

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Lewis County General Hospital-Nursing Home Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 7785 North State Street Lowville, NY 13367	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052</b></p> <p>Based on observation, record review, and interview during the recertification and abbreviated (NY00308041 and NY00343021) surveys conducted 7/24/2024-7/31/2024 the facility did not ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible for 2 of 4 resident units (Units 1 and 3) observed and for 1 of 4 residents (Resident #77) reviewed.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- Unit 1 (dementia unit, also known as the Rainbow Community) had environmental accident hazards readily accessible to residents.</li> <li>- Resident #77, who resided on Unit 1, had a history of wandering throughout the unit and ingesting inedible items, including bar soap. Resident room [ROOM NUMBER] was observed with multiple bars of soap on the sink counter.</li> <li>- the door to the clean utility room on Unit 1 was unsecured and contained oxygen equipment, wound care supplies, and other nursing care items.</li> <li>- Unit 1 common area had metal wheelchair leg rests on a table.</li> <li>- An unsecured, open cart with needle-nose pliers and other electrical test items was left unattended in the hallway.</li> <li>- Unit 2 had environmental accident hazards in resident rooms including a four-slice toaster and a microwave on a long dresser at the foot of a bed, and a microwave on the dresser behind the head of a bed.</li> </ul> <p>Findings include:</p> <p>The facility philosophy for the Rainbow Community (Unit 1) dated 3/2006, documented every resident at the facility had the right to thrive, to flourish, and to be treated with dignity and function at the highest practicable level. The environment and creative caring concern for residents resulted in special approaches to individuals with the diagnosis of dementia.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy, Behavior Management, revised 6/2024, documented the facility promoted and supported a resident-centered approach to care. Behavioral health encompassed a resident's whole emotional and mental well-being. Training would be completed for all frontline staff on the care and services of residents with behavioral health needs and dementia which included caring for the residents' environment and care of the cognitively impaired residents.</p> <p>The facility policy, Food preparation on all Units and in Facility Departments, reviewed by the facility 3/2024, documented staff were to follow manufacturer's instructions for items being prepared in a microwave or toaster and were not to leave the microwave or toaster unattended until the cycle was complete. The policy did not include use of toasters or microwaves in resident rooms.</p> <p>The facility policy, Electrical Equipment, effective 7/2023, documented any new electrical equipment brought in by a resident's family had to be inspected and tagged by the Plant Operations Department before it could be used. It was the responsibility of the residential health care facility staff to enter a Plant Operations work order requesting the inspection of the equipment.</p> <p>Resident #77:</p> <p>Resident #77 had diagnoses including dementia with behavioral disturbance, major depressive disorder, and insomnia. The 6/3/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had inattention and disorganized thinking that was continuously present, did not wander, did not exhibit behavioral symptoms, and was independent for bed transfers and ambulation.</p> <p>A facility incident dated 12/1/2023 at 6:30 PM and entered by documented Resident #77 wandered into other resident rooms and throughout the unit while awake as the resident was independent. The resident had been witnessed with a soapy smell coming from their mouth and white residue around their mouth. The resident was observed on video coming out of resident room [ROOM NUMBER] with the soap bar. To prevent reoccurrence, the staff would ensure residents' personal hygiene products were locked up if residents did not independently use them. For residents who preferred to have their soap in the bathroom, travel containers that closed would be ordered and they would ensure residents could use them. An addendum to the report was made on 1/19/2024 that documented the residents and staff had been using the travel soap containers.</p> <p>A facility incident report dated 3/19/2024 at 7:57 PM documented Resident #77 was found with a bar of soap in their mouth; there were no chunks of soap gone but the soap bar had bite marks in it. The resident had a reaction to the soap indicated by a swollen lip. An addendum added on 3/21/2024 by the Registered Nurse Unit Manager #17 documented residents had taken soap out of the soap containers and Resident #77 found them in the rooms. The soap used on the unit was changed to a different soap Resident #77 was not sensitive to.</p> <p>The 7/23/2024 Comprehensive Care Plan documented the resident was independent with ambulation, was not allowed condiment packages on their meal tray after setting up to prevent accidental consumption of non-food items, required frequent visual checks for behaviors, and had a history of wandering and invading the privacy of others. The care plan documented the resident did not have a soap preference. The resident stayed up late at night. Make environment safe for exploring. Eliminate items that could cause harm but offer substitutions.</p> <p>The following observations were made:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 7/24/2024 at 11:52 AM Resident #77 was walking up to the activities cart and reached their hand into the basket that contained the nail polish. Activities Aide #30 told the resident they could paint their nails. Resident #77 walked away from the cart and went into resident room [ROOM NUMBER]'s bathroom.</p> <p>- On 7/25/2024 at 9:43 AM Resident #77 was wandering to the unit entrance door pushing on the door. An unidentified certified nurse aide called the resident's name and the resident turned away from the door. They wandered back down the hallway with an Alzheimer's association pamphlet in their hand. At 2:21 PM Unit Helper #19 took the resident out of room [ROOM NUMBER] for a walk down the hallway to their own room.</p> <p>- On 7/26/2024 at 9:40 AM Resident #77 was walking into room [ROOM NUMBER]. At 10:05 AM, Resident #77 was lying asleep in the window side bed in resident room [ROOM NUMBER]. At 12:51 PM, they took a baby doll from the nursing station and walked down the hallway.</p> <p>- On 7/29/2024 at 12:40 PM, Resident #77 was lying on a bed in resident room [ROOM NUMBER].</p> <p>- On 7/29/24 at 4:36 PM the bathroom sink in resident room [ROOM NUMBER] had 3 pieces of disintegrating white soap: one in the sink, one in between the cold water handle and faucet, and one in between the hot water handle and faucet.</p> <p>- On 7/30/24 at 10:17 AM the bathroom sink in resident room [ROOM NUMBER] had 2 pieces of disintegrating white soap: one in between the cold faucet handle and faucet, and one between the hot water handle and faucet.</p> <p>- On 7/30/2024 at 10:27 AM, Resident #77 was wandering into room [ROOM NUMBER]'s bathroom.</p> <p>During an interview on 7/25/24 at 10:03 AM, Resident #77's family representative stated they had been informed over the last few months the resident had attempted to ingest two bars of soap and a foam Easter egg. The staff could not tell them where the resident had obtained the soap bars or the foam Easter egg. They had informed the social worker that the interventions that were put into place after the first incident with the soap were not working and they needed to take away the resident's access to soap. They felt lack of supervision was an issue on the unit.</p> <p>Accident Hazards on Units 1 and 3:</p> <p>Unit 1 (dementia unit) observations:</p> <p>- On 7/24/2024 at 10:48 AM a gray handled, open bag full of wound care supplies which included dressings in wrappings, adhesive bandages, saline syringes, and scissors were on the lower counter of the nursing station within reach of a resident.</p> <p>- On 7/24/24 at 11:40 AM the bathroom of resident room [ROOM NUMBER] had therapeutic shampoo with ingredients consisting of coal tar 0.5%, sitting on the sink with a prescription label for a resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 7/24/24 at 11:43 AM the bathroom of resident room [ROOM NUMBER] had two full bags of shampoo and body wash on the floor for a dispenser under the sink and a bar of soap on the floor of the shower.</p> <p>- On 7/24/24 at 11:49 AM the window side of resident room [ROOM NUMBER] had a 250 milliliter bottle of wound solution on the nightstand. The pharmacy label on the bottle had a dispense date documented as 7/12/2024.</p> <p>- On 7/25/2024 at 2:38 PM a contract employee was in a closed clean linen room and left their open cart unattended in the hallway. The cart contained tools, electrical testers, needle-nose pliers, electrical tape, a laptop, stickers, and small packets of wipes. At 2:41 PM, the contract employee returned to the cart, walked away, and left the cart unattended in the hallway.</p> <p>- On 7/25/24 at 2:02 PM the bathroom of resident room [ROOM NUMBER] had two dispenser bags of shampoo and body wash hanging over the edge of the sink, a bar of soap was on floor of the shower, and the therapeutic shampoo with coal tar 0.5% was on top of the paper towel dispenser.</p> <p>- On 7/25/24 at 2:03 PM the window side of resident room [ROOM NUMBER] had a medicine cup with ointment on the bedside table and a bottle of wound wash on the nightstand.</p> <p>- On 7/26/24 at 9:58 AM in resident room [ROOM NUMBER] there was a bag of shampoo and soap on the bedside table next to the bathroom door. The therapeutic shampoo with coal tar 0.5% was on the towel dispenser in the bathroom.</p> <p>- On 7/29/24 at 10:06 AM there were metal wheelchair legs on a table in the back corner of the unit outside resident room [ROOM NUMBER].</p> <p>- On 7/29/24 at 11:00 AM the door to the clean linen room across from resident room [ROOM NUMBER] was partially open. The room contained oxygen cylinders and medical supplies such as bandages, tape, and disposable bed pans. There were no staff in the clean linen room at that time.</p> <p>- On 7/29/24 at 4:36 PM the bathroom sink in resident room [ROOM NUMBER] had 3 pieces of disintegrating white soap: one in the sink, one in between the cold water handle and faucet, and one in between the hot water handle and faucet.</p> <p>- On 7/30/24 at 10:17 AM the bathroom sink in resident room [ROOM NUMBER] had 2 pieces of disintegrating white soap: one in between the cold faucet handle and faucet, and one between the hot water handle and faucet.</p> <p>- On 7/30/24 at 10:14 AM resident room [ROOM NUMBER] had a bag of soap and shampoo for the dispenser on the sink in the bathroom.</p> <p>Unit 3 observations:</p> <p>- On 7/24/24 at 12:15 PM resident room [ROOM NUMBER] had a toaster and a microwave.</p> <p>- On 7/24/24 at 12:37 PM resident room [ROOM NUMBER] had a microwave with a 2024 black sticker on the appliance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 7/26/24 at 12:14 PM resident room [ROOM NUMBER] had a microwave on their dresser behind the bed. The microwave had a 2024 black circular sticker on it,</p> <p>- On 7/26/24 at 12:16 PM resident room [ROOM NUMBER] had a long dresser at the foot of the bed that had a four-slice toaster and a small microwave; both items had a circle sticker with 2024 on it.</p> <p>During an interview on 7/29/2024 at 4:58 PM, the Director of Nursing stated the procedure for residents who brought in their own items was the unit clerk would put in a work order for the maintenance department, and a maintenance employee would go to the floor and inspect the equipment before use. Staff would document what the maintenance staff was to inspect in the work orders and Maintenance would document what was inspected. They did have some residents who were allowed to have a microwave, but they did not have a toaster policy. They were not aware the resident in room [ROOM NUMBER] had a toaster.</p> <p>During an interview on 7/29/2024 at 5:02 PM, Registered Nurse Manager #28 stated the risk of having a toaster and microwave in a resident room could be the potential for something catching on fire and burning. There were some wandering residents on the unit, but they were unsure if they would wander into room [ROOM NUMBER]. They followed the directions on a package of food when heating up an item but did not take the temperature of the food, so there was always a risk of burns. Residents were not care planned to use a toaster or a microwave in their room, but they did have care plans for residents who preferred their coffee hotter. There should be a care plan to say if they could use the equipment properly.</p> <p>During an interview on 7/29/2024 at 5:07 PM, the Director of Plant Operations stated they did not have a master list of equipment/appliances residents could have in their rooms. A work order would document what the equipment/appliance was. They were unaware the resident in room [ROOM NUMBER] had a toaster. A toaster could pose a safety risk for fires, burns, and electrocution.</p> <p>During an interview on 7/30/24 at 10:19 AM, Unit Helper #21 stated residents were showered in the bathroom in their rooms. They did not believe medicated shampoos or soap bars were supposed to be left in the bathrooms, but it depended on what a resident's plan of care stated. Wheelchair leg rests were not supposed to be left out on the unit. There was a designated area to put wheelchair leg rests away as it was a safety hazard to leave them out. The clean utility room door should be pulled shut as that was where they stored their supplies and the clean laundry. They had several residents who wandered around the unit and in and out of other resident rooms. Resident #77 was one of those residents.</p> <p>During an interview on 7/30/24 at 10:30 AM, Licensed Practical Nurse #22 stated most of the residents on the unit wandered in and out of other resident rooms. The showers in resident rooms usually had a bin with soap in it that was locked up after the shower was completed. Soap bars were okay to be left in a resident's bathroom, but all liquid soaps should be locked up. They did not have travel containers for bar soaps on the unit and the bars of soap were just left out. The bags of shampoo and body wash for the dispensers should not be left on the floor. Medicated shampoo should not be left in a resident's room, it should be given back to the nurse or brought into the clean utility room. Wheelchair leg rests should not be left out on a table on the unit and were supposed to be put in a resident's closet, on the wheelchair, or a pocket on the back of the wheelchair when not in use. The clean utility room door should not be accessible to residents. They could get stuck in the room and panic if the door was to shut completely behind them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/30/24 at 10:48 AM, Certified Nurse Aide #23 stated they had several residents who wandered in and out of other resident rooms and removed items. If a resident was showered in their room, medicated shampoos should go back to the nurse to be locked up in the medication room. Non-medicated shampoos should be locked up in a resident's closet or in the cabinet in the resident's bathroom. Bars of soap were not to be left out and could be stored in the mirrored cabinet. Soap that was left out could be a hazard as a resident could eat it. The soap bags that went into the dispensers should be thrown out when empty and placed in the dispensers when full. Wheelchair leg rests should not be left out as a resident could pick them up or trip over them. The clean utility room door should be pulled shut and locked.</p> <p>During an interview on 7/30/24 at 11:32 AM, the Director of Nursing stated they were aware that Resident #77 had two incidents where they attempted to ingest a bar of soap. The soap was now non-toxic because of the incidents. Some residents had soap bars accessible in their rooms if they were able to use them independently; otherwise, they were locked in their closets in shower caddies. The bagged shampoo and soap for the dispensers should not be left on the sinks or the floors of resident bathrooms. Medicated shampoos and wound washes should not be left in resident rooms, as they could be a potential hazard on the dementia unit. Wheelchair leg rests should not be left out on the dementia unit. Residents could pick up the leg rests and they could be a potential hazard. A maintenance or bio-med employee leaving their cart on the dementia unit unattended was not appropriate, and leaving their cart on outside of a closed door was considered unattended.</p> <p>During an interview on 7/30/2024 at 11:54 AM, the Director of Plant Operations stated when maintenance went to the dementia unit, they were supposed to keep all their tools secured and not out on the unit. They should also take as little equipment as possible onto the unit. The bio-med staff member who was on the unit with the open cart was contracted with the hospital. Contracted employees went through the same trainings as the facility staff.</p> <p>During an interview on 7/30/2024 at 12:03 PM, Bio-Med Technician #25 stated they were on the dementia unit recently. They had not received any training regarding dementia residents or the dementia unit specifically, only safe patient handling. Their open cart should not had been left unattended while on the dementia unit. Going behind a closed clean utility door with their cart outside the room in the hallway was considered unattended. An unattended cart could have been taken by a resident and items including needle nose pliers and other equipment, could be considered a safety hazard if left unattended on the dementia unit.</p> <p>10 NYCRR 483.25(d)</p>		