STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335185	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Manor Nursing & Rehabilitation Center	32 Cedar Lane Ossining, NY 10562

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record reviews and interviews during an abbreviated survey (NY00343399, NY00332174, NY00337805), the facility did not ensure the residents right to be free from abuse for 1 (Resident #3) out of 3 residents reviewed for abuse. Specifically, on 4/1/2024 Certified Nurse Assistant #7 witnessed Resident #3 been bopped on the head by Certified Nurse Assistant #5 while in their wheelchair. The incident was not reported to the nursing supervisor or the administrator by the staff until Resident #3 reported the incident to the Medical Director of the Managed Long Term Care during a visit on 4/2/2024, that they were left in the shower for a longtime wearing their adult brief and that Certified Nurse Assistant #5 bopped them on their head using their knuckles because they would not follow their commands. Findings include: The facility abuse policy documented each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Resident #3 had diagnoses including but not limited to Asperger's syndrome, muscle weakness and dysphagia. An Admission Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15/15 denoting intact cognition. Resident #3 socially isolates sometimes and exhibits physical and verbal behaviors. Resident #3 also exhibits other behavioral symptoms not directed towards others. Resident #3 had impairment to the upper extremity on one side and to both lower extremities; required set up for meals, maximal assistance for toileting and transfers and moderate assistance for bed mobility. (continued on next page)

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 a behavior care plan dated 3/1/2024 documented Resident #3 has a behavioral problem (refusal to participate in activities of daily living) related to uncooperative behavior and a developmental problem. Intervention listed include anticipate and meet the resident's needs, assist the resident with developing more appropriate methods of coping and interacting, caregivers to provide opportunity for positive interaction, attention, stop and talk with resident when passing by, explain all procedures to resident and allow a few minutes to adjust to changes. A nursing progress note dated 4/2/2024 at 6:38PM documented Resident #3 complained of staff deliberately hitting them on the head using knuckles yesterday (4/1/2024) in the evening shift. Documented body assessment done; no visible injuries noted, no discoloration noted. Range of Motion within normal limits. Director of Nursing made aware. A review of the investigative summary signed on 4/8/2024 documented that on 4/2/2024, at approximately 4:30 PM the Social Worker was informed by the medical director of Managed Long-Term Care, that Resident #3 reported they were left in the shower by a Certified Nurse Assistant #6 wearing only their adult depends on 4/1/2024. Resident #3 also reported another Certified Nurse Assistant #5 (a friend of the certified nurse assistant #6 who provided the shower) bopped them on the head with their knuckles because they would not follow their demands. The report documented that Certified Nurse Assistant #7 stated while in the hallway, they saw Resident #3 been wheeled back to their room and Certified Nurse Assistant #5 was walking next to Resident #3 Certified Nurse Assistant #7 stated they heard Resident #3 telling Certified Nurse Assistant #5 don't hit on my head. Certified Nurse Assistant #7 looked and saw Certified Nurse Assistant #5 hit Resident #3 on the head. Certified Nurse Assistant #7 did not report the incident to the Nurse supervisor because they stated that Resident #3 was alert and they assumed Resident #3 will report the incident. The investigation summary concluded that based on the investigation Resident #3's complaint of being left in the shower for a long time by Certified Nurse Assistant #6 could not be corroborated. Resident #3's report of being bopped on the head by Certified Nurse Assistant #5 was witnessed by Certified Nurse Assistant #7. Therefore, it was concluded that Certified Nurse Assistant #5 bumped Resident #3 on their head at some point while passing by the resident. A review of Certified Nurse Assistant #5's employee file revealed a disciplinary action form with a documented date of offense as 4/1/2024. Documented the nature of offense as resident abuse or neglect mistreatment. Documented the action taken as suspension from 4/11/2024 until 4/18/2024. Based on the investigation including Resident #3's report, and eyewitness account, it is concluded that Certified Nurse Assistant #5 at some point bumped Resident #3 on the head while passing them. As a result, Certified Nurse Assistant #5 was issued a 5-day suspension for mistreatment of a resident and final written warning. During an interview on 6/6/2024 at 12:05 PM, the Director of Nursing stated they did not report the Certified Nurse Assistant to the licensing board. The Director of Nursing stated Resident #3 was developmentally challenged, and their mood and attitude would fluctuate. The Director of Nursing stated Resident #3 would play around and joke around with the staff and on this day, they became upset instead. The Director of Nursing stated the resident has been in the facility prior and that is how they were. (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 6/6/2024 at 4:40 PM Certified Nurse Assistant #7 stated they have been working in the facility since 2017. Stated when Certified Nurse Assistant #6 and certified nurse assistant #5 were passing in the hallway with Resident #3. Stated Certified Nurse Assistant #6 was pushing the wheelchair and Certified Nurse Assistant #5 was walking next to the wheelchair. Certified Nurse Assistant #7 stated they heard Resident #3 say do not hit me, and they turned and looked and saw Certified Nurse Assistant #5 tap Resident #3 in the back of the head. Resident #3 then said, I told you do not touch me, then Certified Nurse Assistant #5 tapped them in the head again. Certified Nurse Assistant #7 stated they then went to get their linen and went back to work. Certified Nurse Assistant #7 stated they did not tell anyone about the incident on the day of the occurrence. The next day the supervisor informed them that Certified Nurse Assistant #6 cannot care for Resident #3, because the resident reported they hit them. Certified Nurse #7 stated they then reported to Registered Nurse #3 that it was not Certified Nurse Assistant #6 that hit Resident #3, because they saw Certified Nurse Assistant #5 tap Resident #3 on the head and heard the resident state I told you not to touch me like that. Stated Registered Nurse #3 reported to the Director of Nursing, and they both came and asked them why they did not tell anyone what they witnessed. Certified Nurse Assistant #7 stated they were worried that their co-worker would retaliate against them. Certified Nurse #7 stated Resident #3 is alert and oriented and could report the incident. Certified Nurse Assistant #7 stated they did not receive in-service after the situation occurred but they do receive in-services on how to care for residents with behaviors. They are aware of Resident #3's behaviors, because the resident use to be on their assignment. Certified Nurse Assistant #7 stated Resident #3 has a history of panic attacks and would sometimes use bad words when they get nervous. During a telephone interview on 6/12/2024 at 1:42 PM Registered Nurse #3, they stated they stated they were notified by a physician from Managed Long-Term Care that Resident #3 reported to they were hit by staff. Resident #3 was alert and oriented and knows what is going on. Registered Nurse #3 stated they went into the Resident #3's room with the physician and spoke with Resident #3 and did an assessment to see if there were bruises or skin changes and there were none. Registered Nurse #3 stated Resident #3 told them they were hit on the head by a certified nurse assistant. Registered Nurse #3 stated the resident could not say the name of who it was that had hit them. Registered Nurse #3 stated they asked Resident #3 to describe the person that hit them, and Resident #3 was apprehensive, maybe even scared but stated a tall black female. Registered Nurse #3 stated they looked at the certified nurse assistants working at the time and were able to identify who the staff member was. Registered Nurse #3 stated they reported what Resident #3 told them to the Director of Nursing and an investigation was initiated and another skin assessment was done. Registered Nurse #3 stated Resident #3 went out to the hospital after that day, because they felt threatened, and they were scared that the staff member would retaliate and wanted to be sent out to the hospital. Registered Nurse #3 stated the investigation continued after the resident left to the hospital. Attempts to interview the Social Worker via phone on 6/11/2024 and 6/12/2024 was unsuccessful. 10 NYRCC 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 - Some	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** 49372 Based on record review and interviews during an abbreviated survey (NY00343399, NY00332174, NY00337805), the facility did not ensure that all alleged violations of abuse, neglect, exploitation or mistreatment including injuries of unknown source was reported in accordance with the Federal Law immediately, but no later than 24 hours after forming the suspicion, if the events that cause the suspicion do not result in serious bodily injury. Incidents were not reported by facility staff to the administration in a timely manner and the facility did not submit the results of all investigations to the New York State Department of Health within 5 working days in accordance with State Law for 3 out of 3 residents (Resident #1, #2, #3) reviewed for abuse. Specifically, (1) on 5/27/2024, Licensed Practical Nurse #1 reported they heard a voice saying, shut up from Resident #1's room and what sounded like a slapping sound, and Housekeeper #1 stated they heard Resident #1 crying in their room and someone saying stop, stop; and what sounded like a slapping sound; (2) on 1/23/2024 there was an incident between Resident #2 and Certified Nurse Assistant #3 while providing care when Resident #2 became aggressive. The incident was not reported to the Administrator until 1/24/2024 when a visitor reported they witnessed Resident #2 being tapped on the back of the head by Certified Nurse Assistant #3 while in a wheelchair in their room; (3) Certified Nurse Assistant #7 witnessed Resident #3 been bopped on the head by Certified Nurse Assistant #5 on 4/1/2024. The incident was not reported to the Administrator by the staff until Resident #3 reported to the Medical Director of Managed Long Term Care during a visit on 4/2/2024 that they were left in the shower for a longtime wearing their adult brief and was bopped in the head by Certified Nurse Assistant #5 using their knuckle because the resident would not follow their commands. No investigative reports were submitted to the New York State Department of Health within 5 working days of the incidents. Findings include: The facility abuse policy documented that for reporting abuse the facility must follow time frames established in the regulations. Federal regulations and state regulations require the reporting of alleged violations of abuse, mistreatment and neglect including injuries of unknown origin, immediately to the facility administrator and in accordance with state law, to the Department of Health. An allegation, as previously stated, must be reported immediately to the Department of Health when meeting the reasonable cause standard. Resident #1 had diagnoses including but not limited to Dementia, Primary Lateral Sclerosis and Adjustment Disorder. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 12/15, associated with moderate cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). Resident #1 had other behavioral symptoms not directed towards others. Resident #1 had limited range of motion and impairment on both sides, upper and lower extremities; required supervision for eating and is dependent for toileting and transfers; required maximal assistance with bed mobility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the investigative summary dated 5/27/2024 documented Licensed Practical Nurse #1 reported that they heard from Resident #1's room a voice saying, shut up and what sounded like a slapping sound. Housekeeper #1 stated they heard Resident #1 crying in their room and someone saying stop, stop; and what sounded like a slapping sound. A review of the investigation conclusion dated 5/29/2024 documented Resident #1 initially reported to the supervisor that Certified Nurse Assistant hit them on the forehead. The resident was emotional at the time and most likely did not understand the question; no signs of redness or bruising were identified at that time or later. The Resident denied being hurt by the Certified Nurse Assistant later that afternoon. Based on the investigation it is concluded that Resident #1 was never hit by the Certified Nurse Assistant. There was no documented evidence of a 5-day investigative summary with conclusion submitted to the New York State Department of Health. Resident #2 had diagnoses including but not limited to Dementia, muscle weakness, and Type II Diabetes Mellitus. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 2/15 associated with severe cognition impairment. Resident #2 exhibited physical and verbal behavioral symptoms as well as rejecting cares. Resident #2 had impairment on both sides to the lower extremities; required supervision for eating, set-up assistance with bed mobility and moderate assistance for toileting and transferring. A review of the investigative summary dated 1/24/2024 documented that the Administrator was notified by a visitor in the facility of a potential abuse on 1/23/2024 in the form of a staff tapping on the head of a resident. The visitor stated that they were visiting their mother, and as they walked down the hall to exit the unit, and they may have witnessed the incident from the back. The resident was identified as Resident #2, and the staff was identified as Certified Nurse Assistant # 3. The report documented that Certified Nurse Aide #3 confirmed that they were assigned to Resident #2 on 1/23/2024 and during cares Resident #2 became combative and aggressive, kicking and slapping and trying to get out of the wheelchair. Certified Nurse Assistant #3 to prevent Resident #2 from falling went to the back of the wheelchair and tried to pull the resident back in the chair. Resident #2-bit Certified Nurse Assistant #3's finger and while trying to get out their finger, they saw a family member walking by. Certified Nurse Aide #3 stated they reported the incident to Licensed Practical Nurse #2(the nurse on duty) who advised them to report to the nursing supervisor. No broken skin was noted on Certified Nurse assistant #3. Certified Nurse Assistant #3 told Certified Nurse Assistant #4 on the day of the incident that they held Resident #2's head backwards to release their finger from the resident's mouth. Nursing Supervisor stated they were only informed by Certified Nurse Assistant #3 that Resident #2 was combative but was not informed that Resident #2 was hit in the head. A complete head to toe assessment was completed on the resident on 1/24/2024 when the administrator was made aware of the incident by the visitor who returned to the facility the day after the incident. Review of the investigation conclusion dated 1/24/2024 documented that based on the investigation it was determined that no abuse occurred. However, it was identified that Certified Nurse Assistant #3 did not call for assistance once Resident #2 became physically combative. It was also recognized that Certified Nurse Assistant #3, Licensed Practical Nurse #2, and Certified Nurse Assistant #4, did not communicate to the nursing supervisor about the visitor's concern of the potential abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence of a 5-day investigative summary submitted to the New York State Department of Health. Resident #3 had diagnoses including but not limited to Asperger's syndrome, muscle weakness and dysphagia. An Admission Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15/15 denoting intact cognition. Resident #3 socially isolates sometimes and exhibits physical and verbal behaviors. Resident #3 also exhibits other behavioral symptoms not directed towards others. Resident #3 had impairment to the upper extremity on one side and to both lower extremities; required set up for meals, maximal assistance for toileting and transfers and moderate assistance for bed mobility. A review of the investigative summary documented that on 4/2/2024, at approximately 4:30 PM the Social Worker was informed by the medical director on the Managed Long-Term Care, that Resident #3 reported that on 4/1/2024 they were left in the shower by a Certified Nurse Assistant wearing only their adult depends. Resident #3 also reported Certified Nurse Assistant#5(a friend of the certified nurse assistant #6 who provided the shower) bopped them on the head with their knuckles because they would not follow their demands. The report documented that Certified Nurse Assistant #7 stated while in the hallway, they saw Resident #3 been wheeled back to their room and Certified Nurse Assistant #5 was walking next to Resident #3 Certified Nurse Assistant #7 stated they heard Resident #3 telling Certified Nurse Assistant #5 don't hit on my head. Certified Nurse Assistant #7 looked and saw Certified Nurse Assistant #5 hit Resident #3 on the head x2. Certified Nurse Assistant #7 did not report the incident to the Nurse Supervisor because they stated that Resident #3 was alert and they assumed Resident #3 will report the incident. Review of the investigation conclusion documented that based on the investigation Resident #3's complaint of being left in the shower for a long time by Certified Nurse Assistant #6 could not be corroborated. Resident #3's report of being bopped on the head by Certified Nurse Assistant #5 was witnessed by Certified Nurse Assistant #7. Therefore, it was concluded that Certified Nurse Assistant #5 bumped Resident #3 on their head at some point while passing by the resident. There was no documented evidence of a 5-day investigative summary submitted to the New York State Department of Health. During an interview on 6/4/2024 at 9:35 AM, the Director of Nursing stated they do not submit a 5-day investigative conclusion because they are usually contacted by the Department of Health and requested to submit, if needed. During a follow up interview on 6/6/2024 at 12:05 PM, the Director of Nursing stated allegations of abuse with no injury are investigated internally and reported to the Department of Health. The Director of Nursing stated if there is found to be an injury then the incident will be reported to the police as well. The Director of Nursing stated none of the incidents were reported to the police as there was no physical evidence of injury to the residents involved. The Director Nursing stated their policy for reporting abuse, they believe is up to date with the current regulations. 10NYCRR 415.4(b)(1)(ii)