn. Offer active listening and processing to promote stabilization; and 1/16/25 observe the resident during interactions with others for gestures, speech, touching and intervene when determined the setting/person is inappropriate or the other person is noted to be upset.</p> <p>The Major Investigative summary documented that on 1/12/25, it was reported that Resident #1 was heard yelling out from inside their room behind the closed room door, and staff entered the room and found Certified Nursing Assistant #1 holding Resident #1's arms and pushing Resident #1 towards their bed away from the door.</p> <p>The 1/12/25 statements from Certified Nursing Assistant #2 and #3 documented that they heard Resident #1 screaming help from their room and when they opened the door, they both observed Certified Nursing Assistant #1 physically pushing Resident #1 backwards and Certified Nursing Assistant #1 was heard saying No you are not going anywhere, sit down while pushing Resident #1 aggressively back into their room to keep them from leaving their room. Licensed Practical Nurse #1 was notified immediately and upon entering the room, observed that Certified Nursing Assistant #1 was holding Resident #1's arms and did not initially let go after being instructed to do so. Resident #1 stated that they wanted to leave their room and Certified Nursing Assistant #1 grabbed them and would not let them out of their room, and that Certified Nursing Assistant #1 threw them on the bed and would not let them go.</p> <p>The 1/12/25 at 8:38 PM nursing progress note documented that at approximately 5:00 PM Certified Nursing Assistant #2 called writer to come assess Resident #1. Certified Nursing Assistant #2 stated, come look, there is a sitter who is not supposed to be sitting with Resident #1 and Certified Nursing Assistant #1 is inappropriately pushing Resident #1 aggressively. Resident #1 was found by writer attempting to push Certified Nursing Assistant #1 and Resident #1 got aggressive and slapped sitter across the face.</p> <p>During an interview on 1/17/25 at 10:00 AM, Resident #1 stated that they remember what happened between them and Certified Nursing Assistant #1 and that the incident happened during the evening. Resident #1 stated that Certified Nursing Assistant #1 grabbed their arms and would not let them leave their room. Resident #1 stated that every time they would try to leave their room, Certified Nursing Assistant #1 would grab their arms throw them on the bed. Resident #1 stated that they started screaming and yelling so someone can come get them out of their room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/17/25 at 10:42 AM Certified Nursing Assistant #1 stated that on the day of the incident, they were originally scheduled to work on another floor and the Nursing supervisor switched them with another Certified Nursing Assistant to work with Resident #1. Certified Nursing Assistant #1 stated that when they received Resident #1, they did not have on socks and their feet were dirty. Certified Nursing Assistant #1 stated that when they went in Resident #1's dresser to look for socks, Resident #1 yelled Get the f**k out of my room and kept saying it and even after telling Resident #1 that they were looking for some socks, Resident #1 continued to yell and was calling them derogatory names. Certified Nursing Assistant #1 stated that Resident #1 got up from their bed and started banging on the wall and was yelling. Certified Nursing Assistant #1 stated that they continuously kept telling Resident #1 to calm down and what's wrong, and Resident #1 kept screaming. Certified Nursing Assistant #1 stated that Resident #1 said I'm going to kill you, while charging at them and Certified Nursing Assistant #1 stated that they grabbed Resident #1's arms and held them down because Resident #1 was swinging their fists trying to hit them. Certified Nursing Assistant #1 stated that they continued to tell Resident #1 to calm down and shortly after, Resident #1 was sitting on their bed, and then grabbed their bedside table and threw their food off the table. Certified Nursing Assistant #1 stated that while they were picking stuff up from the floor, Resident #1 got up from the bed and started coming towards them very upset and they were telling them to calm down. Certified Nursing Assistant #1 stated that the nurse came in the room and saw them holding Resident #1's arms down and said, you can't do that. Certified Nursing Assistant #1 stated that they took their hands from Resident #1's arms, and then Resident #1 slapped them and then ran out the room. Certified Nursing Assistant #1 stated that the nurse told them that they cannot put their hands on residents. Certified Nursing Assistant #1 stated that they were never taught about holding residents' arms down if they are trying to hit them or a code rainbow (behavior code). Certified Nursing Assistant #1 stated that they were not taught that if a resident hits you, you can't protect yourself. Certified Nursing Assistant #1 stated that they were working at the facility through an agency (Shift Key) and that they had no training in the facility and had no in-services in reference to abuse or behaviors.</p> <p>During an interview on 01/17/25 at 11:31AM, the Assistant Director of Nursing stated that the employee chart given to the surveyor by Human Resources were all the trainings that Certified Nursing Assistant #1 was given by the facility. The trainings did not include behavior training.</p> <p>During an interview on 01/17/25 at 11:32 AM, the Staff Educator stated that they have been employed in the facility since June 2024 and did not do any trainings with Certified Nursing Assistant #1. The Staff Educator stated that the facility staff normally does quarterly in-services, and that in-services are not given to agency staff. The Staff Educator stated that they give annual mandatory Mandt training (specific facility trainings to teach you how to deescalate behaviors). The Staff Educator stated that Mandt training is mandatory for all floor staff and but not for agency staff. The Staff Educator stated when agency staff is hired, they verbally inform agency staff on the behaviors that they will have to deal with, and they do not have them sign any documents that they were informed.</p> <p>During an interview on 01/17/25 at 11:51 AM, the Assistant Director of Nursing stated that they were the previous staff educator and that they do not give agency staff Mandt training because it is an agency, it is a lot of time to invest with an individual to do Mandt training that will potentially not show up to work the next week. The Assistant Director of Nursing stated that the facility did not have anything documented to ensure that agency staff are aware of their behavior code (code rainbow) or how to react to a resident having a behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/17/25 at 12:19 PM, the Director of Nursing stated that the Mandt training is done for all employees except agency staff. The Director of Nursing stated that Mandt training is a crisis response for dealing with behaviors and de-escalation tactics. The Director of Nursing stated that part of the training includes how staff should handle a resident if they become physically abusive. The Director of Nursing stated agency staff does not get the training because the training is 2 days and they cannot get agency staff to commit to do the training, so they do not offer it to them.</p> <p>During an interview on 1/17/25 at 12:30 PM, the Administrator stated that Certified Nursing Assistants learn in school that they are not to restrain a resident. The Administrator stated that they cannot afford to give the agency staff the Mandt trainings because last time they did, they wasted \$30,000 and not one of the agency staff stayed working in the facility. The Administrator stated that Resident #1 is hard to deal with, and they let Certified Nursing Assistant #1 go because the facility has a zero-tolerance policy for holding or touching anyone, and that Resident #1's door should not have been closed if the resident wanted to leave the room, and that they were kept in their room involuntarily.</p> <p>10NYCRR 415.4(b)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50729</p> <p>Based on observations, record review, and interviews conducted during the abbreviated survey (NY00368528), it was determined that the facility did not ensure that staff were competent and trained in providing care to a resident with behavioral health diagnoses of traumatic brain injury, post-traumatic stress disorder and persistent mood disorder. Specifically, Certified Nurse Aide #1 was not trained to help Resident #1 with their behaviors and instead held Resident #1's arms down and prevented them from leaving their bedroom as per the Resident's ir request and they did not let go of the Resident #1's arms until told to multiple times.</p> <p>The facility policy titled Policy and Procedure Mandt training (facility specific behavioral crisis intervention training that teaches staff how to provide care for resident's with behavioral disturbances), initiated on 1/22/2010 and revised 11/1/2013 documents that it is the policy of the facility to provide employee training in behavior prevention and intervention, with an emphasis on prevention. Employees include those hired in full-time, part-time, and per-diem positions. Staff provided by contracting agencies are not included in this policy.</p> <p>The undated facility job description for a Certified Nursing Assistant documents that the facility shall ensure that all staff assigned to the direct care of the residents will have pertinent experience or have received training in the care and management of individuals with severe behaviors.</p> <p>Resident#1 was admitted on [DATE] with the following diagnoses including but not limited to diffuse traumatic brain injury with loss of consciousness, persistent mood disorder, post-traumatic stress disorder, and schizophrenia.</p> <p>The 10/28/24 Comprehensive Minimum Data Set documented that Resident #1 had physical and verbal behaviors towards others, rejection of care, and wandering that all occurred daily. The Social Worker assessment dated [DATE] documented that Resident #1 was assessed to be cognitively intact.</p> <p>The Potential to abuse others Care Plan dated 11/20/24 documented that Resident #1 is abusive to caregivers/staff, has poor impulse control, and exhibits threatening or intimidating behaviors. Interventions included 11/20/24-to observe for signs of agitation in overly stimulated areas, redirect them, remove other residents from area. Psychiatry and/or psychologist consults prn. Offer active listening and processing to promote stabilization. 1/16/25-observe the resident during interactions with others for gestures, speech, touching and intervene when determined the setting/person is inappropriate or the other person is noted to be upset.</p> <p>The Major Investigative summary documented that on 1/12/25, it was reported that Resident #1 was heard yelling out from inside their room behind a closed door and staff went into the room and the staff member assigned which was staff agency Certified Nurse Aide #1, was holding Resident #1's arms and pushing Resident #1 towards their bed away from the door.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 1/12/25 certified nurse statements from Certified Nurse Aides #2 and #3 documented that they heard Resident #1 screaming help from their room and when they opened the door, they both observed Certified Nurse Aide #1 physically pushing Resident #1 backwards and Certified Nurse Aide #1 was heard saying No you are not going anywhere, sit down while pushing Resident #1 aggressively back into their room to keep them from leaving their room. Licensed Practical Nurse #1 was notified immediately and upon entering, it was observed that Certified Nurse Aide #1 was holding Resident #1's arms and was not initially letting go after being instructed to do so. Resident #1 stated that they wanted to leave their room and Certified Nurse Aide #1 grabbed them and would not let them out of their room, and that Certified Nurse Aide #1 threw them on the bed and would not let them go.</p> <p>The 1/12/25 at 8:38 PM nursing progress note documented that at approximately 5PM Certified Nurse Aide #2 called writer to come assess Resident #1. Certified Nurse Aide #2 stated, come look, there is a sitter who is not supposed to be sitting with Resident #1 and Certified Nurse Aide #1 is inappropriately pushing neighbor aggressively. Resident #1 was found by writer attempting to push sitter and neighbor got aggressive and slapped sitter across the face.</p> <p>During an interview on 1/17/25 at 10:42 AM Certified Nurse Aide #1 stated that on the day of the incident, they were originally scheduled to work on another floor and the Nursing supervisor switched them with another Certified Nurse Aide to work with Resident #1. Certified Nurse Aide #1 stated that they were never taught about holding residents' arms down if they are trying to hit them or a code rainbow. Certified Nurse Aide #1 stated that they were not taught that if a resident hits you, you can't protect yourself. Certified Nurse Aide #1 stated that they were working at the facility through an agency (shift key) and that they had no training in the facility and had no in-services in reference to abuse or behaviors. They did not know what Mandt training was.</p> <p>During an interview on 01/17/25 at 11:31AM, the Assistant Director of Nursing handed over agency staff Certified Nurse Aide #1's employee chart in review it was noted that the trainings did not include behavior training, and the special Mandt training that the facility uses.</p> <p>During an interview on 01/17/25 at 11:32 AM, the Staff Educator stated that they did not do any trainings with Certified Nurse Aide #1, that in-services are not given to agency staff and that they do not give agency staff Mandt training (specific facility trainings to teach you how to deescalate behaviors). The Staff Educator stated when agency staff is hired, they verbally inform agency staff on the behaviors that they will have to deal with, and they do not have them sign any documents that they were informed.</p> <p>During an interview on 01/17/25 at 11:51 AM, the Assistant Director of Nursing stated that they were the previous staff educator and that they do not give agency staff Mandt training because it is an agency, it is a lot of time to invest with an individual to do Mandt training that will potentially not show up to work the next week. The Assistant Director of Nursing stated that the facility did not have anything documented to ensure that agency staff are aware of their behavior code (code rainbow) or how to react to a resident having a behavior.</p> <p>During an interview on 1/17/25 at 12:19 PM, the Director of Nursing stated that the Mandt training is done for all employees except agency staff. The Director of Nursing stated that Mandt training is a crisis response for dealing with behaviors and de-escalation tactics. The Director of Nursing stated that part of the training includes how staff should handle a resident if they become physically abusive.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/17/25 at 12:30 PM, the Administrator stated that Certified Nurse Aides learn in school that they are not to restrain a resident. The Administrator stated that they cannot afford to give the agency staff the Mandt trainings, the Administrator stated that Resident #1 is hard to deal with, and they let Certified Nurse Aide #1 go because the facility has a zero-tolerance policy for holding or touching anyone, and that Resident #1's door should not have been closed if the resident wanted to leave the room, and that they were kept in their room involuntarily.</p> <p>10NYCRR 415.4(b)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50729</p> <p>Based on observations, record review, and interviews conducted during the abbreviated survey (NY00368528), it was determined that the facility did not include all facility staff in their training program on behavioral health care that is appropriate and effective as determined by staff need and the facility assessment. Specifically, agency staff Certified Nurse Aide #1 was not trained to help Resident #1 with their behaviors and instead held Resident #1's arms down and prevented them from leaving their bedroom as per their request and they did not let go of the Resident #1's arms until told to multiple times.</p> <p>the Findings include but are not limited to:</p> <p>The facility policy titled Policy and Procedure training (facility specific behavioral crisis intervention training that teaches staff how to provide care for residents with behavioral disturbances), date initiated 1/22/2010 revised 11/1/2013 documented that it is the policy of the facility to provide employee training in behavior prevention and intervention, with an emphasis on prevention. Employees include those hired in full-time, part-time, and per-diem positions. Staff provided by contracting agencies are not included in this policy.</p> <p>The undated facility job description for a Certified Nursing Assistant documented that the facility shall ensure that all staff assigned to the direct care of the residents will have pertinent experience or have received training in the care and management of individuals with severe behaviors .</p> <p>The facility assessment dated [DATE] does not document anything about the number of agency staff that are used , it also does not delineate any of their duties or trainings. It does document that the assessment aims to determining what resources are necessary to care for their residents competently during the day-to-day operations. One of the resources listed is staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. It documents all the different types of psychiatric/mood disorders that the facility provides services for. On Page seven of the facility assessment, it documented that staff competencies are discussed at orientation and annually, including dementia, behavior management training, and resident abuse prevention training.</p> <p>Resident #1 was admitted on [DATE] with the following diagnoses including but not limited to diffuse traumatic brain injury with loss of consciousness, persistent mood disorder, post-traumatic stress disorder, and schizophrenia.</p> <p>The 10/28/24 Comprehensive Minimum Data Set documented that Resident #1 had physical and verbal behaviors towards others, rejection of care, and wandering that all occurred daily. The Social Worker assessment dated [DATE] documented that Resident #1 was assessed to be cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/17/25 at 11:51 AM, the Assistant Director of Nursing stated that they were the previous staff educator and that they do not give agency staff Mandt training because it is an agency, it is a lot of time to invest with an individual to do Mandt training that will potentially not show up to work the next week. The Assistant Director of Nursing stated that the facility did not have anything documented to ensure that agency staff are aware of their behavior code (code rainbow) or how to react to a resident having a behavior.</p> <p>During an interview on 1/17/25 at 12:19 PM, the Director of Nursing stated that the Mandt training is done for all employees except agency staff. The Director of Nursing stated that Mandt training is a crisis response for dealing with behaviors and de-escalation tactics. The Director of Nursing stated that part of the training includes how staff should handle a resident if they become physically abusive.</p> <p>During an interview on 1/17/25 at 12:30 PM, the Administrator stated that Certified Nurse Aides learn in school that they are not to restrain a resident. The Administrator stated that they cannot afford to give the agency staff the Mandt trainings.</p> <p>10NYCRR 483.95(i)</p>		