

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2024
NAME OF PROVIDER OR SUPPLIER Schulman and Schachne Inst for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Rockaway Parkway Brooklyn, NY 11212	

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 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907</p> <p>Based on observation, record review, and interviews during an Abbreviated Survey (NY00364046), complaint investigation concluded the facility failed to ensure a resident was treated with respect and dignity including the right to be free from physical or chemical restraints imposed for the purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. This was evident for 1 out of 39 residents (Resident #1). Specifically, on several occasions Resident #1's wrists were tied with bed sheets to the bed rails. Certified Nursing Assistant #6 admitted to placing Resident #1 in these restraints and intentionally not removing them to prevent Resident #1 from removing their brief and smearing feces. Resident #1 was restrained for the purposes of discipline or convenience. This resulted in serious harm to Resident #1 that was determined to be Immediate Jeopardy Past Noncompliance.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Physical Restraints was revised on 06/2024. The policy states the facility ascribes to the philosophy of the least restrictive environment for its residents. Restraints will be used only to protect residents' health and safety and to help them attain and maintain their individual levels of physical and emotional function. Residents requiring continued restrains after two weeks, determination will be re-evaluated monthly by the physician and responsible nurse. It will be documented in the resident's medical record, comprehensive care plan, and Nursing Assistant Accountability Record.</p> <p>Resident #1 was admitted to the facility with diagnoses including Hypertension (high blood pressure), Renal Insufficiency (poor function of the kidneys) and Non-Alzheimer's Disease (loss of memory).</p> <p>The Minimum Data Set (an assessment tool), dated 10/02/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderately impaired cognition.</p> <p>The Comprehensive Care Plan titled: At Risk for Victimization dated 09/14/2024 documented Resident #1 was at risk for victimization due to cognitive impairment. The interventions documented to place Resident #1 on one-to-one close monitoring (a person is assigned to always watch the resident), continued visual checks as per protocol and plan of care.</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 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Physician's Order dated 08/02/2024 documented an order to apply hand protector to Resident #1's bilateral hands, remove/release every 2 hours and as needed for 15 minutes to prevent pulling of Perma catheter (flexible tube) located on Resident #1's left front chest wall. Monitor for circulatory impairment.</p> <p>There is no documented evidence the hand protector order was renewed after 08/02/2024.</p> <p>The facility's investigation into an injury of unknown origin concerning Resident #1 was initiated on 12/09/2024. During the investigation Certified Nursing Assistant #5 provided a written statement to the facility dated 12/12/2024. According to their statement, on 10/14/2024 at about 7:02 AM they observed Resident #1 wearing mittens and their wrist tied with a bed sheet to the bed rail. Certified Nursing Assistant #5 wrote they observed Resident #1's family members heading to Resident #1's room, so they ran to the nursing station and notified Licensed Practical Nurse #1 about the restraint. They further wrote Licensed Practical Nurse #1 asked them if they removed the restraint, and they said no. Certified Nursing Assistant #2 also provided a written statement dated 12/12/2024. In the statement Certified Nursing Assistant #2 wrote on 10/15/2024 and 11/15/2024 they observed Resident #1 being restrained with a bed sheet and mittens. They wrote they observed this during their rounds on the 7:00 AM -3:00 PM shift. Certified Nursing Assistant #2 wrote that on both occasions they untied the resident and immediately reported the incidents to Licensed Practical Nurse #1 and #2. License Practical Nurse #1 and #2 worked on the 7:00 AM - 3:00 PM shift. Certified Nursing Assistant #2 wrote that License Practical Nurse #1 and #2 did not check on the resident after they reported the incident. The Facility's investigation concluded restraints were used, and abuse did occur.</p> <p>The facility investigative file contained pictures provided by the family of Resident #1. The photographs revealed the resident being restrained by bed sheets tied to the bed rail. The pictures were not time or date stamped.</p> <p>Licensed Practical Nurse #1 and #2 refused to write statements to the facility. Both denied being informed by Certified Nursing Assistants that Resident #1 was tied to the bed with a bed sheet at any time.</p> <p>Certified Nursing Assistant #6 refused to submit a written statement to the facility. The facility investigative report documented they admitted to the Director of Nursing they used mittens, and bed sheets to restrain the resident because they had been known to smear feces over themselves.</p> <p>Resident #1's adult child's personal cell phone with pictures from 12/17/2024 at 1:52 PM was reviewed. Observed: (1) a picture dated 10/14/2024 at 7:40 AM of Resident #1 lying in bed with their left and right hand tied with bed linens to the bed rails; (2) a picture dated 11/02/2024 at 3:35 PM showing Resident #1 lying on their back with right and left hand tied with bed linens to the bed rails; (3) a picture dated 11/09/2024 at 12:11 PM showing Resident #1 lying in bed with a twisted bed linen placed across their midbody and tied to both bed rails.</p> <p>During an interview on 12/17/2024 at 9:41 AM, Resident #1 stated they do not know how they sustained the fracture. Resident #1 stated everyone is nice to them.</p> <p>During an interview on 12/17/2024 at 9:54 AM, Certified Nursing Assistant #2 corroborated what she wrote in her 12/12/2024 statement to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 12/17/2024 at 10:58 AM, Certified Nursing Assistant #4 stated they observed Resident #1 with their hands tied to the bed rails on 11/09/2024 on the 3:00 PM - 11:00 PM shift. Certified Nursing Assistant #4 stated they did not report the restraint because they were afraid.</p> <p>During an interview with the Director of Nursing on 12/17/2024 at 12:59 PM, the Director of Nursing stated on 12/09/2024 during their investigation into an incident involving Resident #1 that occurred on 12/04/2024, they learned Resident #1's adult child had observed Resident #1 in restraints. The Director of Nursing stated on 12/10/2024 the adult child showed them (on their cell phone) pictures of the Resident's wrists being tied with a bed sheet to the bed rails on 10/14/2024 at 7:40 AM and on 11/02/2024 at 3:35 PM, and on 11/09/2024 at 12:11 PM with bed sheet across Resident #1's waist and tied to the bed rails. The Director of Nursing stated they interviewed Certified Nursing Assistant #6 who admitted they used pillowcases and sheets to restrain Resident #1's hands to prevent Resident #1 from removing their incontinent brief and smearing feces all over themselves. The Director of Nursing stated Certified Nursing Assistant #6 stated they were not wrong for restraining Resident #1.</p> <p>During a telephone interview on 12/17/2024 at 1:45 PM, Resident #1's adult child stated they visited Resident #1 on 10/14/2024 and observed Resident #1's wrists tied with a bed sheet to both side rails at 7:40 AM and that they took pictures with their cell phone. Resident #1's adult child stated they visited Resident #1 on 11/02/2024 at 3:35 PM and Resident #1 had both their wrists tied with a bed sheet to the side rails. Resident #1's adult child stated they visited Resident #1 again on 11/09/2024 at 12:11 PM and Resident #1 had a bed sheet across their waist tied to both side rails. Resident #1's adult child stated they took pictures but did not report the restraints to anyone in the facility because they thought it was okay.</p> <p>During a telephone interview on 12/17/2024 at 3:27 PM, Certified Nursing Assistant #6 stated they put mittens on Resident #1's hands to stop Resident #1 from scratching and playing with their feces. Certified Nursing Assistant #6 stated they removed the mittens when Resident #1 was asleep or was not agitated. Certified Nursing Assistant #6 stated they never used a sheet to tie Resident #1's hands. Certified Nursing Assistant #6 stated they put pillowcases on Resident #1's hands, then put Resident #1's hands into the mittens.</p> <p>During an interview on 12/18/2024 at 4:00 PM, Certified Nursing Assistant #5 corroborated what they wrote in their statement to the facility on [DATE].</p> <p>During an interview on 12/19/2024 at 4:47 PM, the Administrator stated they received a phone call from the Director of Nursing just after midnight on 12/09/2024 notifying them Resident #1's adult child reported Resident #1 being restrained. The Administrator stated a meeting was held with the adult child, Director of Nursing, Medical Director, and Director of Social Service on 12/10/24 at 11:00 AM. The Administrator stated during the meeting the adult child presented their evidence of Resident #1 being restrained. The Administrator stated the pictures were date and time stamped. The Administrator stated the adult child stated they did not report the restraint to anyone because they were afraid. The Administrator stated they provided education to Resident #1's adult child that advised they should report concerns or issues. The Administrator stated the police were called.</p> <p>The Immediate Jeopardy was determined to have begun on 10/14/2024. The Administrator was informed of the Immediate Jeopardy and provided with the Past Noncompliance Immediate Jeopardy Template on 12/23/2024 at 5:35 PM.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to the start of this survey. As such, a Plan of Correction is not required for this citation.</p> <p>The facility took immediate corrective actions and was found to be in substantial compliance on 12/12/2024 at 9:00 AM prior to survey initial onsite visit on 12/16/2024 at 9:00 AM.</p> <p>Facility initiated an investigation on 12/09/2024 at 10:40 PM after receiving an x-ray result from the hospital on 12/09/2024.</p> <p>12/10/2024 at 12:07 AM - Reported to Department Of Health</p> <p>12/10/2024 - Resident #1 was assigned a staff to do 1:1 supervision (ongoing).</p> <p>12/10/2024 - 67th Precinct notified.</p> <p>12/10/2024 - AD HOC QAPI Committee Meeting held (titled Abuse, Neglect, Mistreatment, and Reportable incidents).</p> <p>12/11/2024 - facility spoke with NYSDOH investigator (name mentioned in documentation) regarding the use of restraint on Resident #1.</p> <p>12/11/2024 - Attorney General's Office notified via website/phone message.</p> <p>12/12/2024 - Attorney General's Office Intake Department - spoke with facility Administrator.</p> <p>12/12/2024 - AD HOC QAPI Meeting held on Resident Safety.</p> <p>12/12/2024 - Audit conducted to review residents with siderails.</p> <p>Facility suspended 1 Nurse Manager, 2 Licensed Practical Nurses and 5 Certified Nursing Assistants pending investigation outcome.</p> <p>Termination Hearing scheduled for 12/18/2024 at 11:30 AM.</p> <p>12/10/2024 - Facility in-service (ongoing). Topic: Resident Rights, Abuse, Siderails/Monitoring, Bed Entrapment & Restraint, Reportable Concerns, Pain Management, Managing Difficult Residents, Resident Safety, and Trauma Informed Care.</p> <p>Audits are being conducted on Risk for Abuse started 12/14/2024 on Resident #1's unit for all residents.</p> <p>Policies/Procedures reviewed (no changes made) on Abuse, Entrapment, Reporting, Restraint, Just Culture, Code of Ethics & Conduct.</p> <p>Inservice of all staff was initiated on 12/10/2024. 91% of nursing staff have been in-serviced.</p> <p>Risk for abuse audits started on 12/12/2024 for all residents on Resident #1's unit.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All nurses must provide rounding every 2 hours on all shifts/units.</p> <p>Certified Nursing Assistant #3 and #6, License Practical Nurse #1 and #2 were terminated on 12/24/2024.</p> <p>Director of Nursing will continue to in-service the remaining 8% of nursing staff as they report to work.</p> <p>10 NYCRR 415.4(a)(2-7)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907</p> <p>Based on observation, record review and interviews conducted during an Abbreviated Survey (NY00364046), the facility did not ensure that an alleged violation involving abuse, neglect, mistreatment, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility. This was evident in 1 out of 39 residents (Residents #1) sampled. Specifically, on 10/14/2024, 10/15/2024, and 11/15/2024 Certified Nursing Assistants #2 and #5 observed Resident #1's wrists tied with bed sheets to the bed rails and reported it to Licensed Practical Nurse #1 and #2. Neither Licensed Practical Nurse #1 nor #2 reported the restraint to Registered Nurse Supervisor, thus the Administrator was not notified within 2 hours of the allegation being made by the Certified Nursing Assistants.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Abuse, Mistreatment, Neglect, Misappropriation of Resident 's Property was revised on 02/2023. The policy states the facility will protect each resident from abuse, neglect, mistreatment in accordance with State and Federal regulations. The policy further documented that any employee noting any change in the resident's condition shall immediately report the findings and/or concerns to their immediate Nurse Manager or Supervisor. The Nurse Manager or Supervisor will verify the employee's concerns and initiate a resident occurrence report. The Reporting/Response section of the policy states that a report is to be filed if an individual has reasonable cause to believe that a resident has been physically abused, mistreated, or neglected by a staff of this facility and/or by a family member or visitor. Reasonable Cause is defined in the Department of Health Regulations as upon review of the circumstances, there is sufficient' evidence for a prudent person to believe that physical abuse, mistreatment, or neglect has occurred.</p> <p>The policy did not mention who staff should report suspicion of abuse to. The policy only mentioned reporting of change in resident's condition.</p> <p>Resident #1 was admitted to the facility with diagnoses including Hypertension (high blood pressure), Renal Insufficiency (poor function of the kidneys) and Non-Alzheimer's Disease (loss of memory).</p> <p>The Minimum Data Set (an assessment tool), dated 10/02/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's investigation into an injury of unknown origin concerning Resident #1 was initiated on 12/09/2024. During the investigation Certified Nursing Assistant #5 provided a written statement to the facility dated 12/12/2024. According to their statement, on 10/14/2024 at about 7:02 AM they observed Resident #1 wearing mittens and their wrist tied with a bed sheet to the bed rail. Certified Nursing Assistant #5 wrote they observed Resident #1's family members heading to Resident #1's room, so they ran to the nursing station and notified Licensed Practical Nurse #1 about the restraint. They further wrote Licensed Practical Nurse #1 asked them if they removed the restraint, and they said no. Certified Nursing Assistant #2 also provided a written statement dated 12/12/2024. In the statement Certified Nursing Assistant #2 wrote on 10/15/2024 and 11/15/2024 they observed Resident #1 being restrained with a bed sheet and mittens. They wrote they observed this during their rounds on the 7:00 AM -3:00 PM shift. Certified Nursing Assistant #2 wrote that on both occasions they untied the resident and immediately reported the incidents to Licensed Practical Nurse #1 and #2. License Practical Nurse #1 and #2 worked on the 7:00 AM - 3:00 PM shift. Certified Nursing Assistant #2 wrote that License Practical Nurse #1 and #2 did not check on the resident after they reported the incident. The Facility's investigation concluded restraints were used, and abuse did occur.</p> <p>The facility investigative file contained pictures provided by the family of Resident #1. The photographs revealed the resident being restrained by bed sheets tied to the bed rail. The pictures were not time or date stamped.</p> <p>Licensed Practical Nurse #2 refused to write a statement to the facility. Licensed Practical Nurse #2 denied being informed by Certified Nursing Assistants that Resident #1 was tied to the bed with a bed sheet at any time.</p> <p>Certified Nursing Assistant #6 refused to submit a written statement to the facility. The facility investigative report documented they admitted to the Director of Nursing they used mittens, and bed sheets to restrain the resident because they had been known to smear feces over themselves.</p> <p>Resident #1's adult child's personal cell phone with pictures from 12/17/2024 at 1:52 PM was reviewed. Observed: (1) a picture dated 10/14/2024 at 7:40 AM of Resident #1 lying in bed with their left and right hand tied with bed linens to the bed rails; (2) a picture dated 11/02/2024 at 3:35 PM showing Resident #1 lying on their back with right and left hand tied with bed linens to the bed rails; (3) a picture dated 11/09/2024 at 12:11 PM showing Resident #1 lying in bed with a twisted bed linen placed across their midbody and tied to both bed rails.</p> <p>During an interview on 12/17/2024 at 9:54 AM, Certified Nursing Assistant #2 corroborated what they wrote in their statement to the facility on [DATE]. Certified Nursing Assistant #2 wrote that they notified Licensed Practical Nurse #1 and #2 on 10/15/2024 and 11/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on 12/17/2024 at 12:59 PM, the Director of Nursing stated on 12/09/2024 during their investigation into an incident involving Resident #1 that occurred on 12/04/2024, they learned from Resident #1's adult child that they had observed Resident #1 in restraints. The Director of Nursing stated on 12/10/2024 at 11:00 AM the adult child showed them (on their cell phone) pictures of the Resident's wrists being tied with a bed sheet to the bed rails on 10/14/2024 at 7:40 AM and on 11/02/2024 at 3:35 PM, and on 11/09/2024 at 12:11 PM with bed sheet across Resident #1's waist and tied to the bed rails. The Director of Nursing stated they interviewed Certified Nursing Assistant #6 who admitted they used pillowcases and sheets to restrain Resident #1's hands to prevent Resident #1 from removing their incontinent brief and smearing feces all over themselves. The Director of Nursing stated Certified Nursing Assistant #6 stated they were not wrong for restraining Resident #1.</p> <p>During a telephone interview on 12/17/2024 at 1:45 PM, Resident #1's adult child stated they visited Resident #1 on 10/14/2024 and observed Resident #1's wrists tied with a bed sheet to both side rails at 7:40 AM and that they took pictures with their cell phone. Resident #1's adult child stated they visited Resident #1 on 11/02/2024 at 3:35 PM and Resident #1 had both their wrists tied with a bed sheet to the side rails. Resident #1's adult child stated they visited Resident #1 again on 11/09/2024 at 12:11 PM and Resident #1 had a bed sheet across their waist tied to both side rails. Resident #1's adult child stated they took pictures but did not report the restraints to anyone in the facility because they thought it was okay.</p> <p>During an interview on 12/18/2024 at 4:00 PM, Certified Nursing Assistant #5 corroborated what they wrote in their statement to the facility on [DATE]. Certified Nursing Assistant #5 wrote that they notified Licensed Practical Nurse #1 on 10/14/2024.</p> <p>During a telephone interview on 12/19/2024 at 12:01 PM, License Practical Nurse #1 stated they are the regular staff nurse on the unit on the 7:00 AM- 3:00 PM shift and that they have never observed Resident #1 in restraints. Licensed Practical Nurse #1 stated they were never informed by any staff member that Resident #1 was found in restraints.</p> <p>During an interview on 12/19/2024 at 4:47 PM, the Administrator stated they received a phone call from the Director of Nursing on 12/09/2024 (about just after midnight) notifying them Resident #1's adult child reported Resident #1 had been restrained. The Administrator stated a meeting was held with the adult child, Director of Nursing, Medical Director, and Director of Social Service on 12/10/24 at 11:00 AM. The Administrator stated during the meeting the adult child presented their evidence of Resident #1 being restrained. The Administrator stated the pictures were date and time stamped. The Administrator stated the adult child stated they did not report the restraint to anyone because they were afraid. The Administrator stated they provided education to Resident #1's adult child that advised they should report concerns or issues. The Administrator stated the police were called.</p> <p>10 NYCRR 415.4(b)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907</p> <p>Based on observation, record review, and interviews conducted during an abbreviated survey (NY00364046), the facility did not ensure that a resident received the necessary care and treatment in timely manner and accordance with professional standards of practices. This was evident in 1 out of 39 residents (Residents #1) sampled. Specifically, a Rewrite Orders Cover Sheet dated 12/05/2024, signed by Licensed Practical Nurse #1 on 12/05/2024, documented x-ray of the left forearm to rule out fracture. A Nursing Progress note dated 12/07/2024 at 3:15 PM documented x-ray was done and result pending. A Nursing Progress note dated 12/09/2024 at 10:40 PM documented x-ray result showed fracture of the midshaft and ulna. Resident #1 to be transferred to the hospital. The x-ray was not done timely, and the results were not obtained in a timely manner.</p> <p>The findings include:</p> <p>The facility's Policy and Procedure titled Provision of Radiology Services, revised 12/2023, documented the facility to ensure efficient provision of services and prompt reporting of test results to the physician or other staff. The policy further documented, Policy Explanation and Compliance Guidelines: (2) final written reports are to be submitted to the nursing home within 48 hours.</p> <p>The Physician Monthly assessment dated [DATE], revealed Resident #1 was assessed by the Medical Doctor. The Medical Doctor also documented will order x-ray of the left forearm to rule out fracture.</p> <p>A form titled Rewrite Orders Cover Sheet dated 12/05/2024 documented x-ray of left forearm to rule out fracture. This form was signed by Licensed Practical Nurse #3 on 12/05/2024 on the 11:00 PM - 7:00 AM shift. Registered Nurse #3 signed the form on 12/07/2024 on the 3:00 PM - 11:00 PM shift. The form was also signed by another nurse on 12/08/2024 on the 7:00 AM - 3:00 PM shift.</p> <p>A Nursing Progress note, by Licensed Practical Nurse #3, dated 12/06/2024 at 6:00 AM documented Resident #1 was seen by the Medical Doctor and an x-ray order was written.</p> <p>A Nursing Progress note dated 12/07/2024 at 3:15 PM, by Registered Nurse #3, documented Resident #1 was accompanied by 2 Certified Nursing Assistants via stretcher for x-ray of left hand to rule out fracture. Resident #1 returned to the unit at 3:54 PM. X-ray was done, and the results are pending.</p> <p>A hospital radiology report dated 12/08/2024 documented status: Final-Result dated 12/08/2024 at 6:01 PM. The report revealed the Physician's Order was faxed to the hospital radiology on 12/06/2024. The order result history report dated 12/08/2024, revealed that x-rays of Resident #1's left forearm were done, and the findings documented there are fractures of the midshaft radius and ulna with mild displacement. No discoloration.</p> <p>Nurse's note dated 12/09/2024 at 10:40 PM documented x-ray results are final and showed fracture of the midshaft radius and ulna with mild displacement. Nursing Supervisor () and the Medical Doctor was notified. Resident #1 to be transferred to the hospital for further evaluation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2024
NAME OF PROVIDER OR SUPPLIER Schulman and Schachne Inst for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Rockaway Parkway Brooklyn, NY 11212	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/16/2024 at 2:14 PM, Medical Doctor #1 stated they were informed Resident #1 had swelling to their left arm either through the communication book or the floor nurse. Medical Doctor #1 stated they evaluated Resident #1 on 12/05/2024 (do not recall exact time) who was observed with a slight swelling to their left arm. Medical Doctor #1 stated that Resident #1 was able to fold their left arm. Medical Doctor #1 stated Resident #1 did not complain of pain, hence the reason they thought the swelling could have been from a thrombose and that was why they did not order a STAT (immediately) x-ray. Medical Doctor #1 stated they ordered the x-ray on the same night (12/05/2024) they assessed Resident #1.</p> <p>During an interview on 12/16/2024 at 2:40 PM, Licensed Practical Nurse #3 stated Medical Doctor #1 arrived on the unit between 11:00 PM and 11:30 PM on 12/04/2024 and they notified Medical Doctor #1 that Resident #1 had swelling and tenderness to their left arm. Licensed Practical Nurse #3 stated Medical Doctor #1 evaluated Resident #1 and reported to them that the swelling could have been from the graft and that they should give Tylenol to Resident #1 and elevate the extremity. Licensed Practical Nurse #3 stated the following night 12/05/2024 (night shift, 11:00 PM- 7: 00 AM) into 12/06/2024 they informed Medical Doctor #1 that the swelling had persisted, and Medical Doctor #1 ordered an x-ray.</p> <p>During an interview on 12/17/2024 at 12:59 PM, the Director of Nursing stated they received a call from Registered Nurse Supervisor #1 notifying them of Resident #1's x-ray result at approximately 11:30 PM on 12/09/2024. They stated Registered Nurse Supervisor #1 reported that they were searching for the database and retrieved the x-ray results for Resident #1. The Director of Nursing stated they did not receive a call from the radiology department (in the hospital) or a fax of the results.</p> <p>During an interview on 12/19/2024 at 1:20 pm, the Medical Director stated the protocol is for the radiology department to review an x-ray, call the unit and report the findings to the nurse, and then the nurse informs the doctor. The Medical Director stated they investigated why the radiology department did not notify the facility of the x-ray result and the radiology department stated that it is the responsibility of the facility to follow up on their results because they are an outpatient department.</p> <p>10 NYCRR 415.12</p>		