STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335332	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eger Health Care and Rehabilitation Center	140 Meisner Avenue Staten Island, NY 10306

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 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** 49081 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00344007), the facility failed to provide adequate supervision to a resident to prevent an accident. This was evident in one out of four residents (Resident #1) sampled for accidents. Specifically, Resident #1 was left unattended in the shower room by Certified Nursing Assistant #1 on 06/01/2024. Licensed Practical Nurse #1 and Certified Nursing Assistant #2 observed Resident #1 sitting on the wet floor in the shower room with the shower chair titled behind Resident #1 on 06/01/2024 at 9:30am. Resident #1 was transferred to the emergency roiagnom on [DATE] and returned to the facility the same day with their left arm in a sling. The findings are: The facility Policy and Procedure of Resident Accident or Incident Reporting dated 02/14/2024 documented that an accident is defined as a second-degree burn, laceration requiring sutures, fracture, or event requiring hospitalization that has occurred in the facility or outside the facility. A report is completed for each fall, injury, unexplained bruise, abrasion, scratch, or purpura or any signs indicating that an event has occurred. This includes un-witnessed fall or injury, resident to resident altercations or resident to staff altercations, or an attempted or actual elopement. The facility Policy and Procedure titled Abuse Prohibition Protocol dated 03/2023 states that it is the policy that facility will ensure that all residents are treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment, and care for personal needs. The facility has zero tolerance for abuse and must provide a safe resident environment and protect the residents from abuse. Resident #1 was admitted to the facility with diagnoses including Anxiety Disorder, Alzheimer's Disease, and Primary Generalized Osteoarthritis. The Minimum Data Set, dated dated dated [DATE] documented Resident #1's cognition was moderately impaired. Resident #1 required substantial/maximal assistance with showering and bathing themself (helper does more than half the effort. Helper lifts or holds trunk or limbs and provide more than half the effort). (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Fall Risk assessment dated [DATE] documented Resident #1 had a score of 14 indicating high risk for falls. According to the instructions on the form, prevention protocol should be initiated immediately and documented on the care plan. A Care Plan for Falls initiated on 02/09/2024 documented interventions for staff to continue to monitor Resident #1 for safety, and to keep the environment clear of clutter. According to an Activities of Daily Living Documentation dated 05/01/2024-05/31/2024, Resident #1 required one-person physical assist for bathing. A Minimum Data Set Kardex Report dated 05/06/2024 documented that Resident #1 required physical help in part of bathing activity with one-person physical assist. A form titled 24-Hour Report-Falls dated 06/01/2024 at 10:44 am, by Registered Nurse Supervisor #1, documented Resident #1 was in the shower chair, released their seatbelt, attempted to stand, and slid onto the floor. Resident #1 was found in an upright sitting position. Resident #1 was assessed with no visible injury and Range of Motion was within normal range. Resident #1 was sent to the hospital for a Computed Tomography (a computerized x-ray imaging) of Head. An Investigation Summary dated 06/01/2024 at 5:42 pm documented Resident #1 had fallen in the shower room when Resident #1 was attempting to stand. Resident #1 was observed sitting in an upright position with the shower chair tipped next to Resident #1. Resident #1 was assessed and transferred to the emergency room for a Computed Tomography Scan due to being on Xarelto (a blood thinner-can treat/prevent clots). Resident #1 denied pain. Resident #1 returned from the emergency room visit with diagnosis of left wrist radial fracture. Resident #1 had a sling and immobilizer in place. The investigation concluded there was no intent of neglect, but Certified Nursing Assistant #1 failed to follow Resident #1's plan of care. A Hospital Patient Discharge Instructions dated 06/01/2024 documented diagnosis of a radial (one of two forearm bones) wrist fracture with splint in place. A Hospital Radiology results of a Computed Tomography dated 06/01/2024 documented x-ray findings of the left forearm (two views) - a definite fracture was not visualized. Three views of the left forearm were repeated and showed no definite fracture was visualized within the radial and ulnar (one of two bones in the forearm) diaphysis (the end part of a long bone). During an interview on 07/11/2024 at 2:02 pm, Certified Nursing Assistant #1 stated that they were assigned to Resident #1 on 06/01/2024. Certified Nursing Assistant #1 stated that they were providing Resident #1 with a shower and told Resident #1 to stay seated while they (Certified Nursing Assistant #1) checked on another resident. Certified Nursing Assistant #1 stated that Resident #1 agreed to stay seated, and they (Certified Nursing Assistant #1) left Resident #1 in the shower room unattended. Certified Nursing Assistant #1 stated that they left Resident #1 to dry themself (Resident #1). Certified Nursing Assistant #1 stated that when they were leaving the shower room, they observed Certified Nursing Assistant #2 entering the shower room (to toilet a resident), but they did not ask Certified Nursing Assistant #2 to monitor Resident #1. Certified Nursing Assistant #1 stated that they left the shower room for less than 2 or 3 minutes (does not remember exact time) and when they return, they observed Resident #1 sitting on the floor in the shower room. Certified Nursing Assistant #1 stated that they knew they were not supposed to leave Resident #1 in the shower room unattended. (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 07/11/2024 at 1:50 pm, Licensed Practical Nurse #1 stated that they were looking for Resident #1 and heard a noise as they (Licensed Practical Nurse #1) were passing by the shower room. Licensed Practical Nurse #1 stated that they went into the shower room together with Certified Nursing Assistant #2 and observed Resident #1 sitting on the wet floor. Licensed Practical Nurse #1 stated that the shower chair was tilted behind Resident #1, and the seatbelt was unfastened. Licensed Practical Nurse #1 stated that Resident #1 was not bleeding and did not complain of pain. Licensed Practical Nurse #1 stated that they notified Licensed Practical Nurse #2 and Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated that Registered Nurse Supervisor #1 came immediately and assessed Resident #1. Licensed Practical Nurse #1 stated they do not know how long Resident #1 was sitting on the floor, and do not recall the time. During an interview on 07/12/2024 at 12:56 pm, Certified Nursing Assistant #2 stated that they were not in the shower room at the time Certified Nursing Assistant #1 was providing shower to Resident #1. Certified Nursing Assistant #2 stated that they took a resident (Resident #2) to be toileted in the toilet area of the shower room on 06/01/2024 at around 9:27 am and observed Resident #1 sitting on the shower chair by themself in the shower room. Certified Nursing Assistant #2 stated that they asked Resident #1 if it was okay for them to toilet Resident #2 and Resident #1 agreed. Certified Nursing Assistant 2 stated that they (Certified Nursing Assistant #2) sat Resident #2 on the toilet then left Resident #2 (by themself) to retrieve an incontinent brief from the hallway. Certified Nursing Assistant #2 stated that they (Certified Nursing Assistant #2) went back to the shower room with Licensed Practical Nurse #1, who was looking for Resident #1) and observed Resident #1 sitting on the floor. In a subsequent interview on 07/23/23 at 10:00 am, Certified Nursing Assistant #2 stated that they were aware that it was unsafe for Resident #1 to be left unattended in the shower room. Certified Nursing Assistant #2 stated that they did not call for help or find out who was assigned to Resident #1. They (Certified Nursing Assistant #2) were focused on toileting Resident #2. Certified Nursing Assistant #2 further stated they left Resident #2 sitting on the toilet unattended for less than 2 minutes. Certified Nursing Assistant #2 stated they should not have left Resident #2 unattended. Certified Nursing Assistant #2 stated that Resident #2 required supervision in toileting. During a telephone interview on 07/15/24 at 10:39 am, Registered Nurse Supervisor #1 stated they were notified that Resident #1 was on the floor in the shower room by Licensed Practical Nurse #1 on 06/01/2024 (does not recall time). Registered Nurse Supervisor #1 stated that they assessed Resident #1 with no visible signs of injury, range of motion was intact, and Resident #1 did not complain of pain. Registered Nurse Supervisor #1 stated that Resident #1 was sent to the hospital because Resident #1 was on a blood thinner, and the fall was unwitnessed. Registered Nurse Supervisor #1 stated that the charge nurses, and the supervisors are responsible for monitoring the staff to ensure they are following the resident plan of care. During an interview on 07/12/24 at 4:00 pm, the Director of Nursing stated that the accident was investigated, and it was determined that there was no intent of neglect. However, Certified Nursing Assistant #1 failed to follow Resident #1's the plan of care. The Director of Nursing stated that they suspended Certified Nursing Assistant #1 pending outcome of the investigation. The Director of Nursing stated that Certified Nursing Assistant #1 has no records of abuse or neglect on file. The Director of Nursing stated that the nurse on the unit and the supervisors are responsible for monitoring and supervising staff to make sure care plans are being followed and implemented. (continued on next page)

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