

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER A Holly Patterson Extended Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 875 Jerusalem Avenue Uniondale, NY 11553	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33316</p> <p>Based on interviews and record review conducted during an abbreviated survey (Complaint # NY00340951) the facility failed to protect a resident from physical abuse by nursing home staff. This was evident for one of three residents reviewed for physical abuse (Resident #1). Specifically, on 5/2/24 at 6:30AM Certified Nurse Assistant #1 was observed by Registered Nurse #1 pushing Resident #1 to the floor.</p> <p>The findings were:</p> <p>Resident #1 was admitted to the facility with medical diagnosis including Non-Alzheimer's Dementia, Diabetes Mellitus, and coronary artery disease (heart disease). The Annual Minimum Data Set, dated dated [DATE] documented Resident #1 had a Brief Interview for Mental Status score of 9 indicating impaired cognition. The Minimum data set further documented no behaviors exhibited, and Resident #1 uses a manual wheelchair for ambulation.</p> <p>The facility policy and procedure titled Resident Abuse dated February 2024 documented it is the policy of the facility to ensure that every resident is free from abuse and that their rights are respected, and dignity maintained.</p> <p>The comprehensive care plan dated 4/2/2024 titled High risk for abuse related to vulnerable population documented Resident #1 will not experience any form of abuse x 90 days. The interventions include 1:1 room visits to provide emotional support, observe for signs of abuse, and monitor for changes in mood and behavior.</p> <p>The physician order dated 4/30/2024 documented Aspirin (blood thinning effect) 81 milligrams to be administered by mouth daily. The Medication Administration Record dated April 2024 documented resident received Aspirin 81milligrams every day for the month of April.</p> <p>A Nursing progress note dated 5/2/2024 at 1:30PM documented Resident #1 was admitted to the surgical intensive care unit with a diagnosis of non-traumatic intracranial hemorrhage . There is no additional documented evidence in the nursing progress note related to a fall or incident on 5/2/2024.</p> <p>The facility communication transfer form dated 5/2/2024 at 6:30AM documented Resident #1 was pushed by a Certified Nurse Assistant #1 and fell on the floor. The form further documented Resident #1 hit his head and left leg and was transferred to the hospital for further evaluation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The undated and unsigned facility investigation titled Investigation of case NY00340951 documented on 5/2/2024 at around 5:50AM Resident #1 became upset when the Certified Nurse Assistant #1 moved their wheelchair. Resident #1 took the wheelchair back to the room. Certified Nurse assistant #1 and Resident #1 had a verbal disagreement as Certified Nurse Assistant #1 refused to keep the wheelchair in the room. Resident #1 became angry and walked towards Certified Nurse Assistant #1 and was pushed away. Resident #1 fell , hitting his head and left leg onto the floor. As per Nursing Supervisor #1 assessment, Resident #1 pointed to his head and was noted with limited range of motion of the left leg. Resident #1 was transferred and admitted to the hospital for further evaluation.</p> <p>The hospital records dated 5/2/2024 documented Resident #1 was found on the floor by staff and complained of left sided pain and unable to move extremities. The Computed Tomography (scan used to take images) of the head dated 5/2/2024 documented there is a round hyper density likely reflecting acute hemorrhage (bleeding) withing the subcortical region of the high right posterior frontal lobe. The hematoma measures 1.3x1.2 centimeters.</p> <p>During a telephone interview conducted with Certified Nurse Assistant #1 on 5/22/2024 at 3:15PM they stated they moved Resident #1 wheelchair into the hallway to get access to the sink. Resident #1 got up and went to get the wheelchair. Certified Nurse Assistant #1 stated as they were walking out from caring for the roommate, Resident #1 walked towards them and attempted to hit Certified Nurse Assistant #1. Certified Nurse Assistant #1 stated they put up their hands to protect themselves from Resident #1 and inadvertently touched them causing Resident #1 to fall to the floor. Certified Nurse #1 stated the Registered Nurse #1 was in the room and did not redirect Resident #1.</p> <p>During an interview conducted with Registered Nurse #1 on 5/6/2024 at 3:04PM , they stated that at about 5:40AM while in the hallway giving medication, they observed Resident #1 upset because Certified Nurse Assistant #1 removed the wheelchair from the room. Registered Nurse #1 stated the wheelchair prevented access to the sink, so Certified Nurse Assistant #1 moved the chair into the hallway. Resident #1 walked to the hallway to retrieve the wheelchair and was engaged in a verbal exchange with Certified Nurse Assistant #1. Registered Nurse #1 stated Resident #1 is non-English speaking so they could not understand what was said. Registered Nurse #1 stated Certified Nurse's Assistant #1 was arguing back and suddenly pushed Resident #1 to the floor causing him to hit his head on the floor and left leg against the bed. Registered Nurse #1 stated Certified Nurse Assistant #1 was immediately removed from the room and they notified the supervisor.</p> <p>During an interview conducted with Nursing Supervisor #1 on 5/6/2024 at 2:17PM they stated Registered Nurse #1 called them to the to the unit because a resident fell . Nursing Supervisor #1 stated when they arrived in the unit, Registered Nurse #1 reported that Certified Nurse Assistant pushed Resident #1 to the floor. Resident #1 speaks Korean, Nursing Supervisor #1 could not understand, however Resident #1 was gesturing towards Certified Nurse Assistant #1 that Certified Nurse Assistant #1 pushed them. Resident #1 was touching his head and had facial grimace and was unable to move the left leg as usual. The physician was notified and instructed to send Resident #1 to the hospital. Nursing Supervisor #1 stated they interviewed Certified Nurse Assistant #1 who stated Resident #1 was coming towards them and they pushed Resident #1 away. Nursing Supervisor #1 stated Certified Nurse Assistant #1 was sent to the nursing office and they notified the Director of Nursing and the physician immediately.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted with the Director of Nursing on 5/6/2024 at 2:30PM who stated they were notified by Nursing supervisor #1 that Resident #1 was pushed by Certified Nurse Assistant #1 and was sent to the hospital. The Director of Nursing states they spoke to the nurse on the unit who reported they witnessed Certified Nurse Assistant #1 push Resident #1, causing a fall. Certified Nurse Assistant #1 was immediately taken off the schedule. The Nurse Supervisor #1 assessed Resident #1 and notified the physician and family. The police were not notified while they completed the investigation, however, they notified the family who stated they did not want the police involved. The Director of Nursing stated there is no tolerance for resident abuse. The facility is reeducating all their staff on the abuse policy.</p> <p>During an interview conducted with the Facility Administrator on 5/6/204 at 2:45pm who stated they were notified by the Director of Nursing reporting an altercation between a resident and an employee. The facility was still investigating and wanted to complete the investigation prior to notifying the police but the family did not want to call the police. The family was informed the employee was terminated and the facility does not tolerate abuse. The staff are educated about abuse on hire, annually and as needed.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		