STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335003	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emerald Peek Rehabilitation and Nursing Center	2000 East Main Street Peekskill, NY 10566

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 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. 47626 Based on record review, and interviews during the Abbreviated Survey (NY 00315316) the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than two hours to the New York State Department of Health. This was identified for one (Resident #2) of 3 residents reviewed for abuse. Specifically, the facility received an accusation of abuse of Resident #2 on 4/24/2023 and did not report the allegation of abuse to the New York State Department of Health. Findings include: The facility Policy and Procedure titled Abuse, Neglect, Exploitation or Mistreatment - Reporting and Investigating, documented if resident abuse, neglect, exploitation, or misappropriation of resident property or injuries of unknown origin is suspected, the suspicion must be reported immediately to the administrator and other officials. The Care Plan titled Victim of Abuse dated 4/19/2023, documented a goal that the resident would not be a victim of abuse. Interventions included to investigate all allegations of abuse, provide support, and ensure resident is not a victim of abuse. The Accident & Incident Investigation dated 4/24/2023, documented the Administrator received an email alleging abuse and mistreatment of Resident #2 with no mention of time or staff. The reported also noted skin discoloration to Resident #2's left forearm. The facility closed out the abuse neglect or mistreatment investigation on 4/28/2023 noting no evidence of abuse, neglect, or mistreatment. A nursing progress note dated 4/24/2023 documented a phone conversation with a family member. The family member expressed concerns regarding staff getting angry with the resident when the resident did not move fast enough. The family member inquired about the bruise on the resident's arm and was informed it was the result of venipuncture. The Event Report dated 4/24/2023 documented Resident #2 had a lightly discolored area to the left forearm. The Accident &Incident report dated 4/24/2023 documented an alteration in skin integrity was investigated and the blueish discoloration on arm was related to a blood draw the previous day. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of email dated 4/27/2023 from the Attorney General's office to the facility requested information be sent for an accusation of abuse. Review of New York State Department of Health intake records for facilities to report allegations of abuse revealed the facility did not report the allegation. When interviewed on 4/1/2024 at 2:45 PM, the Director of Nursing stated they began the investigation as soon as we were made aware of the allegation. They stated the Administrator was working with the New York State Attorney General's office, and they were told the Attorney General would report the allegation to the Department of Health and the ombudsman. When interview on 4/1/2024 at 3:15PM, the Administrator stated they were made aware of the concerns from the family late on 4/24/2023 and received a forwarded email from corporate which was written by the family about allegation of abuse. The nurse manager on the unit immediately investigated the allegation and ruled out abuse. The Administrator stated they thought the Attorney General's office would notify the Department of Health. When interviewed on 4/2/2024 at 10:49 AM, the investigator from the Attorney General's Office stated the first time they spoke with the facility about the allegation was on 4/27/2023. At the time the facility was advised the family made a complaint regarding abuse. The facility was aware of the complaint and sent us a copy of the investigation. The facility was not told that the Attorney General's office would report the allegation to the Department of Health. When interviewed on 4/2/2024 at 11:25 AM, the Assistant Director of Nursing stated they were notified there was an allegation of the overall treatment of the resident and bruising. The Assistant Director of Nursing stated they were aware that allegation of abuse it needed to be reported to the Department of Health. The Nurse Manager was able to assess the resident's physical status and at that time saw no signs of abuse. 10 NYCRR 415.4(b)(2)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on record reviews and interviews during the abbreviated surveys (NY00321069), it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for one (1) of three (3) residents (Resident #1) reviewed for accidents. Specifically, Resident # 1 fell from their bed on [DATE] when the plan of care for a 2-person assist with bed mobility was not followed. Resident #1 sustained a subdural hemorrhage (brain bleed) and a lip laceration. The resident expired in the hospital on [DATE]. This resulted in actual harm that was not immediate jeopardy. Findings include: Resident #1 was admitted to the facility with diagnoses including a history of subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane) with residual neurological deficits, and a Stage IV sacral pressure injury. The Admission Minimum Data Set (a resident assessment tool) dated [DATE] documented the resident had severely impaired cognition and required total assistance for activities of daily living. The Activities of Daily Living Care Plan dated [DATE] documented the resident required total assist of 2 persons for all activities of daily living including bathing and bed mobility. The Kardex (instructions for direct care staff) dated [DATE] documented the resident required a 2 person assist for bathing, bed mobility, toilet use and transfers. The Certified Nurse Aide task documentation record dated [DATE], revealed the resident was totally dependent on staff for bathing and bed mobility and required a 2 person assist. For bathing and bed mobility during the 7:00 AM to 3:00 PM shift, the resident received a 1 person assist 59% of the time. For bed mobility during the 3:00 PM to 11:00 PM shift, the resident received a 1 person assist 67% of the time, and during the 11:00 PM - 7:00 AM shift, received a 1 person assist 89% of the time. The Registered Nurse Supervisor #1 progress note dated [DATE] at 8:56 AM, documented they were called to the resident's room around 7:48 AM for an assessment. The Certified Nurse Aide had been providing hygiene care when the resident rolled off the other side of the bed and ended up on the floor on their right side with a pillow underneath the right side of their face. There was a cut noted on top of the right lip. The resident was assessed, assisted back to bed, and hygiene care resumed. The physician progress note dated [DATE] at 10:20 AM, documented the resident was seen status post fall out of bed. The resident had a small laceration to their right upper lip and no other head trauma noted. The resident was on Eliquis (blood thinner) and would be sent to the emergency room for evaluation including head CT to rule out bleed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The Accident & Incidence Investigation dated [DATE] documented at approximately 8:00 AM the resident fell off the bed while receiving care. The resident was rolled to the side of the bed when their legs slid off the edge of the bed and their body followed. The resident landed on their right side with their head maintained on a pillow. The resident was assessed by the registered nurse with a laceration to the lip and no other visible signs of injury. The resident was returned to bed and seen by the primary care physician around 9:15 AM for evaluation and an order was given to transfer to the acute care setting for further evaluation, treatment of lip laceration and to rule out head trauma. Certified Nurse Aide #4's written statement dated [DATE] at 8:00 AM, documented they had given the resident a bed bath and was repositioning the resident during an incontinence brief change and went to reach for supplies when the resident fell . A typed statement written by the Assistant Director of Nursing, dated [DATE], documented they interviewed Certified Nurse Aide #4 who acknowledged the resident was care planned for a 2 person assist and they were providing the resident's care without a second person. The nursing progress note dated [DATE] at 2:27 PM documented Hospital #1 informed the facility Resident #1 had a subdural hematoma and was being transferred to Hospital #2. When interviewed on [DATE] at 10:00 AM, the Assistant Director of Nursing stated they arrived at work on [DATE] and were informed the resident had fallen out of bed. Registered Nurse Supervisor #1 assessed the resident and called the attending physician who stated they would be at the facility soon and would see the resident. Vital signs and neurological checks were within normal limits. Attending Physician #1 arrived, assessed the resident and ordered the resident be sent to the Emergency Department related to the lip laceration and the possible need for a Computed Tomography (CT) scan. The Assistant Director of Nursing stated Certified Nurse Aide #4 knew the resident should have been a 2 person assist with care. They did not know why Certified Nurse Aide #4 did not ask for help and they were not short staffed. They stated there was a care plan violation. When interviewed on [DATE] at 3:45 PM, Registered Nurse Supervisor #1 stated at the end of the shift on [DATE], they were called to the resident's room because the resident fell . The resident was on the floor, they were assessed, and vital signs were stable. The family and the attending physician were called. The attending physician stated they were on the way and would see the resident when they arrived. Certified Nurse Aide #4 was sent home (and later terminated) because the resident was a 2 person assist and Certified Nurse Aide #4 was caring for the resident alone when the resident fell . When interviewed on [DATE] at 9:00 AM, Attending Physician #1 stated they were notified of the resident's fall on their way to the facility and assessed the resident upon arrival. The resident was in no acute distress, but since the resident was on blood thinners, they decided to send the resident to the emergency room for further testing. The physician stated they were unaware of the hospital findings and the resident did not return to the facility. Review of hospital records from Hospital #2, on [DATE], revealed on [DATE] Resident #1 was transferred from Hospital #1 to Hospital #2 after a Computed Tomography of the head showed a subdural hematoma (brain bleed) after a fall from the bed at the nursing home. The laceration to the lip was repaired at Hospital #1. The resident expired at Hospital #2 on [DATE] at 6:10 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of hospital records from Hospital #1, received on [DATE], documented on [DATE] Resident #1 arrived via Emergency Medical Services from the skilled nursing facility. Reported to have a fall from bed while being turned, patient was noted with a laceration to right lip. Further notes documented a 1-centimeter jagged laceration to right maxilla/right upper lip, through and through with intraoral laceration (soft tissue wound). Computed Tomography scan of head was done with findings of acute subdural hematoma overlying the right cerebral hemisphere. The case was discussed with Neurosurgery who recommended the resident be transferred to Hospital #2. Clinical Impression was documented as a right-sided subdural hematoma with mass effect; fall from bed. The plan was to transfer the resident to Hospital # 2 for a higher level of neurological management. When interviewed on [DATE] at 11:40 AM, the neurosurgeon from Hospital #2 stated the resident had a subdural hematoma following a fall in the skilled nursing facility. The resident had an acute subdural hematoma with a large midline shift resulting in the need for surgery. The resident returned to baseline after the surgery, at that time the family decided to implement palliative care and the resident expired in the hospital. The subdural hematoma was most likely caused by the fall, and the resident's prior brain injury, the presence of a shunt and the use of anticoagulants put the resident at risk for this injury. During a telephone interview on [DATE] from 11:19 AM to 11:47 AM, the Director of Nursing and Assistant Director of Nursing stated they did not interview other certified nurse aides regarding how they performed care for Resident #1 as the fall was an isolated incident of one certified nurse aide not following the care plan. During review of the Certified Nurse Aide task documentation record dated [DATE], the Director of Nursing and Assistant Director of Nursing explained the resident's assistance level should be coded as a 3 for a 2 person assist. They reviewed the documentation and stated it was coded as a 2 which meant a 1 person assist for bed mobility and toilet use on multiple occasions. They stated it was a coding error and staff knew the resident required a 2 person assist. They stated they did not interview the individuals that documented the performed bed mobility or toilet use as a 1 person assist to determine if it was a coding error. They stated they did a full house education, and the consensus was the staff were using a 2 person assist. During the interview the Accident & Incidences Investigation dated [DATE] and signed off by the Director of Nursing on [DATE] was reviewed and the corrective actions including education and periodic audits on certified nurse aide's compliance/competency with care plan recommendations and understanding importance of ensuring residents safety was requested. Review of the In-Service Attendance Sign-In Sheet dated [DATE], ongoing Following assigned plan of care and assist levels for caregiving revealed, there is ongoing education of certified nursing staff. A sign in sheet dated [DATE], Topic/Meeting for Activities of Daily Living level of assistance for bed mobility, transfers and toileting for bed ridden residents in regular and air mattresses revealed, there is ongoing education of certified nursing staff. 10 NYCRR 415.12(h)(2)