STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335188	A. Building B. Wing	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Paltz Center for Rehabilitation and Nursing	1 Jansen Road New Paltz, NY 12561

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. 43478 Based on record review and interviews conducted during an abbreviated survey (NY00326941), the facility did not ensure residents right to be free from abuse for 1 of 3 sampled residents (Resident #1) Specifically, on 10/19/2023 and 10/24/2023 a Certified Nursing Assistant (CNA #2) was witnessed slapping Resident #1 in the face and push them back to bed forcibly. The findings are: The Facility Policy titled 'Abuse' last revised on 12/2022 documented that the facility prohibits abuse and strives to ensure the prevention and reporting of suspected or alleged resident abuse. Resident #1 had diagnoses that included hypertension, cerebrovascular accident, and dementia. The Minimum Data Set (MDS-a resident assessment tool) dated 9/08/2023 documented that Resident #1 had severe cognition impairment and required one-person physical assistance with Activities of daily Living (ADLs). The facility Accident & Incident (A&I) report / investigation dated 10/26/2023 concluded that abuse occurred on 10/19/2023 and on 10/24/2023. The facility documented CNA#1 reported they saw CNA#2 push Resident #1 down by the neck into their bed. The facility documented that CNA#1 reported they saw CNA#2 strike Resident#1 in the face after Resident#1 punched CNA#2 in the abdomen on 10/24/2023. Attempted to conduct a telephone interview with CNA #2 on 11/7/2023 at 11:45, 11:47 AM, and 1:30 PM but was unsuccessful. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with CNA #1 on 11/06/2023 at 9:30 AM, CNA #1 stated that on 10/19/2023 at approximately 8:30 PM, Resident#1 kept getting out of their chair and CNA #1 stated they took Resident #1 to their room and put them in bed, but Resident #1 got up and went into another resident's room. CNA #1 stated they tried to get Resident #1 out of the room but Resident #1 was combative. CNA #1 stated that CNA #2 came to assist them to bring Resident #1 to their room. CNA #1 stated that when CNA #2 tried to assist Resident #1 to bed, Resident#1 swung at and hit CNA#2, and CNA#2 pushed Resident#1 onto the bed with one hand on Resident #1's neck, put Resident#1's covers on and told Resident#1 not to get up. CNA #1 stated that on 10/24/2023, Resident#1 was combative and went into another resident's room. CNA#1 stated they went to get Resident #1 out of the other resident's room with CNA #2 assisting. CNA #1 stated that Resident #1 punched CNA #2 in the stomach and CNA #2 slapped Resident #1 on the tip of the jaw. CNA #1 stated they were scared to report because CNA #2 is big and tall and knows where they live because they all live in a boarding house together. During an interview conducted with the Director of Nursing (DON) on 11/06/2023 at 10:35 AM, the DON stated they became aware of both incidents on 10/26/2023, and immediately reported to the New York State Department of Health (NYSDOH) and initiated an investigation. The DON stated they gave 1:1 re-education on abuse reporting to each staff who may have known about any abuse incidents involving Resident#1 or had been involved in Resident#1's care. The DON stated they immediately suspended CNA#2 and gave disciplinary action to CNA#1. The DON stated they terminated CNA#2 on 10/30/2023 after concluding that abuse had occurred. During an interview on 11/06/2023 at 10:55 AM, the Administrator stated they became aware of both incidents on 10/26/2023, and immediately reported the incidents to the NYSDOH. The Administrator stated they started their investigation immediately upon learning of the abuse. The Administrator stated that the staff had been educated on abuse reporting previous to the dates of the incident, and the CNAs should have reported the abuse immediately. The Administrator stated they immediately suspended CNA#2, gave disciplinary action to CNA#1, and terminated CNA#2 on 10/30/2023 after concluding that abuse had occurred. During an interview conducted with the Diet Tech on 11/06/2023 at 11:30 AM, the Diet Tech stated that while they were providing a 1:1 observation with Resident #1 on 10/25/2023, CNA #1 told them that CNA #2 had pushed Resident #1 onto their bed a few days prior. The Diet Tech stated they reported to the DON the following morning. The Diet Tech stated they should have reported immediately but did not know if the allegation was true. During an interview on 11/06/2023 at 1:35 pm, the Director of Housekeeping stated that on 10/24/2023 Resident#1 was disrobed, sitting at the nurse's station. Director of Housekeeping stated they talked to Resident#1 to calm him down, which was effective. Durector of Housekeping stated they heard that Resident#1 had been combative previously and had hit an aide. Stated that Resident#1 went to the emergency room (ER) for aggressive behavior. During an interview on 11/06/2023 at 2:15 pm, CNA#4 stated they have been working at the facility for a few weeks ago and received orientation training which included abuse protocol education, dementia care, and behavioral care prior to performing resident care. CNA#4 stated Resident#1 displayed aggressive behaviors towards staff at times. 415.4(b)(l)(i)

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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** 47626 Based on record review and interviews conducted during an abbreviated survey (NY00326941), the facility did not ensure an alleged violation involving abuse was reported to the New York State Department of Health (NYSDOH) within 2 hours of occurrence. This was evident for 1 of 3 residents (Resident #1) reviewed for abuse and mistreatment. Specifically, a Certified Nursing Assistant (CNA #2) was witnessed by CNA #1 on 10/19/2023 and 10/24/2023 slap Resident #1 in the face and push them back to bed forcibly. The facility did not report the incident to the NYSDOH until 10/26/2023. The findings are: The policy and procedure titled Abuse last revised 12/2022 documented that the facility has designed and implemented process, which strive to ensure the prevention and reporting of suspecting or alleged resident/patient abuse, neglect, or mistreatment and or misappropriation of property. Trainings for staff include obligation to report alleged violations, reinforce staff education, with the emphasis on required reporting of incidents and concerns. Staff will be instructed to report immediately, without fear of reprisal, any knowledge or suspicion of suspected abuse, neglect, and mistreatment. Resident #1 had diagnoses that included hypertension, cerebrovascular accident, and dementia. The Minimum Data Set (MDS) (Minimum Data Set; a resident assessment tool) assessment dated [DATE] documented that Resident #1 had severe cognition impairment and required one-person physical assistance with Activities of Daily Living (ADLs). The facility Accident & Incident (A&I) report / investigation dated 10/26/2023 documented on 10/19/2023, CNA#2 grabbed Resident #1 by the neck and threw them down on the bed. The A/I additionally documented witness statements, statement by the accused employee, other staff statements. The facility documented that the accused employee was removed from the facility immediately, and their employment was terminated and reported to the proper licensing authority. The investigation concluded abuse had occurred, During an interview conducted with CNA #1 on 11/06/2023 at 9:30 AM, CNA #1 stated that on 10/19/2023 at approximately 8:30 PM, Resident#1 kept getting out of their chair and CNA #1 stated they took Resident #1 to their room and put them in bed, but Resident #1 got up and went into another resident's room. CNA #1 stated they tried to get Resident #1 out of the room but Resident #1 was combative. CNA #1stated that CNA #2 came to assist them to bring Resident #1 to their room. CNA #1 stated that when CNA #2 tried to assist Resident #1 to bed, Resident#1 swung at and hit CNA#2, and CNA#2 pushed Resident#1 onto the bed with one hand on Resident #1's neck, put Resident#1's covers on and told Resident#1 not to get up. CNA #1 stated that on 10/24/2023, Resident#1 was combative and went into another resident's room. CNA#1 stated they went to get Resident #1 out of the other resident's room with CNA #2 assisting. CNA #1 stated that Resident #1 punched CNA #2 in the stomach and CNA #2 slapped Resident #1 on the tip of the jaw. CNA #1 stated they were scared to report because CNA #2 is big and tall and knows where they live because they all live in a boarding house together. (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 conducted with the Director of Nursing (DON) on 11/06/2023 at 10:35 AM, the DON stated they became aware of both incidents on 10/26/2023, and immediately reported to the NYSDOH and initiated an investigation. During an interview on 11/6/23 at 10:55 AM, the Administrator stated they started their investigation immediately upon learning of the abuse. The Administrator stated that the staff had been educated on abuse reporting previous to the dates of the incident and they should have reported the abuse immediately During an interview conducted with the Diet Tech on 11/06/2023 at 11:30 AM, the Diet Tech stated that while they were providing a 1:1 observation with Resident #1 on 10/25/2023, CNA #1 told them that CNA #2 had pushed Resident #1 onto their bed a few days prior. The Diet Tech stated they reported the allegation to the DON the following morning. The Diet Tech stated they should have reported immediately but did not know if the allegation was true. 415.4(b)