STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335406	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Nursing Home	1529 Nye Road Lyons, NY 14489

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49368 Based on interviews and record review conducted during an Abbreviated Survey (ACTS Reference Number: NY00329762), the facility did not ensure that an investigation was initiated following a fall to rule out abuse, neglect, or mistreatment for one (Resident #11) of three residents reviewed. Specifically, Resident #11 had a witnessed fall, and the facility was unable to provide evidence that the fall was thoroughly investigated. This is evidence by the following: The facility policy Investigations of Incidents & Allegations of Abuse, Neglect or Mistreatment, reviewed February 2024, documented the purpose is to determine a cause for an incident or accident and to determine if there is reasonable cause to believe abuse, mistreatment, or neglect took place. The results of all investigations must be reported to the administrator or designee. Forms to be used include Incident and Accident Report Form (Occurrence Report) and Witness Statement Form. The procedure included the person who observes or discovers an incident must immediately document information on an incident/accident report or Investigators Statement form, and the immediate supervisor/designee must immediately make determination of suspected abuse, neglect, or mistreatment. Resident #11 had diagnoses including seizure disorder, brain tumor, and depression. The Minimum Data Set Resident Assessment, dated 11/06/2023, documented that Resident #11 was severely impaired cognitively and was dependent on staff for transfer. Review of the Comprehensive Care Plan revealed Resident #11 was at risk for falls related to a history of falls, decreased mobility, and poor safety awareness related to dementia. The Comprehensive Care Plan also included that Resident #11 was dependent on two staff members for transfers via a mechanical lift. In a nursing progress note, dated 12/05/2023 at 5:33 PM, Licensed Practical Nurse #2 documented that Resident #11 slid out of their wheelchair as the full lift (mechanical lift) was being used (to transfer the resident from bed to wheelchair). Resident #11 was assessed by the supervisor, returned to bed, the sling readjusted, and the resident was transferred back to their wheelchair. In a nursing progress note, dated 12/05/2023 at 10:40 PM, labeled Late Entry, Registered Nurse # 1 documented that upon entry into the room Resident #11 was observed sitting on the pedals of their wheelchair and per staff the resident was being lifted from the bed to the wheelchair and that there was a nurse and two Certified Nursing Assistants in the room at the time of the occurrence. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Post Fall Evaluation form, dated 12/05/2023 and signed by Licensed Practical Nurse #2, included the time of fall was 8:16 PM and the fall was witnessed by CNA (Certified Nursing Assistant) in Resident #11's room. The evaluation documented the resident was being lifted using a full lift to get from the bed to the wheelchair and slid out of the wheelchair and sat on the footboard of the wheelchair. During an interview on 09/12/2024 at 11:24 AM, Certified Nursing Assistant #4 (not involved in the incident on 12/05/2024) stated that two staff are required for all mechanical lifts and that the correct sling must be in place. During an interview on 09/12/2024 at 1:30 PM, the facility's Compliance Officer stated when an incident happens on the unit, the staff on site and the immediate supervisor on site should gather interviews and do reports. The Compliance Officer said they do not have an investigation for Resident 11's fall on 12/05/2023, any incident and accident report, or statements from any witness(es) present during the fall. The Compliance Officer stated there should have been an investigation for this fall. The facility was unable to provide any additional information such as an incident and accident report, witness statements, and/or a summary of the investigation to determine a root cause analysis, that the correct equipment was used, and the potential need for staff re-education or care plan revision. NYCRR 415.4(b)