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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335339 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/26/2024 |
| NAME OF PROVIDER OR SUPPLIER Mountainside Residential Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 42158 State Highway 28 Margaretville, NY 12455 | |

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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538</p> <p>Based on observations, record review and interviews during a recertification survey, the facility did not ensure a safe, clean, comfortable, home-like environment for on the second and third floor care units two of two resident care units reviewed. Specifically, the resident rooms and common spaces were not cleaned, sanitized, and areas of disrepair were repaired.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled Residential Room Cleaning Procedure, last revised 10/01/2022, documented that the intent of the procedure was to ensure complete and systematic cleaning and disinfection of each residential unit. The bathroom cleaning procedure included the following: dampen clean cloth in solution and clean bathroom beginning with the light over the sink, moving downward and clean the ledge of the mirror. Using the window cleaning cloth and window cleaner, clean the mirror. Using a fresh cloth, disinfect the sink, pipes under the sink and spot clean walls around the sink area. Using the bowl mop and germicide, clean under the rim of the toilet and all around the inside of the toilet in a circular motion. Dip the cloth and disinfect the top and bottom of the toilet seat, then the outside of the toilet, then flush the toilet and leave toilet seat up in position and apply a toilet band if applicable. The floors were to be cleaned utilizing the following procedure: dust mop the room beginning with the corners and edges, moving from the far side of the room toward the door and maintain one leading edge with the dust mop. Dust under the bed, furniture and behind the door. Leave the dust mop at the door and bring the dustpan and counter brush/squeegee to the doorway. Gently remove the material from the duster and floor and place in the cart bag. Mop all hard floor surfaces including corners, edges and behind doors. The policy included that residential cleaning frequencies varied from facility to facility depending on occupied and discharged resident protocols.</p> <p>The Policy and Procedure titled, Maintenance Work Request System last revised July 2024, documented the maintenance department would carry out a program to effectively maintain all real property, capital, and non-capital equipment and to identify the types of work orders and procedures for requesting the services. Work order would be scheduled by the maintenance department according to the following priorities: urgent, routine, and deferred.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a group resident interview on 7/23/2024 at 1:30 PM, Resident #30 stated their room was not being cleaned regularly. They stated someone would come to empty their trash, but that the room would not be cleaned and sanitized. Resident #33 stated housekeeping was not regularly cleaning their room either. The resident stated when they had asked about having their room cleaned, they had been told by housekeeping staff that it had been completed, however it was evident to them it had not been cleaned.</p> <p>During an observation and interview on 7/23/2024 at 12:43 PM, the closet doors in room [ROOM NUMBER] were not secured in the sliding track and the closet could not be closed. The closet doors had holes and scrapes across the bottom of the doors. The lower section of walls in the bedroom room were covered in carpet that had large brown stains in multiple areas and was ripped away from the wall in sections. In the bathroom, the toilet had brown staining in the toilet bowl and around the water line. Resident #26 was seated in a reclining chair in the room and stated their room was cleaned maybe once or twice a week. They pointed to some tissue under their bed and stated it had been left for a few days. They stated housekeeping staff would come in and empty the trash bin but would not clean the room. They stated the closet door in their room was broken, and the closet could not be closed.</p> <p>During an observation on 7/23/2024 at 12:46 PM in room [ROOM NUMBER], there was carpeting on the walls that was stained and pulled away from the wall in sections. The corner of the wall near the entrance to the shared bathroom, had a baseboard that was pulled away from the wall with dry wall and debris accumulated on the floor. The bathroom wall had square of dry wall that appeared to have been replaced but then became scratched and was not painted to match the walls of the bathroom. The bathroom had a white powder/dust that covered most of the area on the vanity around the sink and on shelving that was hung on an adjacent wall. On the shelving, there was a soiled hairbrush that also had a white substance on it and had hair and debris stuck in the bristles.</p> <p>During an observation on 7/24/2024 at 12:24 PM, the carpeting on the wall of room [ROOM NUMBER] had stained in multiple areas and was frayed and pulling away from the wall in sections.</p> <p>During an observation on 7/24/2024 at 12:26 PM, the shower room on the second-floor care unit had a deep scrape in the drywall along the left side of the bathroom wall and sections of the wall that showed repairs in the dry wall that were not painted over. The caulking on the top of the sink was cracked peeling away. The toilet had brown staining inside the bowl along the waterline and there were yellow stains under the toilet seat. There was brown staining in the linoleum flooring in the corners of the bathroom and under the sink. The shower tiles were missing grout in sections.</p> <p>During an observation on 7/24/2024 at 12:30 PM, there was a recliner chair in the common sitting area near the nurse's station on the second-floor care unit that had a large rip across the base of the recliner and a flap of material from the chair hanging down. The recliner next to it had multiple stains and appeared soiled.</p> <p>During an observation on 7/24/2024 at 12:41 PM, the shower room on the third-floor care unit had dirt/debris and staining on the linoleum floor in the corners and edges of the flooring. The flooring was curled back at the wall creating a gap between the baseboards. There was boarding stapled to the right wall. The floor outside the shower room had dust/debris/dark areas in the corners. The toilet seat had yellow and brown colored stains, a dark ring/staining inside the toilet bowl at the water line and a substance on the back of the toilet where the toilet seat hinged to the toilet bowl.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview and environmental tour on 7/25/2024 at 9:50 AM, Director of Maintenance #1 observed the stain, torn carpeting on the walls of the resident rooms and stated that the carpeting in resident rooms needed to be replaced because it could not be cleaned or sanitized without damaging the wall behind it. They stated there was no way to thoroughly sanitize the resident rooms with carpeting on the wall. They stated they had recently taken down the carpeting on the walls of one resident room. They stated there had been a proposal to remove the carpeting from all the walls in the resident rooms and estimates had been obtained. They observed the shower rooms on the second and third floor care units and took photos of areas of concern that required repair/ were soiled. They stated resident rooms should be cleaned and sanitized daily to prevent spread of infection. They observed the recliner chairs in the common room of the second-floor care unit and stated chairs that were in disrepair should be repaired or replaced. They stated many of the chairs had come from resident rooms and were shared by residents in the common area. They stated shared chairs should be sanitized daily to prevent spread of infection. They observed the third-floor shower room and noted the staining in the toilet and areas in need of repair and stated they did not have existing work orders for the shower room. They noted the dark areas in the corners of the hallway floor leading to the shower room on the third-floor care unit and stated the corners of the floor needed to be cleaned more thoroughly. During a subsequent observation of room [ROOM NUMBER] at 10:16 AM, while on the environmental tour, it was observed that the toilet in the bathroom continued to have stains inside the toilet bowl and around the water line and there was still a white substance that look like dust or a powder all around the sink of the bathroom sink and on the shelving. When water was applied by Director of Maintenance #1, the substance could be wiped off. They stated resident bathrooms should be thoroughly cleaned and sanitized daily. They stated the housekeeping department was short staffed, and the facility was trying to hire more housekeepers. They stated the facility required three housekeepers each shift to complete the needed cleaning of the resident rooms/environment but presently have staff two housekeepers to complete the work.</p> <p>Review of Environmental Rounding completed on 4/03/2024 documented carpeting on the walls in resident Room #'s 302, 304, 305, and 308 was stained or coming off the wall.</p> <p>Review of Environmental Rounding completed on 4/09/2024 documented carpeting on the walls in resident Room #'s 309, 311, and 312 was stained, soiled or coming off the wall.</p> <p>Review of Environmental Rounding completed on 4/17/2024 documented carpeting on the walls in resident Room #'s 314, 316, 319 and 322 was stained, soiled or coming off the wall.</p> <p>A Project Proposal dated 11/02/2023 titled Knee Wall Replacement Project documented the objective of the project was the removal of the carpeted knee wall in resident rooms and to replace it with a durable and easily cleanable board to provide a clean finish to the room. The proposal documented the project was necessary to correct an infection control issue identified by the Department of Health during an inspection of the facility and the project would also provide the residents with a healthier living environment. Estimates to complete the removal of carpeting on the walls of 46 rooms was included, however, as of the completion of the recertification survey on 7/26/2024, only one resident room had the carpeting on the wall replaced.</p> <p>(continued on next page)</p> |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 7/25/2024 at 9:17 AM, Director of Nursing #1 stated the carpeting on the walls in the resident rooms needed to be replaced because there was no way of cleaning it. They stated having carpeting on the walls presented the risk of breeding infection and there was not a routine cleaning project for carpeting on the walls because it would destroy the wall behind it. They stated cleaning of resident rooms, and the resident environment should be done daily, and deep cleaning completed once a month.</p> <p>10 New York Codes, Rules, and Regulations 415.5(h)(2)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538</p> <p>Based on record review and staff interviews during the recertification survey and abbreviated survey (Case #NY003318803), the facility did not have documented evidence that all alleged violations were thoroughly investigated for 2 (Residents # 34 and 56) of 7 residents reviewed for accidents. Specifically, Resident #34 had a fall with a left hip fracture (a break in thigh bone) on 3/21/2024, and Resident # 56 was found with facial bruising and swelling. The facility did not thoroughly investigate the root cause to rule out abuse or neglect.</p> <p>This is evidenced by:</p> <p>The Policy and Procedures titled, Resident Abuse, Mistreatment, Exploitation, Misappropriation, Reporting, and Elder Justice Act, last reviewed 4/2024 documented if an incident was considered reportable, the Administrator or designee would make an initial report to the New York State Department of Health and a follow-up investigation would be submitted within five working days. When reporting the facility representative should have available documentation on witness statements, resident statements, accused statements, facility investigation report, resident medical records, employee training records, and plan to prevent reoccurrence.</p> <p>Resident #34 was admitted to the facility with the diagnoses of dementia, constipation, and anxiety disorder. The Minimum Data Set (as assessment tool) dated 6/21/2024 documented the resident had severe cognitive impairment, could usually understand others, be understood by others.</p> <p>The Accident and Incident report dated 3/21/2024 documented the resident had an unwitnessed fall.</p> <p>The Progress Note dated 3/22/2024 documented the resident complained of left hip pain. The provider was made aware, and ice applied.</p> <p>The Progress Note dated 3/22/2024 documented the resident was not able to bear weight on left leg due to pain. The provider ordered a hip x-ray.</p> <p>The Progress Note dated 3/22/2024 documented the X-ray was completed and showed an intertrochanteric comminuted fracture of left hip (a break in the femur that occurs between the greater and lesser trochanter at the top of the thigh bone). The resident was transferred to the hospital for further treatment.</p> <p>There was no documented evidence provided that an investigation was completed.</p> <p>During an interview on 7/25/2024 at 1:44 PM, Director of Nursing #1 stated no investigation was completed for the incident on 3/21/2024 that resulted in a major injury. They stated they were not the director of nursing at that time and did not know why it was not done.</p> <p>Resident #56 was admitted to the facility with diagnoses of malignant neoplasm (cancer) of the prostate, Alzheimer's disease with early onset and restlessness with agitation. The Minimum Data Set, dated dated [DATE] documented the resident had severe cognitive impairment, rarely be understood, could rarely understand others.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>ASPEN Complaints/Incidents Tracking System documented incident NY00318803, documented the facility's previous Director of Nursing submitted an initial report on 6/23/2023. An injury (facial bruising) of unknown origin was reported with a likely cause reported as the resident may have rolled over in bed hitting the nightstand. There was no follow-up investigation submitted.</p> <p>A Progress Note dated 6/22/2023 signed by Registered Nurse #1, documented unexplained bruising, and swelling on left side of face found during morning care. No other signs of trauma.</p> <p>A Progress Note dated 6/23/2023 signed by Physician Assistant #1 documented the resident had bruising of the left peri-orbital region and upper lip. No evidence of other trauma. Further work up of this soft tissue injury not indicated.</p> <p>During an interview on 7/25/2024 at 11:00 AM, Registered Nurse #1 stated they recall an incident where Resident #56 was found to have bruises on their face but does not recall if they were able to determine what happened. It was likely the resident fell out of bed during the night and got back to bed without telling anyone. Resident would not have been able to recall or report later what had happened.</p> <p>During an interview on 7/26/2024 at 11:22 AM, Director of Nursing #1 stated, the previous Director of Nursing completed investigations on paper, and they could not find anything in the files related to this incident. They stated that all allegations of abuse, neglect, and injuries of unknown origin should be investigated.</p> <p>10 New York Codes, Rules and Regulations 483.12(c)(2 - 4)</p> <p>43805</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47140</p> <p>Based on observations, record review, and interviews during a recertification and abbreviated survey (Case #NY00338924), the facility did not ensure the resident environment remained free of accident hazards for one resident (Resident #25) out of six sampled residents. Specifically, on 4/11/2024 a windowpane on the third floor care unit, which had previously been identified as a potential hazard and in need of repair; fell inward when Resident #25 tried to close the window. Subsequently, Resident #25 sustain a laceration to their scalp which required six staples to close the wound. This resulted in actual harm that was not immediate jeopardy for Resident #25.</p> <p>This is evidenced by:</p> <p>Resident #25 was admitted to the facility with diagnoses of dementia without behavioral disturbance, age-related reticular degeneration of retina (a group of diseases that cause the retina of the eye to deteriorate), and age-related osteoporosis (a skeletal disorder characterized by low bone density). The Minimum Data (an assessment tool) dated 5/16/2024 documented the resident had severe cognitive impairment for decisions of daily living, could sometimes be understood, and could sometimes understand others.</p> <p>The Policy and Procedure titled, Near Miss Reporting Tool, last revised November 2022, documented the facility's goal was to promote a safe care and living environment for residents and work environment for staff by addressing potential concerns before they caused harm or injury.</p> <p>The Policy and Procedure titled Fall Prevention, Fall Risk Assessment, and Registered Nurse Notification, last revised 6/23/2022, documented the purpose of the policy was to provide residents with an environment as free of accident hazards as possible. The procedure included the identification of environmental hazards that could contribute to falls.</p> <p>The Policy and Procedure titled, Maintenance Work Request System effective date 01/2011 documented the maintenance department would carry out a program to effectively maintain all real property, capital, and non-capital equipment, and to identify the types of work orders and procedures for requesting the services. Work orders would be scheduled by the maintenance department according to the following priorities: urgent, routine, and deferred. Urgent repairs or corrective actions to equipment involving patient care were those which required immediate attention and could affect patient services, endanger life, or seriously damage campus equipment. Maintenance personnel were to respond immediately to urgent work orders, assess the situation and render repair or remove equipment/system from service as needed. The Director of Maintenance should be notified immediately of any urgent work orders.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>The Facility's Incident and Accident Investigation dated 4/11/2024, documented per witness statements, Resident #25 had attempted to shut a common area window on the third floor and as they were pushing down, the window came out of the frame towards the resident which resulted in them losing their balance and fell backwards with the back of their head hitting the floor. Staff were unable to intervene quick enough to prevent the fall. The investigation concluded that Resident #25's fall and injury were the result of the clips on the window being broken which allowed the windowpane to fall and caused Resident #25 to lose their balance. A work order was placed on 4/09/2024 (two days prior to the incident) by the Director of Nursing stating the window was a safety concern and needed to be fixed immediately. The work order was marked as completed on 4/09/2024. Upon further investigation, per the maintenance department, completed meant they locked the window on 4/09/2024. The investigation documented the resident's fall could have been prevented if the window was fixed properly and the injury was the result of a faulty environment. Corrective actions taken were documented to include that the window was immediately secured, education was provided to the maintenance department, a review of the maintenance work order process was completed, and a building wide window audit was conducted immediately following the incident and any window with a similar problem was fixed.</p> <p>A Maintenance Work order dated 4/09/2024, documented a window on the third-floor common area required that the clips that held the window in place needed to be replaced. The window clips were documented to require replacement as soon as possible due to the window being a safety concern.</p> <p>A Nursing Progress Note dated 4/11/2024 at 2:00 PM written by Registered Nurse #2, documented Resident #25 was heard to call out Oh my from the common area and then a thump was heard. The resident was found lying on their left side on the floor in the common area. A small amount of bleeding was noted to the left side of the back of the resident's head with a hematoma (collection of blood outside of the blood vessels due to injury/trauma) developing. The area was cleansed, ice, and pressure were applied. Resident #25 complained of their head and left elbow hurting. A hematoma was also noted to the resident's left elbow. The resident was seen by Physician Assistant #1 and an order was given to send the resident to the emergency room .</p> <p>A Medical-Acute Problem progress notes dated 4/11/2024 written by Physician Assistant #1 documented Resident #25 was evaluated in the third-floor common area following a fall. The resident sustained a 1.5-centimeter laceration and surrounding hematoma to their mid posterior scalp. Resident #25 was transported to the emergency room for imaging of their head and treatment for the laceration that the resident sustained.</p> <p>A Nursing Progress Note dated 4/11/2024 at 5:11 PM written by Registered Nurse #3 documented Resident #25 returned from the emergency room at 5:00 PM. Imaging completed at the emergency room was negative for abnormalities. The laceration to the back of their scalp was approximated (closed) with six staples and a new order to cleanse the wound and apply anti-bacterial ointment for two days and to then clean and dress daily as needed. Staples were to be removed after ten days.</p> <p>Upon request on several attempts, the facility could not produce documentation that a facility-wide audit of all windows was conducted immediately following the incident to prevent recurrence. Environmental rounding of the facility was conducted on 4/17/2024 (six days after the incident) and documented seven resident rooms were observed. Four of the seven rooms observed during the rounding (Room #'s 314, 315, 316, and 321) were documented to have broken window clips.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 7/25/2024 at 10:50 AM, Director of Maintenance #1 stated maintenance had received a work order for the window on the third-floor common room prior to the incident with the window falling in and causing Resident #25 to fall on 4/11/2024. They stated after the incident occurred; the facility had implemented a new work order system to triage work orders that could present a hazard to residents. They stated maintenance staff received education on the prioritization of environmental hazards and immediately completed an environmental audit to identify any other windows in need of repair.</p> <p>During an interview on 7/25/2024 11:33 AM, Registered Nurse #2 stated they were working on the third-floor care unit on 4/11/2024 when they heard Resident #25 state oh my and then they heard a thump. They stated Resident #25 had attempted to close the window in the common area of the unit, and it fell in on Resident #25. They stated the resident was assessed to have a laceration to their scalp and was sent to the emergency room where they required six staples to close the wound. They stated the window had a sign placed on it for a long time which indicated the window should not be opened due to need of repair. They stated it had previously been identified that the window needed repair and presented a potential hazard to residents. They stated when they had previously inquired about the repair of the window, they were told the facility was waiting on parts to complete the work order. They stated Resident #25 had dementia and due to cognitive limitations, would not be able to comprehend the signage left on the window which indicated that it was a hazard. They stated the incident was preventable and should not have occurred.</p> <p>During an interview on 7/25/2024 at 1:53 PM, Physician Assistant #1 stated they were called to assess Resident #25 following their fall on 4/11/2024, observed that the resident had sustained a laceration and bruising to their head and gave the order for Resident #25 to be sent out to the emergency room . They stated Resident #25 had advanced dementia and would not be able to comprehend signage indicating a window was broken or recognize potential hazards. Physician Assistant #1 stated Resident #25 had attempted to open the window which broke and caused them to fall back. They stated they were aware of the window needing repair and that nursing staff had asked to have the window repaired prior to the incident.</p> <p>During an interview on 7/26/2024 at 9:17 AM, Director of Nursing #1 stated the root cause of Resident #25's fall/injury on 4/11/2024 was due to an unstable window in the common area of the resident's care unit. They stated the window needed repair for a long time approximately a year. They stated Resident #25 was sent to the emergency room following the incident and required staples to treat the laceration to their head. They stated following the incident, the facility changed how work orders were prioritized and environmental rounding was completed to ensure that no other windows could present a risk to the residents and that issues with windows were given high priority due the potential of being hazardous.</p> <p>10 New York Codes, Rules, and Regulations 415.4(b)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335339 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/26/2024 |
| NAME OF PROVIDER OR SUPPLIER Mountainside Residential Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 42158 State Highway 28 Margaretville, NY 12455 | |
| 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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>335338</p> <p>Based on records reviewed and interviews during the recertification survey, the facility did not ensure each resident's drug/medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for 1 (Residents #39) of 5 residents reviewed for unnecessary medications. Specifically, for Resident #39, as-needed psychotropic medication orders did not include a stop date., Additionally, for twenty administrations of Ativan (an antianxiety/sedative/hypnotic medication) there were two notes documenting indications for use, one of the two documented non-pharmacological interventions attempted, and one documented monitoring of medications for efficacy.</p> <p>This is evidenced by:</p> <p>Resident #39 was admitted with the diagnoses of nontraumatic subarachnoid hemorrhage (bleeding in the brain), diabetes, and anxiety disorder. The Minimum Data Set (an assessment tool) dated 6/20/2024 documented the resident was usually able to be understood, could usually understand others and had moderately impaired cognitive skills.</p> <p>A facility policy titled Psychotropic Drug Usage last revised 2/25/2022 documented, All PRN (as needed) Psychotropic drugs would be ordered and under review by physician for 14 days at that time, Physician would continue order for 14 more days if warranted. At the end of the second 14-day physician reviewed trial, the as needed (PRN) drug must become a Standing Order or be discontinued.</p> <p>A Comprehensive Care Plan titled Mood dated 6/24/2024, documented the following interventions; Periodically evaluate resident mood and behavior and report to supervisor, social work, and/or medical staff if there were any symptoms of acute depression or anxiety, if resident struggled with behavioral issues, there were several actions that could be helpful in assisting resident such as.</p> <ol style="list-style-type: none"> 1. approaching resident calmly and using touch as appropriate 2. ensuring a calm, low stimulation environment. as possible 3. being aware of actions or situations that could trigger in resident an adverse behavioral reaction. <p>A Medication Order dated 6/13/2024 documented the resident was to be given Ativan 0.5 milligrams every 12 hours as needed for prophylaxis related to anxiety disorder.</p> <p>The Medication Administration Record documented Ativan 0.5 milligrams was administered 7 times in June 2024, and 13 times in July 2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Progress Notes from 6/13/2024 (date of admission) through 7/24/2024 documented 2 notes related to Ativan use. On 6/25/2024 it was documented that the resident was continued to exit seek. All interventions attempted to no avail. As needed Ativan was administered with positive effect. On 7/08/2024 it was documented, resident was agitated, going in and out of other's rooms, was given Ativan per order.</p> <p>Medical Progress Notes from 6/13/2024 (date of admission) through 7/24/2024 did not document indications for the use of Ativan per physician orders.</p> <p>A Medication Regimen Review dated 7/24/2024 documented no recommendations.</p> <p>During an interview on 7/24/2024 at 12:41 PM, Registered Nurse #1 stated as needed orders should have a corresponding progress note documenting why it was given, and a follow-up note saying if it was effective or not.</p> <p>During an interview on 7/24/2024 at 1:05 PM, Registered Nurse #2 stated, when an as needed medication was given, there should be documentation of what the resident was doing, what was tried to alleviate the symptoms and what happened after the medication was administered. Upon review of Resident #39's Progress Notes, Registered Nurse #2 stated there was only one note providing that documentation.</p> <p>During an interview on 7/26/2024 at 10:56 AM, Physician Assistant #1 stated the Ativan should have been a 14-day script. When that order drops off it should be reassessed. They stated they then would review behavioral documentation of what was happening before and after administering to monitor for efficacy and determine if it should be renewed, changed, or discontinued.</p> <p>10 New York Codes, Rule and Regulations 415.18 (c)(2)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>43805</p> <p>Based on observations, record review, and staff interviews during the recertification survey, the facility did not ensure infection prevention control practices were followed to help prevent the spread, development, and transmission of communicable diseases and infections for 1 (Resident #26) of 1 resident reviewed for respiratory care. Specifically, for Resident #26, the nebulizer mask was observed in the resident's room not properly protected from infection.</p> <p>This is evidenced by:</p> <p>Resident #26 was admitted to the facility with the diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), type 2 diabetes mellitus, and gastro-esophageal reflux disease (Acid Reflux). The Minimum Data Set (an assessment tool) dated 5/30/2024 documented the resident was cognitively intact, could be understood, could understand others.</p> <p>National Institute of Health (https://www.nhlbi.nih.gov/sites/default/files/publications/How-to-Use-a-Nebulizer-21-HL-8163.pdf) stated nebulizer parts should be stored in a dry clean plastic storage bag between uses.</p> <p>There was no facility policy on infection Control practices provided.</p> <p>During an observation on 7/22/2024 at 12:58 PM, the resident's nebulizer mask was on the bedside table facing down not bagged or covered.</p> <p>During an observation on 7/25/2024 at 8:34 AM, the resident's nebulizer mask was on bedside table next to nebulizer machine. The nebulizer mask was not in a bag or covered.</p> <p>During an observation on 7/26/2024 at 9:29 AM, the resident's nebulizer mask was on bedside table next to nebulizer machine. The nebulizer mask was not in a bag or covered.</p> <p>During an interview on 7/26/2024 at 8:43 AM, Licensed Practical Nurse #1 stated a nebulizer mask should be cleaned after each use and stored in a plastic bag.</p> <p>During an interview on 7/26/2024 at 9:11 AM, Registered Nurse #2 stated a nebulizer mask should be stored in a plastic bag.</p> <p>During an interview on 7/26/2024 at 10:00 AM, Director of Nursing #1 stated a nebulizer mask should be stored in a clean plastic bag when not in use.</p> <p>10 New York Codes, Rules, and Regulations 415.19(a)(1-3)</p> | | |