STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335396	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Nursing and Rehabilitation Center	2817 Albany Post Road Montgomery, NY 12549

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44673 Based on observation, record review and interview conducted during an abbreviated survey (NY00358461) on 10/28/24, the facility did not ensure each resident received treatment and care in accordance with professional standards of practice for 1(Resident #1) of 3 residents reviewed for accidents. Specifically, a left hip x-ray was not performed as per the 10/20/24 physician order after Resident #1 who was admitted status post (previous) left hip open reduction and internal fixation (hip fracture repair) sustained a fall 3 days after admission. The findings include: The Policy titled Medication and Treatment Orders with a revision date of 4/8/24 documented orders treatments will be consistent with principles of safe and effective orders. Verbal orders must be recorded immediately in the resident chart by the person receiving the order. Resident #1 had diagnosed including but not limited to dementia, open reduction internal fixation of the left hip (repair of a hip fracture) and metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood that affects brain function). The 10/20/24 Incident and Accident Report completed by Registered Nurse Supervisor #2 documented the resident attempted to transfer and put the bed up and was found on the floor. Educated resident to call for assist. Physician updated and ordered a left hip x-ray. The Comprehensive Care Plan titled Risk for Falls updated 10/20/24 documented x-ray left hip. The 10/20/24 Physician Order documented x-ray left hip unilateral and pelvis/four views. There was no documented evidence in the electronic medical record to indicate the left hip x-ray was done as per physician order. The 10/22/24 Discharge Minimum Data set documented Resident #1 had severely impaired cognition and was totally dependent on two staff for transfer with a mechanical lift. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/24 at 2:00 PM Registered Nurse Supervisor #2 stated the resident fell at 11:00 PM on 10/20/24, the staff called them, and they assessed the resident. They stated the resident was not sent to the hospital. Registered Nurse Supervisor #2 stated the resident denied hitting their head, no ecchymosis noted, no external rotation or shortening of either lower extremity. The Physician ordered a left hip x-ray and they endorsed it to the oncoming shift They stated they did not know why it was not done During an interview on 10/28/24 at 2:15 PM Registered Nurse Unit Manager #1 stated they were unable to find the left hip x-ray result on the Diagnostic Imaging Company wbsite. They also stated that the physician order for the left hip x-ray was not sent to the x-ray company. During an interview on 10/28/24 at 2:30PM the Director of Nursing stated they checked the Diagnostic Imaging Company requisitions and found that the company was not notified of the physician order for a left hip x-ray. The Director of Nursing stated Registered Nurse Supervisor #2 who took the order for the left hip x-ray from the physician should have ordered the x-ray on the Diagnostic Imaging website after entering the order into the facilities electronic medical system. The Director of Nursing stated the Registered Nurse Unit Manager, should have followed up the next morning to ensure the physician ordered left hip x-ray was entered in the electronic medical record and that the Diagnostic Imaging Company was notified. 10 NYCRR 415.

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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 conducted during an abbreviated survey (NY00358461) the facility did not ensure each resident received adequate supervision consistent with resident's needs goals and care plan to prevent accidents. This was evident for 1 (Resident #1) of 3 residents reviewed for accidents. Specifically, Resident #1 who was assessed as having suicidal ideation and a high risk for falls on admission had a physician's order for 15-minute safety checks. There was no documented evidence that 15-minute safety checks were consistently done as per the 10/18/24 physician's order. The certified nursing aide care instructions did not include the order for 15-minute safety check. Resident #1 was found on the floor in their room on 10/20/24. The findings include: The Policy titled Accidents/Incident Report with a 3/2/24 revision date documented the facility is responsible to investigate accidents to determine possible causative factors and implement interventions that may prevent a reoccurrence. Administer treatment to resident per physician orders. Resident #1 was admitted with diagnoses which included dementia, open reduction internal fixation of the left hip (repair of a hip fracture), and metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood that affects brain function). The Fall Risk assessment dated [DATE] documented a score of 10 indicating the resident was at a high risk for falls. The 10/18/24 Comprehensive Care Plan titled Suicidal Ideations care plan note documented to start 15-minute safety checks. The 10/18/24 Physician's Order documented 15-minute safety checks x 72 hours. The 10/20/24 Incident and Accident Report documented the resident attempted to transfer out of bed and put the bed up. Resident was found on the floor at 11:00 PM. The resident denied hitting their head. The resident was last seen by staff at 9:30 PM. The resident was educated to call for assistance. The physician was updated, and an order was obtained for an x'ray of the left hip. The 5-day Minimum Data Set assessment dated [DATE] documented the resident had moderately impaired cognition and a Patient Health Questionnaire -9 score of 21 indicating severe depression. The 10/22/24 discharge Minimum Data Set documented the resident is totally dependent on two staff members for transfer with a mechanical lift. Review of the October 2024 Medication Administration Record revealed that 15-minute safety checks were not documented on 10/19/24 and 10/20/24 on the night shift (11PM-7AM). There was no documented evidence in the October 2024 Certified Nurse Aide Care instructions for15-minute safety checks. (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 10/30/24 at 11:30 AM, Certified Nurse Aide #1 stated that they did not know that resident was on 15-minute safety checks. They stated that they would usually be told in report when coming on shift if a resident is on 15-minute safety checks. When asked how they know what other interventions are in place for residents, Certified Nurse Aide #1 stated that care instructions are also provided during report or instructions can also be found in the computer where they document cares. Certified Nurse Aide #1 stated they remember the resident trying to get out of the bed on the evening of 10/20/24 so they were frequently checking on the residnt. During an interview on 10/30/24 at 11:36 AM, Licensed Practical Nurse # 1 stated they worked the evening shift on 10/20/24 however they don't remember if the resident was on 15-minute safety checks. They stated they would normally get that information from report from the previous shift. They stated the resident was attempting to get out of bed, and they believe they performed frequent checks. Licensed Practical Nurse # 1 stated they signed the 15-minute safety checks in the Medication Administration Record. During an interview on 10/30/24 11:18AM, Registered Nurse #2 stated they worked the overnight shift(11pm-7am) on 10/19/24 and 10/20/24 and they received report about Resident #1 falling on 10/20/24, however they could not recollect specifically about the 15-minute safety checks. Registered Nurse #2 stated the 15-minute safety checks were probably an intervention for the fall, however they could not remember all the details. When made aware of the omissions on the Medication Administration Record for the 15-minute safety checks, Registered Nurse #2 stated that the omissions does not necessarily mean it was not done. When asked how Certified Nurse Aides are made aware of 15-minute safety checks, they stated the Certified Nurse Aides would get that information in report. When asked why the resident was last seen at 9:30 PM and was on 15-minute check they stated I was doing frequent checks on the resident. During an interview on 10/28/24 at 2:00 PM, Registered Nurse Supervisor #2 stated the resident fell at 11:00 PM and the staff called them, and they assessed the resident. The resident denied hitting their head, there was no ecchymosis noted, no lower extremity external rotation or shortening of both legs. They stated the resident was not sent to the hospital. Registered Nurse Supervisor #2 stated they did not know why the 15-minute safety checks were not documented as being done during the night shift on 10/19/24 and 10/20/24. Registered Nurse Supervisor #2 stated when staff was interviewed, they stated the last time the resident was seen was at 9:30 PM. During interview on 10/28/24 at 2:33 PM, the Director of Nursing stated the nurse should have signed the 15-minute safety checks in the Medication Administration Record on 10/19/24 and 10/20/24 during the night shift and the unit manager should have checked that the Medication Administration Record documented 15-minute safety checks were done. 10 NYCRR 415.12 (h) (2)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on record review and interviews conducted during the abbreviated survey (NY00358461), the facility did not ensure that a resident received appropriate behavioral care intervention to address suicidal ideation for 1 (Resident #1) of 3 residents reviewed for behavioral health care. Specifically, Resident #1, was admitted with a diagnosis of depression and verbalized having suicidal ideation with no plan of self-harm on 10/18/2024. A physician's order dated 10/18/2024 for 15-minute safety checks documented no indication for the order. 2)The 15-minute safety check was not listed as an intervention on the suicidal ideation history care plan or included on the certified nurse aide instruction. The 15-minute safety checks were not consistently documented by staff per the physician's order. Resident #1 was found on the floor on 10/20/2024 when they attempted to transfer self without assistance. Findings include: The Facility Policy titled Suicidal Precaution revised 10/2024 documented resident suicide threats should be taken seriously and addressed appropriately. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the residents' behavior immediately, staff shall document details of the situation objectively in the resident's medical record. The facility policy titled comprehensive care plan dated July 2024 documented the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment and identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are the end point of the interdisciplinary process. The resident was admitted with diagnoses which included hip fracture, Alzheimer's dementia, and depression. The 5-day Minimum Data Set assessment dated [DATE] documented the resident had moderately impaired cognition and a Patient Health Questionnaire -9 score of 21 indicating severe depression. It documented the resident reported symptom frequency which included; little interest or pleasure in doing things, felt down depressed or hopeless, had trouble falling asleep or staying asleep or sleeping too much, felt tired or had a little energy, had a poor appetite or overate, felt bad about themselves, and thought they would be better off dead or of hurting themselves in someway 12 to 14 days over the last two weeks. A Facility progress note dated 10/18/2024 documented resident told social services they Sometimes have thoughts of wanting to die and finding a way out. Denied plan for self-harm. Physician informed and an order received to commence a 15-minute safety checks. Wander guard applied to left wrist. Son updated and agreeable to all plan of care. Family confirmed resident had left assisted living twice and often states why they am I still here when others have passed. No attempts of self-harm. The Physician's Order dated 10/18/2024 at 3:56 PM documented 15-minute safety checks daily x 72 hours, every day 7 AM am-3 PM, 3 PM pm-11 PM, 11 PM pm-7 AM for 3 days. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order dated 10/21/2024 at 1:38 PM documented 15-minute checks every day. The Suicidal Ideation History Care Plan dated 10/18/2024 documented the resident presented with history of suicidal ideation. The interventions did not include 15-minute safety checks. The Accident/Incident report dated 10/20/2024 at 11:00 PM documented the resident was found on the floor and was last seen by staff at 9:30 PM. Resident stated they were trying to get out of bed, and they raised the bed. The 10/21/2024 Social Services note documented they met with both the resident and the resident representatives regarding suicidal ideation statements made to staff, the representatives stated that this was resident's baseline and that the resident thinks a lot about death. Resident #1 had been diagnosed with depression by their primary care provider but had not taken any medications. Social work continues to monitor as needed. The 10/25/2024, 1:19 pm social services note documented Resident #1 stated that they often thought about dying given their medical status and age and if there was a way out, they would take it. Resident Representatives stated this is the resident's baseline. Resident has no history of substance abuse, alcohol use, or a mental health diagnosis. Resident has dementia diagnosis. Resident has no history of significant trauma. Resident referred to psychology. The October 2024 Medication Administration Record revealed 15-minute checks were only documented once every shift and not every 15 minutes as indicated on the physician's order, and there was no documentation on the medication administration record on 10/19/2024 and 10/20/2024 on during the night shift (11PM-7AM). On 10/28/2024 at 2:33 PM during an interview with the Director of Nursing, a review of the resident's Medication Administration Record was completed. There was no documentation for the 15-minute check on 10/19/2024 and 10/20/2024 on the night shift. The Director of Nursing stated the night nurse responsible for medication administration was also responsible to sign the 15-minute safety checks. The unit manager should have checked that the Medication Administration Record signage was not completed. In addition, the nurse documented on the incident & accident report dated 10/20/2024, that the resident was last seen at 9:30 pm, however the 15-min safety check on the medication administration record dated 10/20/2024 for the 3-11 shift was signed as completed for the shift. On 10/28/2024 at 6:34 PM and on 10/29/2024 at 11:34 AM during interviews and review of the resident's medical record with the Director of Nursing, they stated the Physician's Order for 15-minute safety checks did not include an indication as to the reason the order was placed, and there was no documentation in the resident's medical record as to the reason why the order was discontinued on 10/27/2024. Additionally, 15-minute safety checks were not documented in the Suicidal Ideation History Care Plan Interventions. The Director of Nursing stated the Social Worker or Unit Manager should have documented the 15-minute safety checks under interventions. The Director of Nursing further stated that the Physician's order for 15-minute safety checks should have had an indication or a reason for the order. The reason for discontinuing the order on 10/27/2024 should have been documented. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/2024 at 2:05 PM during an interview with Registered Nurse Supervisor #1, they stated after they spoke with the resident's primary physician and received an order to discontinue the 15-minute safety checks, they forgot to write a note documenting the reason for discontinuing the 15-minute safety checks. They stated they realize they should have documented in the resident's medical record. 10 NYCRR 415.12