

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER St Catherine Laboure Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2157 Main Street Buffalo, NY 14214	

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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>47750</p> <p>Based on observation, interview, and record review conducted during a Standard survey completed on 10/1/24, the facility did not ensure each resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (Resident #41) of one resident's reviewed. Specifically, Resident #41 was not provided with a right hand and right elbow splint as planned by Occupational Therapy. Additionally, staff lacked knowledge regarding the correct application of the right elbow splint.</p> <p>The finding is:</p> <p>The policy and procedure titled Community Based Care: Contractures with effective date 4/2/24 documented that a plan of care would be developed regarding contracture management. Approaches to prevent or treat contractures may include positioning, range of motion, ambulation, application of a splint/brace, and /or therapy treatment programs.</p> <p>The policy and procedure titled Community Based Care: Minimum Data Set, Comprehensive Care Planning, and Kardex Utilization with effective date 11/30/21 documented that prior to providing hands on care, staff will review the content of the Kardex and will then provide care in accordance with Kardex guidelines/instructions.</p> <p>Resident #41 had diagnoses of cerebral infarction with right sided hemiplegia (stroke with paralysis on one side of body), contracture to right elbow (loss of joint mobility), and aphasia (absence or difficulty with speech). The Minimum Data Set (MDS - an assessment tool) dated 9/6/24 documented Resident #41 had severe cognitive impairment, was rarely understood, and rarely understands, dependent on staff for all activities of daily living, and had no refusals care.</p> <p>The comprehensive care plan revised on 10/18/23 documented that Resident #41 had ADL self-care performance deficit related to weakness. Interventions included a right resting hand splint and right elbow extension splint to be donned (put on) by the certified nursing assistant after morning care, and doffed (to take off) before evening care.</p> <p>Review of the Visual/Bedside Kardex Report (a guide used by staff to provide care) dated 9/27/24 documented under dressing/splint care Resident #41 was to have right resting hand splint and right elbow extension splint to be donned by the certified nursing assistant after morning care, doffed before evening 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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the occupational therapy note dated 6/13/22 documented that occupational therapy educated certified nursing assistants on proper donning technique for Resident #41's right elbow and resting hand splint. The Occupational Therapist updated Resident #41's care plan to include: right resting hand splint and right elbow extension splint to be donned by Certified Nurse Assistant after morning care, doffed before evening care.</p> <p>Review of the nursing progress notes dated 9/1/24 - 9/30/24 revealed there was no documented evidence that Resident #41 had refused application of the right hand and right elbow splints.</p> <p>During an observation on 9/25/24 at 9:57 AM, Resident #41 was lying in bed, there were no splints visualized to their right hand and right elbow. Resident #41's right thumb was touching their right index finger, and their pinky finger was bent towards the palm of the hand.</p> <p>During an observation on 9/25/24 at 2:53 PM, Resident #41 was observed lying in bed without their right resting hand splint or right elbow extension splint in place. Resident #41's right arm was resting to their side in a bent position.</p> <p>During an observation of morning care on 9/27/24 at 9:26 AM, Certified Nursing Assistant #1 provided morning care to Resident #41. Certified Nursing Assistant #1 completed care, gathered soiled items, and exited the room without applying Resident #41 splints to their right hand and elbow.</p> <p>During an observation and interview on 9/27/24 at 9:45 AM, Certified Nursing Assistant #1 stated Resident #41 does not get out of bed, morning care had been completed, and the resident did not need anything additional for care to be completed. Certified Nursing Assistant #1 re-entered Resident #41's room to review the closet care plan (Kardex - guide used by staff to provide care) and stated Resident #41 was to have splints on their right hand and elbow. Certified Nursing Assistant #1 was unable to locate the right-hand splint. Certified Nursing Assistant #1 attempted to apply the right elbow splint, and stated they were unsure how to properly apply the splint and would have to get the nurse.</p> <p>During an observation and interview on 9/27/24 at 9:50 AM, Licensed Practical Nurse #2 entered Resident #41's room and brought in a right-hand splint. Licensed Practical Nurse #2 assisted Certified Nursing Assistant #1 with Resident #41's right elbow extension splint. Licensed Practical Nurse #2 stated they believed the elbow splint was applied correctly. Licensed Practical Nurse #2 then applied the resident's right hand splint. They stated they had not received any education on splint application. Licensed Practical Nurse #2 stated the Certified Nursing Assistant providing care to Resident #41 would be responsible for applying splints. Licensed Practical Nurse #2 stated if certified nursing assistants needed help, they would notify them, and they would assist.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 9/27/24 at 10:03 AM, the Director of Rehabilitation stated Resident #41's right elbow splint had been incorrectly applied and was backwards. The Director of Rehabilitation took the elbow splint off and reapplied the splint without any difficulty. They stated Resident #41 would not get the full benefit of the splint without it being applied correctly. The Director of Rehabilitation stated Resident #41 utilized the right hand and elbow splints due to a spastic arm (stiff or rigid muscles) and the resident was at risk for further decline due to the lack of mobility. They stated the splints were utilized to reduce the risk of decline. The Director of Rehabilitation stated the nurses and certified nursing assistants were trained by therapy staff when a resident was issued a new splint/device and that annual mandatory in-services were completed. They stated the certified nursing assistants would be responsible for splint application.</p> <p>During an interview on 9/27/24 at 2:52 PM, Licensed Practical Nurse Manager #1 stated that Resident #41 was dependent on staff for all care needs and was unable to their make needs known. They stated the resident has had both splits for approximately two years, and they would expect that staff knew how to apply the devices correctly. Licensed Practical Nurse Manager #1 stated it was the certified nursing assistant and restorative nursing aides' responsibility to apply splints. The nurses were responsible to ensure sure the splints were on, and the care plan was followed. They stated there were no physician orders for splint application, splints were listed on the care plan, and they expected staff would follow the care plan.</p> <p>During an interview on 9/30/24 at 12:24 PM, the Director of Nursing stated the certified nursing assistants and licensed practical nurses were responsible for putting on splints and that the restorative nursing aides could assist if working on the floor. They stated all splints were listed on the closet care plan/Kardex, and they would expect staff to review their closet care plan before providing care. The Director of Nursing stated if certified nursing assistants were unsure how to apply splints they should ask the nurse for assistance. They stated that both the nurses and certified nursing assistants received training on splint application when a new splint was ordered and would expect staff to contact therapy for additional training if needed. They stated they would have expected staff to follow the care plan and apply devices/splints per plan of care.</p> <p>During an interview on 9/30/24 at 2:50 PM, Certified Nursing Assistant #2 stated splints would be listed on the resident's care plan and they would review the plan prior to providing care. They stated they had not received education on applying splints.</p> <p>During an interview on 9/30/24 at 3:24 PM, Certified Nursing Assistant #3 stated the restorative nursing aides applied Resident #41's splints and the nurse would remove them in the evening. Certified Nursing Assistant #3 stated they would notify the nurse or therapy if a resident did not have their splints on and was unsure how to apply them. They stated they have not received any training on splint application.</p> <p>During an interview on 9/30/24 at 3:46 PM, Licensed Practical Nurse #4 stated the nurse team leaders and supervisors were responsible to ensure certified nursing assistants were following the care plan and applying splints. They stated that the nurses and therapy department should make sure splints were applied correctly. Licensed Practical Nurse #4 stated they would contact therapy or their supervisor if they were unsure how to apply a splint/device.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/1/24 at 9:01 AM, the Administrator stated that they would expect staff to visualize and read the care plan before providing care. They stated they would expect staff to review all details of the care plan to provide safe care, they would expect staff to follow the care plan and report any discrepancies.</p> <p>10 NYCRR 415.12 (e)(2)</p>		