STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335006	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Luther Residential Hlth Care & Rehab	110 Utica Road Clinton, NY 13323

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interview during the abbreviated and extended survey (NY00323717), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 of 6 residents reviewed (Resident #2 and #7. Specifically, Resident #2 had a fall with a hematoma (pooling of blood under the skin) to the back of their head and neurological checks were not completed. When the resident had a change in condition (lethargy, sluggish eye movement, slow to speak, and vomiting), a medical provider was not notified in a timely manner (approximately 2 hours after symptoms began). Additionally, a delay in transport to the hospital occurred when the facility was not able to reach Emergency Medical Services. Subsequently, the resident was sent to the hospital 3.25 hours after their change in condition was identified, diagnosed with a severe brain hemorrhage (bleed) and expired the next day. Resident #7 had a fall with a hematoma to the back of their head and was sent to the emergency room for evaluation. When Resident #7 returned to the facility approximately 4 hours later, neurological checks did not resume. The facility's failure to monitor the neurological status of Resident #2 and respond to a change in condition places all 102 residents in the facility at risk. This resulted in actual harm that was Immediate Jeopardy and Substandard Quality of Care to resident's health and safety. Findings include: The Neurological Checks Policy effective/renewed on [DATE] documented nursing staff would identify changes in a resident's neurological status based on evaluation of several factors and report changes to the physician immediately. The licensed nurse identified the need for a resident's neurological exam based on physician order and resident complaints of neurological symptoms. If a physician did not order routine neurological exams, the facility default process would be as follows: every 15 minutes x 1 hour, every 30 minutes x 1 hour, every 1-hour x 4 hours and every 4 hours until 24 hours had elapsed. The procedure included to check vital signs, check the mental status as it related to the resident's normal routine mental state (were they alert and oriented, did they respond to simple verbal commands, was their behavior within normal limits), and check the resident's pupil size, equality, and reactiveness to light. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Notification of Resident Conditions to Providers Policy effective/renewed on [DATE] documented changes in a resident's condition or treatment were to be immediately shared with the resident and/or the resident representative and reported to the primary care provider/on call practitioner to prevent delay in treatment. Nursing would immediately notify the resident's physician of a significant change in the resident's physical, mental or psychological status that was a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications including any symptom, sign, or apparent discomfort that was: acute or sudden in onset; a marked change in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Examples of when to notify the medical provider immediately included any neurological changes or emesis. 1) Resident #2 had diagnoses including diabetes, cirrhosis (chronic liver damage) and dementia. The [DATE] Minimum Data Set assessment documented the resident's cognition was severely impaired, they needed assistance of one staff with bed mobility and locomotion in their room, and they were independent with transfers. The [DATE] comprehensive care plan documented the resident was alert and able to make most of their needs known. They were at risk for falls and had falls on [DATE], [DATE], [DATE], [DATE], and [DATE]. Interventions included to ensure the resident wore appropriate footwear, call light within reach and encourage its' use, encourage use of a walker as resident was forgetful at times, dresser bolted to wall, and non-skid strips in room. The [DATE] 10:57 AM, Registered Nurse #2's progress note documented they were called to the resident's room by a Certified Nurse Aide (unidentified). The resident was found on the floor, seated upright, next to the closet and stated they were cleaning up their room. They had a hematoma (pooling of blood under the skin) to the back of their head and no other injury noted. Ice was applied, vital signs were stable, and the initial neurological check was within normal limits. Nurse Practitioner #8 was notified, and neurological checks were initiated per facility protocol. The [DATE] neurological check list, completed by Registered Nurse #2 documented: - at 10:30 AM and 10:45 AM, the resident was alert and oriented to person and situation and could follow a finger with their eyes. They had pain of 5 out of 10 (moderate pain) and stated their head hurt. - At 11:00 AM and 11:30 AM, the resident was oriented to person, level of consciousness was lethargic (sluggish) and they were lethargic when following a finger with their eyes. They were resting with an ice pack on their head. - At 12:30 PM, the resident continued to be oriented to person, level of consciousness was lethargic, they were lethargic when following a finger with eyes, and they were also slow to speak. There was no documented evidence neurological checks were completed at the intervals per the required facility process and no documented evidence a medical provider was notified timely after the resident had multiple documented episodes of changes in condition. The [DATE] Incident Statements obtained by the facility documented: (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- by Registered Nurse #2 at 10:30 AM, a Certified Nurse Aide (unidentified) alerted them the resident was on the floor and was found next to their closet. They had a hematoma to the back of their head, pupils were reactive to light, hand grip strength was equal, and speech was clear. At 10:35 AM, the medical provider was notified. At 11:45 AM, the resident was becoming more lethargic, speech was clear but slow. At 12:15 PM, the resident had emesis of undigested food. At 12:30 PM, vital signs were stable. At 1:00 PM, the on-call medical provider was notified and ordered to send the resident to the hospital. - by Registered Nurse Supervisor #3, at approximately 12:50 PM, Registered Nurse #2 updated them the resident fell at 10:30 AM. Registered Nurse #2 reported they completed the paperwork, initiated neurological checks, and the resident's vital signs were normal. Registered Nurse #2 reported the resident had one episode of emesis and they instructed them to immediately update the on-call medical provider. Registered Nurse Supervisor #3 also documented at 1:10 PM, the facility had difficulty reaching Emergency Medical Services. - A second statement from Registered Nurse #2 documented all times in their initial statement were approximate and the resident's vital signs were within normal limits. The resident started to show signs of lethargy however only slightly. The resident answered questions clearly and appropriately the entire duration. When emesis was noted, they immediately went to Registered Nurse Supervisor #3, called Nurse Practitioner #8, and began the process of sending the resident to the hospital. The [DATE] Incident Summary completed by the Director of Nursing documented: - Per interview with Certified Nurse Aide # 5, they found the resident on the floor in their room at 10:30 AM. - Per interview/statements from Registered Nurse #2, at 11:45 AM, the resident complained of a headache and acetaminophen (Tylenol) was given. The resident was slightly lethargic, and speech was slow but clear. - At 12:00 PM, the resident was given lunch in their room and at 12:15 PM, the resident vomited. - At 12:30 PM, vital signs were stable. - At 1:00 PM, per interview/statements from Registered Nurse #2 and Registered Nurse Supervisor #3, the resident was noted with increased lethargy and speech was clear but slower and softer. Registered Nurse #2 notified Registered Nurse Supervisor #3 of the fall that morning, they were now showing signs of increased lethargy and vomited once a medium amount. Registered Nurse Supervisor #3 directed Registered Nurse #2 to call the on-call medical provider and notify them of the resident's changes. An order was received to send to hospital. - At 1:45 PM, the ambulance arrived, and the resident left the facility at 2:15 PM. - At 6:25 PM, the hospital reported the resident had a severe brain hemorrhage (bleed), their family declined surgical intervention, and they had a poor prognosis. - At 6:54 AM ([DATE]), they were notified the resident expired. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Abuse and neglect were ruled out and there were no care plan violations. The [DATE] Prehospital Care Report completed by Emergency Medical Services Providers #9 and 10, at 1:41 PM documented Emergency Medical Services was contacted and dispatched, and they arrived at the facility at 1:52 PM. During a telephone interview on [DATE] at 10:02 AM, Certified Nurse Aide #4 (assigned to care for the resident on [DATE]) stated the resident was often very confused, needed help with ambulating and was non-compliant. They only saw the resident once after they fell and when Certified Nurse Aide #4 asked the resident questions, they were not their normal chatty self. They did not recall what time this was. The resident was lying in their bed with their eyes closed with an ice pack on their head. During a telephone interview on [DATE] at 10:38 AM, Certified Nurse Aide #5 stated the resident knew their own name, knew their family members names, and liked to talk. The day of the fall, they went into the resident's room about ,d+[DATE] minutes after lunch trays were served. The resident was in bed, was tired and lethargic and was not presenting per their usual self. Registered Nurse #2 mentioned to them the resident vomited during the lunch meal and Certified Nurse Aide #5 asked Registered Nurse #2 if they were going to call the physician because vomiting was a sign of a concussion. Certified Nurse Aide #5 was not sure how soon after that the physician was called. During a telephone interview on [DATE] at 11:22 AM, Registered Nurse #2 stated neurological checks were to be done every 15 minutes for 1 hour, every 30 minutes for 1 hour, and every 1 hour for 4 hours until 24 hours had passed. They stated they would be concerned if a neurological check showed a resident had unequal pupils or if they were lethargic unless that was their normal presentation, and they would call the medical provider immediately for those concerns. When they did neurological checks for the resident's [DATE] fall, they wrote all the neurological checks on a piece of paper and entered the information into the medical record later that day. They believed they completed all neurological checks however might have missed documenting some because they wrote them on a piece of paper and documented them in the electronic medical record later on. At 11:00 AM, they documented the resident was lethargic because they believed the resident wanted to take a nap and kept stating they just wanted to lie down. The resident was responding clearly at that time. At 12:15 PM, they checked on the resident, found they had vomited and that was when they had a change in condition. At 12:30 PM, the resident was slow to speak and that was a change in condition. After the resident vomited, they notified Registered Nurse Supervisor #3 about their change in neurological status. Registered Nurse Supervisor #3 assessed the resident, the medical provider was notified, and the resident was sent to the hospital. They stated that all the times they documented in the medical record were approximate as they had documented notes later in the shift. They stated they did not recall any certified nurse aides reporting concerns regarding the resident that day. During a telephone interview on [DATE] at 12:11 PM, Registered Nurse Supervisor #3 stated as the Supervisor, staff typically reported to them when someone fell or was ill and they assessed the individual in question. If there was another Registered Nurse on the unit, then the Supervisor did not have to be notified. On [DATE], Registered Nurse #2 reported to them the resident fell earlier in the shift, Registered Nurse #2 started neurological checks and started the required paperwork. Registered Nurse #2 also reported the resident vomited and they instructed them that it was a change in condition, and they needed to notify a medical provider. (continued on next page)

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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 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

During a telephone interview on [DATE] at 10:22 AM, the Director of Nursing stated they expected a medical provider to be immediately notified for any alteration in mental status or for a change in neurological checks after a resident hit their head. When they completed the investigation into the resident's fall, they were not aware Registered Nurse #2 had not completed neurological checks per facility policy process. Registered Nurse #2 should have notified a medical provider on [DATE] at 11:00 AM when the resident first showed signs of being lethargic. They interviewed Registered Nurse #2 after the incident and asked them why they did not intervene, and Registered Nurse #2 stated the change in condition was very close to the resident's baseline with only a slight shift noted. At 12:15 PM, the resident was noted to vomit and at around 1:00 PM the Supervisor was notified. The Director of Nursing interviewed Registered Nurse #2 about the delay in notification and Registered Nurse #2 reported they were cleaning up vomit and doing vital signs. The Director of Nursing stated the Supervisor and medical provider were not notified timely of the resident's change in condition. That day, Certified Nurse Aide #5 reported to them concerns with the resident's care. Certified Nurse Aide #5 stated they had to tell Registered Nurse #2 to go and get the Supervisor because vomiting was a sign of a concussion.

During an interview on [DATE] at 10:54 PM, former Medical Director #7 (Medical Director at the time of the resident's incident) stated after a resident hit their head, they expected a medical provider to be immediately notified for a change in cognition from their baseline or for nausea, vomiting, or headache. When the resident showed a change in their alertness at 11:00 AM, Registered Nurse #2 should have notified a medical provider. When the resident vomited, that could have indicated a worsening in their neurological status. When it took approximately 3 hours from when the first symptom began to transport to the hospital, they stated the nurse should have notified a medical provider sooner. Earlier intervention could have resulted in a different outcome for the resident however that was dependent on the resident's conditions including comorbidities.

During an interview on [DATE] at 9:40 AM, Registered Nurse Supervisor #3 stated when a resident had a change in condition, the Registered Nurse completed an assessment, notified the medical provider, and completed any follow-up orders from the medical provider. Registered Nurse Supervisor #3 stated if a resident needed to be sent to the hospital because of a change in condition, the facility called the Emergency Medical Service company directly and they should call Emergency Medical Services as soon as possible once they have an order to send a resident to the hospital . On [DATE], Registered Nurse #2 notified Nurse Practitioner #8 of the resident's change in condition and Nurse Practitioner #8 ordered the resident to be sent to the hospital. Registered Nurse Supervisor #3 called the ambulance company using the first number in the book on the unit and got a voicemail. After that, they tried the company's emergency number and that did not work either. When they called the third time, they reached someone. Registered Nurse Supervisor #3 stated it could have taken them 30 minutes to reach someone at the ambulance company but they did not think to try 911 instead. They stated a head injury with vomiting was considered an emergency. They started calling Emergency Medical Services at 1:10 PM and got ahold of them at 1:41 PM and that was a delay. After this incident, they did not recall speaking to anyone in Administration about the issue with getting in contact with Emergency Medical Services.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 9:54 AM, the Emergency Management System Chief #11 stated the facility had a 7-digit emergency number to contact them directly or could call 911 in the event of an emergency. They stated it was their understanding that in the event of a cardiac arrest (when someone's heart stopped), the facility called 911 and for all other events, they called Emergency Medical Services directly. They stated if the facility called their 7-digit emergency number and the call was not picked up after 3 rings, it automatically forwarded to 911. They stated the company had other non-emergent numbers that go to an automated line. They stated the facility was provided literature that clearly defined who to call for emergencies. During an interview on [DATE] at 10:26 AM, Registered Nurse #2 stated in an emergency, they called Emergency Medical Services directly or called 911. They stated there was a paper posted on the wall with the number of the ambulance company. They stated on [DATE], they were aware that Registered Nurse Supervisor #3 stated it took around 20 minutes to reach Emergency Medical Services and they did not discuss calling 911. During an interview on [DATE] at 11:15 AM, the Director of Nursing stated the telephone numbers for Emergency Medical Services were posted at each nursing station. They called 911 for cardiac arrest situations. They thought this was reviewed in orientation. After the incident, they discussed with the Administrator, Registered Nurse Supervisor #3's difficulty reaching Emergency Medical Services after 3 different numbers were used. The Director of Nursing stated they discussed what the time frame they wanted nursing to reach Emergency Medical Services. Their preferred window was 10 minutes and if they did not reach them within 10 minutes, they would call 911. They questioned whether the Emergency Medical Services documentation of time frame was accurate, and they never followed up with them after this incident. After the incident, Registered Nurse Supervisor #3 called the supervisor's number for the company and whoever answered gave the correct number to call. They stated 30 minutes to reach Emergency Medical Services was not timely and they should have called 911. During an interview on [DATE] at 11:45 AM, current Medical Director #12 stated they were not sure if there was a protocol for how quickly staff should try and reach Emergency Medical Services in the event someone needed to be sent out related to a change in condition. They stated the nurse should call for Emergency Medical Services promptly after receiving an order. They stated they could not provide more specific information as they were not directly involved in the incident. 2) Resident #7 had diagnoses including Alzheimer's Disease, epilepsy (seizure disorder), and cellulitis (skin infection) of the right lower leg. The [DATE] Minimum Data Set assessment documented the resident had severe cognitive impairment and had no falls since admission or the last assessment. The [DATE] at 5:10 AM, Incident Report by Registered Nurse Supervisor #14 documented the resident had an unwitnessed fall and was found on their back between the footboard and closet in a very tight spot, with their feet facing the door. The resident stated they were trying to get to the bathroom but was found in front of the closet. The resident was last seen at 4:39 AM when checked for incontinence and was provided water. The resident stated they hit their head when landing on the floor and complained of shoulder pain. Registered Nurse Supervisor #14 palpated the resident's head and found a big bump on their posterior (back) head, with no blood. They did not move the resident, called the on-call medical provider and Emergency Medical Services and the hospital was made aware. The [DATE] at 5:10AM Registered Nurse Supervisor #14's progress note documented Emergency Medical Services was notified and arrived at the facility at 5:37 AM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The [DATE] at 7:44 AM, hospital emergency room progress note documented the resident was seen for evaluation after a fall. Laboratory results were reviewed, the resident was on medication for cellulitis (skin infection) of the right leg. The hospital care timeline included: laboratory blood tests and a change in antibiotic medication. The resident was discharged at 9:30 AM. The [DATE] hospital After Visit Summary and Discharge Recommendations documented the resident was seen for a fall and the diagnosis was bacterial skin infection of the leg. Tests completed included multiple blood tests. An antibiotic was given with a new order to start an antibiotic. The [DATE] at 8:51 AM Registered Nurse Supervisor #14's progress note documented the hospital called and the resident was being sent back to the facility. The note further documented no extensive diagnostic testing was done regarding the head injury or shoulder pain. The resident was prescribed an antibiotic for cellulitis on the right leg. The hospital's Emergency Department Provider note timeline of care documented the resident was discharged to the nursing facility on [DATE] at 9:30 AM. Per the facility's process, neurological checks were to be completed following the Emergency Department visit including: - Every 1 hour from 6:10 AM to 10:10 AM (resident returned to the facility at 9:30 AM). - Every 4 hours from 10:10 AM on [DATE] through 5:10 AM on [DATE] (neurological check was due to be done on [DATE] at 2:10 PM, 6:10 PM, 10:10 PM, and on [DATE] at 2:10 AM). The [DATE] neurological check sheet documented neurological checks were completed at 2:58 PM . A neurological check in the morning of [DATE], when the resident returned from the hospital, was not documented. The [DATE] at 10:18 PM Registered Nurse #2's progress note documented a fall follow-up; the resident was alert with confusion, they had no signs of injury , denied pain, and their vital signs were within normal limits. The [DATE] at 10:46 PM, progress note entered by Registered Nurse #15 documented the resident's vital signs at 6:00 PM and 10:00 PM, and noted they were alert, hand grips equal, moved all extremities, had clear speech, and pupils were equal, round, and reactive to light and accommodation. There was no documented evidence neurological checks were resumed per facility process when the resident returned from the hospital. During an interview with Registered Nurse Supervisor #14 on [DATE] at 11:19 AM, they stated on [DATE] they received a call from the hospital the resident would be returning, around 9:00 AM and they completed a progress note. The resident did not arrive back to the facility prior to them leaving the facility for the day. They reported to Registered Nurse #2, including the information from the hospital that no diagnostic testing related to the head injury was completed. They did not provide any specific instructions to Registered Nurse #2. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

During an interview with Registered Nurse #2 on [DATE] at 1:39 PM, they stated the resident returned from the hospital on [DATE] at approximately 9:30 AM. They stated they were aware the hospital did not do any head scans or testing related to the head injury. The hospital did blood work and changed the resident's antibiotic for the cellulitis on their leg. Registered Nurse #2 received report from Registered Nurse Supervisor #14 related to the resident's fall, head injury, and lack of diagnostic testing in the hospital. Registered Nurse #2 did not review the discharge paperwork from the hospital. Registered Nurse Supervisor #14 went through the hospital paperwork and called medical to clarify the antibiotic change order. Registered Nurse #2 stated the Supervisor did not provide them with instructions to resume the neurological checks. Registered Nurse #2 stated neurological checks would not need to be resumed following return from the hospital even if was within the 24 hours of the head injury, due to the resident being cleared at the hospital. If there were no tests at the hospital, that must have meant the resident was fine and testing was not needed. There were no instructions to continue the neurological checks from the hospital. At approximately 2:30 PM, Registered Nurse supervisor #13 returned to the unit to advise they should resume the neurological checks on Resident #7 to be on the safe side. Registered Nurse #2 stated they did not understand the reason for resuming the neurological checks and was not sure of the time they did them. They went to another unit at 3:00 PM and may have returned to Resident #7's unit later and did the neurological check.

During an interview with Registered Nurse Supervisor #13 on [DATE] at 3:30 PM, they stated the neurological check protocol was to be implemented immediately following a head injury or unwitnessed fall. Neurological checks were to be done every 15 minutes the first hour, every 30 minutes for the next hour, then every hour for 4 hours, and every 4 hours until 24 hours had passed. If a resident went to the hospital and returned within the 24-hour period, they were considered cleared and neurological checks would not be resumed. There was no specific means to verify if the resident's head injury was cleared at the hospital , as it varied. Typically, the hospital nurse would call and provide report and possibly state if scans were completed at the hospital. If it was reported that no testing was done or no documentation the resident was cleared, Registered Nurse Supervisor #13 stated they would resume neurological checks based on the current time (number of hours since the head injury, not starting over with every 15 minutes). The decision to resume neurological checks was nursing judgment. For Resident #7, Registered Nurse Supervisor #13 stated they assumed the resident was cleared at the hospital since they did not perform any diagnostic testing. They called the medical provider regarding the medication change order and did not discuss the head injury or lack of diagnostic testing or instructions related to the head injury. Registered Nurse Supervisor #13 spoke with the Director of Nursing at approximately 3:00 PM on [DATE] and the Director of Nursing suggested they resume neurological checks for Resident #7. Registered Nurse Supervisor #13 communicated the instructions to Registered Nurse #2 after speaking to the Director of Nursing. The neurological check schedule should have been every 4 hours up to the 24-hour time (from the time of the fall) from the time the Registered Nurse Supervisor communicated it to Registered Nurse #2. Neurological checks were documented under assessments in the resident's medical record, for each time the neurological check was completed.

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

During an interview with the Director of Nursing on [DATE] at 12:38 PM, they stated neurological checks were initiated after any known head injury or unwitnessed fall and monitored for 24 hours at preset time increments (every 15 minutes, 30 minutes, hourly, and every 4 hours). When a resident was sent to the hospital for a head injury and returned within 24 hours, it was the understanding that the resident was cleared at the hospital and neurological checks were not resumed. There was no current policy that addressed discontinuation of neurological checks upon return from the hospital if it was within 24 hours of the injury. Nursing staff typically received a verbal report from the hospital related to how the resident was cleared. If it was reported that there was no diagnostic testing or other assessment of the resident's head injury, it would be expected that neurological checks resumed. When Resident #7 returned from the hospital on [DATE] and it was reported that no diagnostic testing had been performed and it was unknown if the resident had been cleared, the neurological checks should have resumed. The receiving nurse should also have clarified the resident's status related to their head injury and any needed follow up.

10 NYCRR 415.12

Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 5:53 PM. Immediate Jeopardy was removed on [DATE] at 11:07 AM prior to survey exit based on the following corrective actions taken.

- 100% of staff on duty were educated according to the approved training plan.

- Staff including 1 registered nurse and 7 licensed practical nurses were interviewed and confirmed participation and understanding of the education.

- The facility developed a plan to educate any staff not working prior to the start of their shift.

- The following from the facility's plan was verified to be implemented:

 - Neurological check policy revised [DATE].

 - Neurological check procedure added to Registered Nurse/Licensed Practical Nurse Orientation checklist.

 - Neurological check sheet now included section for signs/symptoms including complaints of headache, slurred speech, and vomiting.

 - Incident Form was revised and now included: a section questioning if the registered nurse was notified of incident, time of registered nurse notification, time of registered nurse arrival; and a section questioning if Emergency Medical Service's

 was notified, time of Emergency Medical Service's notification, time Emergency Medical Service's arrived at facility and time of Emergency Medical Service's departure.

 - Transfer of resident in Emergency Situation Policy implemented [DATE].

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335006	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Luther Residential Hlth Care & Rehab	110 Utica Road Clinton, NY 13323

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Signage with instructions for calling Emergency Medical Service's posted at all nursing stations. - Transportation procedure added to Registered Nurse/Licensed Practical Nurse Orientation checklist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interview during the abbreviated survey (NY00323717), the facility did not ensure licensed nurses had the appropriate competencies and skill sets to provide nursing and related services to assure residents attained or maintained the highest practicable physical well-being for 2 of 6 residents reviewed (Resident #2 and 7). Specifically, Resident #7 had a fall with a hematoma (pooling of blood under the skin) to the back of their head and was sent to the emergency room for evaluation. When the resident returned approximately 4 hours later, neurological checks did not resume per facility protocol. Resident #2 had a fall with a hematoma to the back of their head and neurological checks were not completed per the facility process. When the resident had a change in condition (lethargy, sluggish eye movement, slow to speak and vomiting), a medical provider was not notified in a timely manner (approximately 2 hours after symptoms began). A delay in transport to the hospital also occurred when the facility was not able to reach Emergency Medical Services. Findings include: Refer to F684 1) Resident #2 had diagnoses including diabetes, cirrhosis (chronic liver damage) and dementia. The [DATE] Minimum Data Set assessment documented the resident's cognition was severely impaired, they needed assistance of one staff with bed mobility and locomotion in their room, and they were independent with transfers. The [DATE] 10:57 AM, Registered Nurse #2's progress note documented they were called to the resident's room by Certified Nurse Aide #5. The resident was found on the floor, seated upright, next to the closet and stated they were cleaning up their room. They had a hematoma (pooling of blood under the skin) to the back of their head and no other injury noted. Ice was applied, vital signs were stable, and the initial neurological check was within normal limits. Nurse Practitioner #8 was notified, and neurological checks were initiated per facility protocol. The [DATE] neurological check list, completed by Registered Nurse #2 documented: - at 10:30 AM and 10:45 AM, the resident was alert and oriented to person and situation and could follow a finger with their eyes. They had pain of 5 out of 10 (moderate pain) and stated their head hurt. - At 11:00 AM and 11:30 AM, the resident was oriented to person, level of consciousness was lethargic (sluggish) and they were lethargic when following a finger with their eyes. They were resting with an ice pack on their head. - At 12:30 PM, the resident continued to be oriented to person, level of consciousness was lethargic, they were lethargic when following a finger with eyes, and they were also slow to speak. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	There was no documented evidence neurological checks were completed at the intervals per the facility process and no documented evidence a medical provider was notified timely after the resident had multiple documented episodes of changes in condition. The [DATE] Incident Statements obtained by the facility documented: - by Registered Nurse #2 at 1:00 PM, the on-call medical provider was notified and ordered to send the resident to the hospital. - by Registered Nurse Supervisor #3, at 1:10 PM, the facility had difficulty reaching Emergency Medical Services. The [DATE] Incident Summary completed by the Director of Nursing documented at 1:45 PM, the ambulance arrived, and the resident left the facility at 2:15 PM. The [DATE] Incident Summary, completed by the Director of Nursing documented at 6:25 PM, the hospital reported the resident had a severe brain hemorrhage (bleed), their family declined surgical intervention, and they had a poor prognosis and at 6:54 AM ([DATE]), they were notified the resident expired. The [DATE] Prehospital Care Report completed by Emergency Medical Services Providers #9 and 10, at 1:41 PM documented Emergency Medical Services was contacted and dispatched, and they arrived at the facility at 1:52 PM. During a telephone interview on [DATE] at 11:22 AM, Registered Nurse #2 stated: - when they did neurological checks for the resident's [DATE] fall, they wrote all the neurological checks on a piece of paper and entered the information into the medical record later that day. They believed they completed all neurological checks however might have missed documenting some. - At 11:00 AM, the resident was lethargic because they believed the resident wanted to take a nap and kept stating they just wanted to lie down. The resident was responding clearly at that time. - At 12:15 PM, they found the resident had vomited and that was when they had a change in condition. - At 12:30 PM, the resident was slow to speak and that was a change in condition. - After the resident vomited, they notified Registered Nurse Supervisor #3 about their change in neurological status. - The medical provider was notified, and the resident was sent to the hospital. - They stated that all the times they documented in the medical record were approximate as they had documented notes later in the shift. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During a telephone interview on [DATE] at 10:22 AM, the Director of Nursing stated they expected a medical provider to be immediately notified for any alteration in mental status or for a change in neurological checks after a resident hit their head. When they completed the investigation into the resident's fall, they were not aware Registered Nurse #2 had not completed neurological checks per facility policy process. Registered Nurse #2 should have notified a medical provider on [DATE] at 11:00 AM when the resident first showed signs of being lethargic. At 12:15 PM, the resident was noted to vomit and at around 1:00 PM the Supervisor was notified. The Director of Nursing interviewed Registered Nurse #2 about the delay in notification and Registered Nurse #2 reported they were cleaning up vomit and doing vital signs. The Director of Nursing stated the Supervisor and medical provider were not notified timely of the resident's change in condition. During an interview on [DATE] at 9:40 AM, Registered Nurse Supervisor #3 stated when a resident had a change in condition, the Registered Nurse completed an assessment, notified the medical provider, and completed any follow-up orders from the medical provider. Registered Nurse Supervisor #3 stated if a resident needed to be sent to the hospital because of a change in condition, the facility called Emergency Medical Services directly and they should call as soon as possible once they have an order to send a resident to the hospital. On [DATE], Registered Nurse Supervisor #3 called the ambulance company. They tried the first number in the book on the unit and got a voicemail. Next, they tried the company's emergency number and that also did not work. After that, they were able to reach someone, and they asked them what to do when they had an emergency, and the company provided another number to call. Registered Nurse Supervisor #3 stated it could have taken them 30 minutes to reach someone at the ambulance company. They stated they started calling Emergency Medical Services at 1:10 PM and reached them at 1:41 PM and that was a delay. After this incident, they did not recall speaking to anyone in Administration about the issue with getting in contact with Emergency Medical Services. During an interview on [DATE] at 9:54 AM, the Emergency Management System Chief #11 stated the facility had a 7-digit emergency number to contact them and they should be using that or 911. The facility typically used 911 for cardiac arrest (when someone's heart stopped). They stated if the facility called their 7-digit emergency number and the call was not picked up after 3 rings, it automatically forwarded to 911. They stated the company had other non-emergent numbers that go to an automated line. They stated the facility was provided literature that clearly defined who to call for emergencies. During an interview on [DATE] at 11:15 AM, the Director of Nursing stated the telephone numbers for Emergency Medical Services were posted at each nursing station. They thought this information was reviewed in orientation with new staff. After the incident, themselves and the Administrator discussed Registered Nurse Supervisor #3's report they could not get ahold of anyone at the ambulance company. They stated the preferred timeframe for this was 10 minutes and after 10 minutes, the nurse should call 911. During an interview on [DATE] at 10:30 AM, the Director of Staff Development stated nursing staff was educated on what to do when a resident had a change in condition during general orientation. The general orientation did not cover neurological checks or how to call Emergency Medical Services and that was covered on the unit with the new nurse's mentor during orientation to the unit. Registered Nurse #2's training records from [DATE] to current did not document training related to neurological checks, resident change in condition, or calling Emergency Medical Services. (continued on next page)

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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 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

Registered Nurse #3's training records from [DATE] to current did not document training related to calling Emergency Medical Services.

2) Resident #7 had diagnoses including Alzheimer's Disease, epilepsy, and cellulitis (skin infection) of the right lower limb. The [DATE] Minimum Data Set assessment documented the resident had severe cognitive impairment and had no falls since the last admission or assessment.

The [DATE] at 5:10 AM Incident Report completed by Registered Nurse Supervisor #14 documented the resident had an unwitnessed fall and was found on their back between the footboard and closet in a very tight spot, feet facing the door. The resident stated they were trying to get to the bathroom but was found in front of the closet. The resident stated they hit their head when landing and complained of shoulder pain. Registered Nurse Supervisor #14 palpated the resident's head and found a big bump on their posterior (back) head, with no blood. They did not move the resident, called the on-call provider and Emergency Medical Services and the hospital were made aware.

The [DATE] at 8:46 AM progress note entered by Registered Nurse Supervisor #14 documented Emergency Medical Services was notified and arrived at 5:37 AM.

The [DATE] at 8:51 AM progress note entered by Registered Nurse Supervisor #14 documented the hospital called and the resident was being sent back to the facility. No extensive diagnostic testing was done regarding the head injury and shoulder pain. The resident was prescribed Augmentin (antibiotic) for cellulitis on the right leg.

The [DATE] neurological check sheet documented neurological checks were completed at 2:58 PM.

The [DATE] at 10:46 PM progress note entered by Registered Nurse #15 documented the resident's vital signs at 6:00 PM and 10:00 PM, and noted they were alert, hand grips equal, moved all extremities, had clear speech, and pupils were equal, round, and reactive to light and accommodation.

There was no documented evidence of neurological checks done per facility protocol following the resident's return from the hospital on [DATE].

During an interview with Registered Nurse Supervisor #14 on [DATE] at 11:19 AM, they stated they received a call from the hospital the resident would be returning, around 9:00 AM (on [DATE]) and completed their progress note. The resident did not arrive back to the facility prior to them leaving that day. They reported to Registered Nurse #2, including the information from the hospital that no diagnostic testing related to the head injury was completed. They did not provide any specific instructions to Registered Nurse #2.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with Registered Nurse #2 on [DATE] at 1:39 PM, they stated the resident returned from the hospital on [DATE] at approximately 9:30 AM. They stated they were aware the hospital did not do any head scans or testing related to the head injury. Registered Nurse #2 received report from Registered Nurse Supervisor #14 related to the resident's fall, head injury, and lack of diagnostic testing in the hospital. Registered Nurse #2 did not review the discharge paperwork from the hospital. Registered Nurse Supervisor #14 went through the hospital paperwork and called medical to clarify the antibiotic change order. The supervisor did not provide Registered Nurse #2 with instructions to resume the neurological checks. Registered Nurse #2 stated neurological checks would not need to be resumed following return from the hospital even if was within the 24 hours of the head injury, due to the resident being cleared at the hospital. If there were no tests at the hospital, that must have meant the resident was fine and testing was not needed. There were no instructions to continue the neurological checks from the hospital. At approximately 2:30 PM, Registered Nurse Supervisor #13 returned to the unit to advise they should resume the neurological checks on Resident #7 to be on the safe side. Registered Nurse #2 stated they did not understand the reason for resuming the neurological checks and was not sure of the time they did it. They went to another unit at 3:00 PM and may have returned to Resident #7's unit later and did the neurological check. During an interview with Registered Nurse Supervisor #13 on [DATE] at 3:30 PM, they stated the neurological check protocol was to be implemented immediately following a head injury or unwitnessed fall. Neurological checks were to be done every 15 minutes the first hour, every 30 minutes for the next hour, then every hour for 4 hours, and every 4 hours until 24 hours had passed. If a resident went to the hospital and returned within the 24-hour period, they were considered cleared and neurological checks would not be resumed. There was no specific means to verify if the resident's head injury was cleared at the hospital, as it varied. Typically, the hospital nurse would call and provide report and possibly state if scans were completed at the hospital. If it was reported that no testing was done or no documentation the resident was cleared, Registered Nurse Supervisor #13 stated they would resume neurological checks based on the current time (number of hours since the head injury, not starting over with every 15 minutes). The decision to resume neurological checks was nursing judgment. For Resident #7, the registered nurse supervisor stated they assumed the resident was cleared at the hospital since they did not perform any diagnostic testing. They called the medical provider regarding the medication change order and did not discuss the head injury or lack of diagnostic testing or instructions related to the head injury. The registered nurse supervisor spoke with the Director of Nursing at approximately 3:00 PM and the Director of Nursing suggested they resume neurological checks for Resident #7. Registered Nurse Supervisor #13 communicated the instructions to Registered Nurse #2 after speaking to the Director of Nursing. The neurological check schedule should have been every 4 hours up to the 24-hour time (from the time of the fall) from the time the registered nurse supervisor communicated it to Registered Nurse #2. Neurological checks were documented under assessments in the resident's medical record, for each time the neurological check was completed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview with the Director of Nursing on [DATE] at 12:38 PM, they stated neurological checks were initiated after any known head injury or unwitnessed fall and monitored for 24 hours at preset time increments (every 15 minutes, 30 minutes, hourly, and every 4 hours). When a resident was sent to the hospital for a head injury and returned within 24 hours, it was the understanding that the resident was cleared at the hospital and neurological checks were not resumed. There was no current policy that addressed discontinuation of neurological checks upon return from the hospital if it was within 24 hours of the injury. Nursing staff typically received a verbal report from the hospital related to how the resident was cleared. If it was reported that there was no diagnostic testing or other assessment of the resident's head injury, it would be expected that neurological checks resumed. When Resident #7 returned from the hospital on [DATE] and it was reported that no diagnostic testing had been performed and it was unknown if the resident had been cleared, the neurological checks should have resumed. The receiving nurse should also have clarified the resident's status related to their head injury and any needed follow up. During an interview on [DATE] at 10:30 AM, the Director of Education stated nursing staff was educated on what to do when a resident had a change in condition during general orientation. The general orientation did not cover neurological checks or how to call Emergency Medical Services and that was covered on the unit with the new nurse's mentor during orientation to the unit. Registered Nurse #2's training records from [DATE] to current did not document training related to neurological checks, resident change in condition or calling Emergency Medical Services. 10 NYCRR 415.26(c)(1)(iv)