STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER New Paltz Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Jansen Road New Paltz, NY 12561	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673 Based on observation, record reviews, and interviews conducted during an abbreviated survey (NY00329438), the facility did not ensure that care and treatments were provided to prevent the development of new pressure ulcers for 1 of 3 (Resident #3) residents reviewed for pressure ulcers. Specifically, Resident #3 was admitted to the facility with a deep tissue injury and skin integrity care plan was not put in place; physician orders for the use of a CAM boot (controlled ankle movements, a walking boot) when out of bed and skin checks every shift were not followed; Resident #3 developed a pressure ulcer to the left heel and treatments were not completed as ordered. Findings include: Resident #3 had diagnoses including fracture of the shaft of the left fibula (fracture of the long bone in the lower leg), Type 2 Diabetes, and Depression. The Nursing Admission Evaluation dated 11/2/23 at 6:44 PM, documented Resident #3 had an unstageable pressure injury to the left dorsal (top) foot that measured 4 centimeters by 1.5 centimeters by 0.0 centimeters (length x width x depth). The weekly skin monitoring form dated 11/2/23 documented the resident's skin was intact. The Admission Minimum Data Set (MDS, assessment tool) dated 11/9/2023 documented Resident #3 cognition was intact, and the resident required moderate assistance of 1 staff for transfers, bed mobility, and toilet use, and set up assistance of 1 staff for personal hygiene and dressing. The resident had 2 unstageable deep tissue injury present on admission, and treatments included pressure-reducing devices for the chair and bed, and pressure ulcer care. Physician orders dated 11/2/23 included: 1) Inspect skin under CAM boot every shift and report any abnormal finding. 2) Weekly skin evaluation done on Monday during the day shift, with additional instructions to complete Weekly Skin Monitoring form to start on 11/6/23. Physician order dated 11/3/2023 documented weight bearing tolerated to the left lower extremity CAM boot when out of bed. Review of physician admission note dated 11/3/23 did not document the unstageable pressure injury to the left dorsal (top) foot that was documented in the Nursing Admission Evaluation of 11/2/23. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The registered nurse progress note and Initial Event Documentation form, dated 11/13/23 at 10:00 AM, documented a new wound was observed under the CAM boot on the left heel, measured 3.5 centimeters by 3.5 centimeters and a new order for Skin Prep was received. The resident was wearing the CAM boot most of the time, even when in bed however only needed when out of bed. The resident and staff were educated. The comprehensive care plan initiated on 11/13/23 documented that the resident was at risk for developing pressure ulcers due to impaired mobility. Interventions included applying moisturizer to the skin as needed and monitoring and documenting skin changes with the physician. The comprehensive care plan initiated on 11/13/23 documented that the resident had an unstageable pressure ulcer on the left heel related to the CAM boot. Interventions included to avoid clothing/devices and footwear that may impede healing; evaluate the wound weekly and as needed, and monitor the dressing daily to ensure it is clean and dry. The physician order dated 11/14/23 documented to apply Skin Prep Wipes to top of left foot and left heel topically every evening shift for Deep Tissue Injury. Cleanse with normal saline, pat dry and apply skin prep daily. The registered nurse progress note dated 11/15/23 at 10:06 AM documented the resident had deep tissue injuries to the left heel (new) and top of foot (present on admission) under the CAM boot. The resident had not been wearing the CAM boot properly and was wearing it at all times. The physician was made aware and stated to continue weight bearing as tolerated and wear the CAM boot when out of bed as per the hospital recommendation. The wound care consult notes dated 11/14/23, 11/21/23, and 11/28/23 documented that the resident's wounds were measured and to continue Skin Prep treatment once a day. The November 2023 Treatment Administration Record documented: - To inspect the skin under CAM boot every shift and report any abnormal findings every shift for CAM boot (initiated 11/2/23). There was no documentation for the 7 AM to 3 PM shift on 9 of 28 days; for the 3 PM to 11 PM shift on 6 of 28 days; for the 11 PM to 7 AM shift on 14 of 29 days. - Skin Prep Wipes to the left heel and top of the left foot (start date 11/15/23) had no documentation for 9 of 16 days. - Weekly skin evaluation done on Monday during day shift with instructions to complete the Weekly Skin Monitoring form was not documented as completed for the month of November 2023. Weekly Skin Monitoring forms dated 11/9/23 at 8:41 PM, 11/16/23 at 8:41 PM, and 11/23/23 at 8:42 PM were all completed on 11/28/23. The wound care consult note dated 12/05/23 documented a Stage 2 pressure wound of the left heel wound measured 2.4 centimeters x 1.7 centimeters x 0.1 centimeters (Length x width x depth) and the treatment was changed to Medihoney. The unstageable deep tissue injury to the left dorsal foot was resolved. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 12/5/23 documented to apply Medihoney Wound Gel to the left heel topically every day shift starting 12/6/23. Review of the December Treatment Administration Record revealed the treatment was not done on 12/6/23 and there was no documented reason for the omission. During an interview on 5/21/24 at 11:00 AM, Certified Nurse Aide # 2 stated they did not remember if the resident's CAM boot had come off. During an interview on 5/21/2024 at 11:14 AM, Licensed Practical Nurse # 8, responsible for 4 of the missed Skin Prep treatments on the November 2023 Treatment Administration record, stated they signed up for all the treatments they performed. They stated the CAM boot did come off when the resident was in bed. During an interview on 5/21/2024 at 11:30 AM, Licensed Practical Nurse # 9 stated all the treatments they performed were documented. They did not remember if the CAM boot came off or was worn all the time. During an interview on 5/21/2024 at 11:45 AM, Director of Rehabilitation # 10 stated that the resident came from Orthopedics with the CAM boot in place and weight bearing as tolerated when wearing the CAM boot. During a phone interview with the Administrator and Director of Nursing #2 on 9/11/2024 from 9:31 AM to 9:58 AM, they reviewed the resident's record and stated Resident #3 was admitted on [DATE]. They stated the skin integrity care plan was initiated on 11/13/23 but the nutritional care plan dated 11/5/24 had interventions for skin monitoring. They stated there was an unstageable ulceration to the left foot on admission. They were unaware if any interventions or treatments were put in place at that time or if the physician was notified. When reviewing the November 2023 Treatment Administration Record, they stated the Skin Prep treatments for the left heel and left dorsal foot were ordered 11/14/23 to be initiated on 11/15/23 and from 11/15/23 to 11/30/23 the treatment was performed 9 of 16 days. They stated the resident was non-compliant with the CAM boot and at times difficult. The facility was unable to provide documentation including care plan interventions for skin integrity prior to the development of the heel pressure injury, physician notification of the dorsal foot pressure injury present on admission, and the resident's non-compliance with treatments. 10NYCRR 415.12(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673 Based on observation, record review, and interviews during an abbreviated survey (NY00336418) the facility did not maintain adequate supervision to prevent an elopement for 1 of 4 residents reviewed for accidents (Resident #2). Specifically, Resident #2 left the building on 1/22/24 and staff did not notice the resident's absence until 1/23/24 when the nurse could not find the resident for morning medications. The facility called a Code Gray (missing resident alert) and the resident was located by phone at a friend's house. The resident returned to the facility around 2 PM on 1/23/24. Findings include: The policy and procedure titled Elopement - Missing Resident, revised 1/2020 documented it was the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical. Should an employee discover that a resident is missing from the facility, they should announce on the overhead paging system CODE GRAY. Upon return to the facility examine the resident, complete and file an incident report; and make appropriate entries into the resident's medical record. The facility policy and procedure titled Out on Pass / LOA (leave of absence) documented it was the policy of the facility to safeguard the health and welfare of all residents in its care. The facility honors the residents' right to temporarily leave the facility if they are determined to be safe to do so. The procedure included that the resident and/or responsible party would complete the Out On Pass Agreement with the unit manager/designee, including their destination, relationship to the resident, contact information and expected time of return to the facility before leaving. The resident or representative will be advised to inform nursing in advance if the time Out on Pass will exceed 4 hours, to ensure there will be no interruption to the resident's medication administration, treatment, therapies, or any nursing care. The procedure also included leaving a copy of the agreement with the receptionist. The Elopement assessment dated [DATE] documented that the resident was not at risk for elopement. A physician order dated 12/11/2023 documented the resident may go out on a leave of absence with the responsible party. Review of Certified Nurse Aide documentation for January 2024 revealed that the Certified Nurse Aide responsible for the resident, did not sign for Resident #2's cares on shift beginning at 11 PM on 1/22/24 and ending at 7 AM on 1/23/24. The facility monthly census dated January 2024, documented the Resident #2 was in attendance at the facility for 31 of 31 days. An Out-on-Pass Agreement form dated 1/22/24 was signed by the resident, their representative and Registered Nurse #6 and documented the resident was leaving the facility on 1/22/24 and returning on 1/23/24, however the form was not complete and did not have the date or time the resident returned. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress note by Registered Nurse #6, dated 1/23/2024, documented that the resident arrived at the facility at approximately 2:00 PM. Upon returning to the facility, the resident was evaluated and denied any discomfort or distress, showed no signs of injury, and showed no bruising. They discussed the leave of absence policy to the resident and the resident verbalized understanding. A physician progress note dated 1/24/24 documented the resident went on a leave of absence overnight with the responsible party and was counseled on the facility process for leave of absence. During an interview on 5/20/24 at 1:10 PM Receptionist #4 stated they covered the front door for the evening shift on 1/22/24. They stated when they left the desk for breaks, someone always relieved them. They stated they were unaware the resident left that evening and there was not an Out on Pass Agreement form left at the front desk. During an interview on 5/20/24 at 1:30 PM, Unit Clerk #5 stated that on 1/23/24 at 8:00 AM, they were covering the front desk and Registered Nurse #6 called Code Gray. They stated there was not an Out on Pass Agreement at the desk. They stated they called Resident #2's designated representative, and found out the resident was there. During a phone interview on 5/23/2024 at 9:53 AM, Resident #2 stated they went on an overnight visit with a friend in late January. They said when they left the building there was no one at the front desk so there was no one to tell. They stated they left around 5 PM or 6 PM and returned the next day in the afternoon. They stated when they returned, they were asked to sign something. During an interview on 5/23/24 at 3:28 PM, Licensed Practical Nurse #12 stated they worked the night shift and did not know the resident was out on pass. The resident was discovered missing during the medication pass on the morning of 1/23/24. The Director of Nursing and the Registered Nurse #6 were notified, and a Code Gray (missing person alert) was called. During the search, Unit Clerk #5 suggested calling the resident's friend and found that the resident was with him. Resident #2 returned to the facility on [DATE] at 2:00 PM. During an interview on 6/14/24 at 11:18 AM, Registered Nurse # 6 stated that the resident went out on pass on 1/22/24 and there was no documentation as to when they left the facility. On 1/23/24, staff could not locate the resident, so Code Gray was called. The resident's designated representative was called and said the resident was with them. Registered Nurse #6 stated upon the resident's return, on 1/23/24 at 2:00 PM, they counseled the resident, checked the resident's body, and updated the care plan. During a phone interview on 6/20/2024 at 1:37 PM., the Director of Nursing #1 stated that the resident did not elope, they were out on pass. They stated an elopement was when a resident with low cognition left the building unwitnessed. They did not do an incident form as they did not classify the event as an elopement. The resident took a leave of absence, and the paperwork was not completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 08/29/24 at 12:06 PM, Registered Nurse #6 stated that on 1/23/24 upon Resident #2's return to the facility from being out overnight, they provided Resident #2 and their representative education on leaving the facility without notifying staff. The education was provided by having Resident #2 and their designated representative sign the Out On Pass Agreement form, which was agreeing to the policy. Staff #6 stated that there was a lack of communication between the nursing staff because a nurse was aware that Resident #2 went out on pass on 1/22/24 and did not alert other staff. Staff #6 stated that they did not know Resident #2 was out of the facility until he was reported missing by staff, and they called a Code Gray. Registered Nurse #6 stated that at the point that the Code Gray was called, Resident #2 was considered missing, because it was not communicated or documented that they went out on pass. During an interview on 08/29/2024 at 01:58 PM, the Administrator stated that the census was done by the Business Office Manager in the morning. The Administrator stated the Business Office was supposed to be notified of resident's not in the building, especially for an extended period. The Administrator stated that anyone would be able to see in the computer if a resident was not in in the building. The Administrator stated there was a drop-down box in the computer system to document when a resident was on a leave of absence. The Administrator signed into the computer system showed the surveyor that there was no documentation that the resident was out of the building. They stated the section for leave of absence in the computer should have been completed. During an interview on 08/29/2024 at 02:55 PM, Certified Nurse Aide #14 stated that when they came in for duty the night of the 1/22/24, they were not given report and were not informed that Resident #2 was missing. Certified Nurse Aide #14 stated that when they did their rounds, they checked Resident #2's room, and reported to the nurse on the unit that Resident #2 was not in their room. 415.12(h)(a)