STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335127	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alice Hyde Medical Center	45 Sixth Street Malone, NY 12953

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on observations, record review and interviews during an abbreviated survey (Case #s NY00301319, NY00313776, NY00318247, NY00318964, and #NY00324492) dated 3/18/2024 through 3/29/2024, the facility did not ensure the facility implemented a comprehensive person-centered care plan for each resident for 5 (Residents #6, 15, 19, 23, and 24) of 25 residents reviewed for comprehensive care plans. Specifically, for Residents #6, 15, and 19, 15-minute safety checks were not completed; Resident #23's bed was not in a low position and appropriate footwear was on the resident on 8/26/2022; and Resident #24's, bed alarm was not in place before the resident was put to bed on 6/11/2023 as per resident care plans. This is evidenced as follows: The Policy and Procedure titled, Fall Assessment, Prevention and Management, dated 1/2024, indicated the prevention tools available to use in the prevention of a fall included 15-minute observation sheet and alarms (bed mat, chair mat and personal alarm). Resident #6 Resident #6 was admitted to the facility with the diagnoses of Alzheimer's disease, chronic obstructive pulmonary disease, and rheumatoid arthritis. The Minimum Data Set (an assessment tool) dated 2/19/2023 documented the resident was understood by others and able to understand others. The Brief Interview for Mental Status documented the resident was cognitively intact. During record review, Resident #6's comprehensive care plan titled, Falls initiated on 2/10/2021 and revised on 6/12/2023, was reviewed and indicated the interventions included 15-minute safety checks to be completed by the Certified Nurse Aide. Record review for Resident #6 indicated a document titled, Resident Nursing Instructions dated 3/1/2023-3/31/2023, listed 15-minute check was initiated on 1/26/2023. Resident #6's record review of a document titled, 15-minute Observation Sheet initiated on 1/26/2023, indicated no documentation of 15-minute checks being done from 2:00 AM to 6:00 AM on 3/30/2023. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress notes for Resident #6, dated 3/30/2023 at 6:50 AM, was reviewed and indicated the resident was found at 5:45 AM after an unwitnessed fall. The resident had a minor injury and did not need to be sent to the hospital for evaluation. Resident #23 Resident #23 was admitted to the facility with diagnoses of Parkinson's disease with dyskinesia, hyperlipidemia, gastroesophageal reflux disease. The Minimum Data Set, dated dated dated [DATE], documented Resident #23 could be understood and could understand others with a Brief Interview of Mental Status indicating of no cognitive impairment. During record review, Resident #23's comprehensive care plan titled, Behaviors, initiated 9/16/2020, was reviewed. It indicated Resident #23 exhibited behaviors including self-ambulation, refusing care and being resistive to care at times with an intervention of safety checks every 15 minutes. Resident #23's comprehensive care plan titled, Falls, initiated 9/17/2020, was reviewed and indicated an intervention of safety checks every 15 minutes. Resident #23's document titled, Resident Nursing Instructions, for the period of 8/1/2022 through 8/31/2022 was reviewed and indicated 15-minute safety checks were to be completed and documented for the resident. Resident #23's document titled, 15 Minute Observation Sheet, was reviewed and indicated no documentation for 15-minute safety checks between 2:00 PM and 7:00 PM on 8/26/2022. During record review, Resident #23's progress note dated 8/26/2022 at 8:11 PM indicated Resident #23 had been found at 7:20 PM after an unwitnessed fall. The progress note indicated Resident #6 was transferred to the hospital for evaluation. Resident #24 Resident #24 was admitted to the facility with the diagnoses of dementia with agitation, chronic obstructive pulmonary disease, and vascular parkinsonism. The Minimum Data Set, dated dated dated [DATE], documented Resident #24 could usually be understood and could sometimes understand others with a Brief Interview of Mental Status indicating severe cognitive impairment. During record review, Resident #24's comprehensive care plan titled, Falls, initiated 8/19/2021, listed a bed alarm as an intervention. Resident #24's document titled, Resident Nursing Instructions, for the period of 6/1/2023 through 6/30/2023 was reviewed and indicated a bed alarm was to be applied to Resident #24's bed when the resident was in bed. Resident #24's progress note dated 6/11/2023 at 8:10 PM, was reviewed and indicated resident had been found on the floor after an unwitnessed fall at 7:40 PM. Further review indicated the progress note documented a bed alarm was not in use on Resident #24's bed. The progress note indicated Resident #24 had a skin tear but no major injury and did not require transfer to a hospital for evaluation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	General interviews: During an interview on 3/28/2024 at 12:10 PM, Licensed Practical Nurse #2 stated that the nurse, either a licensed practical nurse or registered nurse, would check over the certified nursing aide paperwork at the end of the shift and will go to the assigned certified nursing aide if there were blanks or discrepancies. They stated that if a 15-minute safety check sheet was not completed, it would be a care plan violation. During an interview on 3/28/2024 at 12:15 PM, Certified Nurse Aide #7 stated the 15-minute safety check sheet was to be completed. If they were to go on lunch or know they would be in another resident's room for an extended amount of time, they would go to the nurse or another certified nursing aide to help complete the checks for them. They stated that not completing the 15-minute safety check sheet was a care plan violation. 10 New York Codes, Rules, and Regulations 415.11 (c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43805 Based on record review and interviews during an abbreviated survey (Case #NY00324492), the facility did not ensure the resident's environment remained as free of accident hazards as was possible for 1 (Resident #15) of 5 residents reviewed for accidents. Specifically, Resident #15 was found on the floor on 9/19/2023, bed was not in a low position, call light not within reach, and resident had no socks on. This is evidenced as follows: Resident #15 Resident #15 was admitted to the facility with diagnoses of heart failure, type 2 diabetes mellitus, and end stage renal disease. The Minimum Data Set (an assessment tool) dated 9/22/2023, documented the resident could be understood and could usually understand others with a Brief Interview of Mental Status indicated moderate cognition impairment. The Policy and Procedure titled, Fall Assessment, Prevention and Management, dated 1/2024 documented the prevention tools available to use in the prevention of a fall included 15-minute observation sheet and alarms (bed mat, chair mat and personal alarm). The Comprehensive Care Plan titled, Falls, initiated 9/26/2022 documented interventions included a low bed and appropriate footwear. The Resident Nursing Instructions for care from 9/1/2023 through 9/30/2023 documented a low bed as a safety instruction. A progress note dated 9/19/2023 at 10:34 PM documented the Resident had an unwitnessed fall. The resident was found on the floor, the bed was not in the low position, the call light was not in reach, and the resident did not have socks on. The Facility Investigation completed 9/20/2023 documented the Certified Nurse Aide did not follow the care plan. The Certified Nurse Aide did not place a bed alarm on the resident's bed prior to placing the resident in bed. The resident also did not have non-skid socks on, and the call light was not in reach. During an interview on 3/20/2024 at 12:40 PM, Human Resource Director #1 confirmed Certified Nurse Aide #2 was still actively employed by the facility. Certified Nurse Aide #2 was provided with education regarding following a resident's care plan to prevent falls and injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/2024 at 10:00 AM, Clinical Educator #1 stated if the incident involved only one resident and one staff member, that staff member would be individually counseled. They stated they were a member of the Quality Assurance and Performance Improvement committee and that falls were discussed not only in morning report but at the quarterly meetings. If a systemic issue was found to be at the root of an incident, they would hold education for all employees. During an interview on 3/21/2024 at 11:56 AM, Certified Nurse Aide #2 stated they knew the care plan should be followed to made sure residents do not become injured. They stated they should have checked the care instructions and known to put a bed alarm on the resident's bed. They stated they should have made sure the call light was in reach and the resident had non-skid socks on. They stated they were given education regarding following a care plan after the incident. They stated they received abuse, neglect, and mistreatment education when they were hired and then again after they had been at the facility for about a year. They stated if they had any questions about a policy or procedure, they felt comfortable asking the nurse manager or going to the clinical specialist. During an interview on 3/28/2024 at 12:15 PM, Certified Nurse Aide #7 stated the 15-minute safety check sheet should have been completed. If they were to go on lunch or know they would be in another resident's room for an extended amount of time, they would go to the nurse or another certified nurse aide to help complete the checks for them. They stated that not completing the 15-minute safety check sheet was a care plan violation. They stated that safety instructions like making sure the bed was in the lowest position before leaving the room and applying non-skid socks to residents' feet were also important to help prevent falls. 10 New York Codes, Rules, and Regulations 415.12(h)(1)