

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  10/10/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>48052</p> <p>Based on record review and interviews during the abbreviated surveys (NY00341596, NY00353814, NY00354138, and NY00354190) the facility failed to ensure residents were free from verbal, physical, and mental abuse for 4 of 16 residents reviewed (Resident #1, #3, #4, and #5).</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- Resident #4 was forced to ambulate against their will by several staff members;</li> <li>- Resident #5 was physically restrained by Registered Nurse #9 and Certified Nurse Aide #8 when the registered nurse attempted to obtain a nasal swab for COVID-19 testing from the resident.</li> <li>- Resident #1 was physically and verbally abused by Certified Nurse Aide #6 who was not immediately removed from resident access;</li> <li>- Resident #3 was verbally abused by Certified Nurse Aide #6 who spoke inappropriately to the resident and shared the resident's personal health information with others which resulted in mental anguish for the resident;</li> </ul> <p>The facility's failure to protect residents from abuse resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Residents #1, #3, #4, and #5 and placed all 123 residents in the facility at risk for the likelihood of serious harm, serious impairment, serious injury, or death.</p> <p>Findings include:</p> <p>The facility policy, Abuse and Neglect / Complaint Investigation, revised 8/2023, documented the facility did not use or permit verbal, mental, sexual, or physical abuse, including corporal punishment or involuntary seclusion of residents or misappropriation of property or exploitation. Abuse was defined by the willful infliction of injury, unreasonable confinement, intimidation, or punishment that resulted in physical harm, pain, or mental anguish. Willful was defined in the definition of abuse meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. All staff would attend annually training on abuse where examples were provided and how to report allegations of abuse. Any allegation of abuse would be investigated immediately. The potential for harm would be determined and the accused person or persons would be removed from the situation until the investigation was completed.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1) Resident #4 had diagnoses including dementia with behavioral disturbance, anxiety disorder, and unspecified disorder of bone density and structure. The 6/24/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, had physical and verbal behavioral symptoms directed toward others 1-3 of 7 days, behavioral symptoms not directed toward others 1-3 of 7 days, did not reject care, and was independent with transfers and ambulation.</p> <p>The Resident Preference and Function (care instructions) initiated 1/8/2021 documented the resident was independent with ambulation and encourage use of four wheeled walker. Resident was walk to dine, must eat in the dining room with supervision. Resident ate in a regular chair with a low table when in their room, preferred to eat in their room, and encourage to eat in the dining room.</p> <p>The comprehensive care plan initiated 7/25/2023 documented the resident had inappropriate behaviors related to cognitive decline, history of wandering, resistance, and agitation. Interventions included the resident did not like to be touched and was very territorial. Do not try to redirect and reapproach.</p> <p>The facility Nursing Home Incident Report submitted on 9/9/2024 at 4:11 PM documented the Nurse Manager (unidentified) was investigating another incident and came across video footage of Resident #4 on 9/6/2024.</p> <p>The facility incident report initiated by Registered Nurse Unit Manager/Supervisor #20 on 9/9/2024 at 1:53 PM, documented on 9/6/2024 at 5:52 PM Resident #4 was observed on video ambulating out of their bedroom with resistance. The resident had 2 certified nurse aides (unidentified) on both sides of their arms, sliding the feet of the resident down the hallway. The resident sat on a loveseat in the mid-hallway and the staff stood across the hall waiting for the resident. Within 1 minute the 2 staff got the resident up and the resident resisted and slid their feet to tell staff not to ambulate at that time . The resident stopped and other staff (unidentified) came to assist the 2 certified nurse aides. The licensed practical nurse, another certified nurse aide, and the supervisor came to assist (unidentified). The 2 certified nurse aides were sliding the resident down the hallway.</p> <p>Witness statements included:</p> <p>- On 9/9/2024 by Registered Nurse Supervisor #13. On 9/6/2024 they were at the nursing station and heard a yell for help. They went down the hallway and saw two certified nurse aides holding a resident up as it looked like the resident was going to fall. The certified nurse aides and the licensed practical nurse assisted the resident from falling and began to ambulate the resident down the hall, with one certified nurse aide on each side and the licensed practical nurse to follow. The resident began to resist and scratched the certified nurse aide. The licensed practical nurse was bitten when the resident was assisted into a chair.</p> <p>- on 9/10/2024 by Certified Nurse Aide #14 . On 9/6/2024 they were in the dining room serving dinner trays and they went to help 2 other staff members when they yelled for help. They helped walk the resident down the hall.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- On 9/11/2024 by Certified Nurse Aide #12. On 9/6/2024 they were asked by the nurse to get Resident #4 for dinner. The Nurse Manager told them all residents had to come out for mealtime. They and Certified Nurse Aide #8 went to get the resident and the resident was pushing them back and forth, so they sat the resident on the couch. They told Certified Nurse Aide #8 they would take the resident to the nursing station so someone could watch them eat. They tried to get the resident up and the resident started sliding and they called for extra help. Certified Nurse Aide #14, Licensed Practical Nurse #15, and the supervisor (not named) came to assist. Licensed Practical Nurse #15 and Certified Nurse Aide #14 had the resident's arms and Certified Nurse Aide #12, and Certified Nurse Aide #8 were behind the resident.</p> <p>- on 9/13/2024 by Certified Nurse Aide #8. On the evening of 9/6/2024 they were asked to bring the resident out for dinner by the nurse. They and Certified Nurse Aide #12 went to get the resident from their room, the resident did not want to come out and fought them down the hall. They sat the resident on the couch, gave the resident a minute to breath, and got them back up. The resident almost fell on the floor and other staff was called to assist.</p> <p>- on 9/14/2024 by Licensed practical Nurse #15. On 9/6/2024 they heard aides yell for assistance. They say two certified nurse aides with the resident who was very agitated and was being walked toward the dining room. The resident started to resist and tried to put them self on the floor. They assisted with the registered nurse and another certified nurse aide to get the resident safely to the chair.</p> <p>- On 9/13/2024 the Director of Quality Assurance documented Certified Nurse Aides #8 and #12 were suspended pending investigation. The way the resident was taken to the dining room was considered abuse. Both certified nurse aides watched the surveillance footage and were educated on a resident's right to refuse, documentation of refusals, communication with change of command regarding refusals, and alternative approaches. All nursing staff would be educated on resident's right to refuse, documentation of refusals, communication with change of command regarding refusals, and alternative approaches which would be headed up by social work.</p> <p>There was no documented evidence of education or corrective action for Licensed Practical Nurse #15, Certified Nurse Aide #14, or Registered Nurse Supervisor #13. There was no documented evidence of education with all nursing staff regarding a resident's right to refuse, documentation of refusals, communication with change of command regarding refusals, and alternative approaches.</p> <p>The facility's surveillance video from the resident's nursing unit on 9/6/2024 from 5:49 PM through 6:15 PM was reviewed:</p> <p>- At 5:51 PM, Certified Nurse Aide #12 entered Resident #4's room, followed by Certified Nurse Aide #8.</p> <p>- From 5:51 PM to 5:52 PM, Certified Nurse Aides #8 and #12 each had one arm holding above the resident's elbow and one arm holding the resident's wrists, while the resident struggled and resisted. The resident was placed on a couch in the hallway by both certified nurse aides.</p> <p>- At 5:53 PM, Certified Nurse Aides #8 and #12 using both arms, attempted to pull the resident off the couch by their arms while the resident swatted out at them and resisted until they forcibly pulled the resident off the couch into a standing position.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- From 5:53 PM to 5:54 PM, Certified Nurse Aides #8 and #12 pulled the resident down the hallway by their arms as the resident struggled and fought and planted their feet, causing their feet to slide against the floor as they were pulled. Certified Nurse Aide #8 attempted to move the resident forward and the resident grabbed onto the railing to stop their movement. Certified Nurse Aide #14 and Licensed Practical Nurse #15 came to assist and got on either side of the resident and held the resident's arms while Certified Nurse Aide #8 and #12 held the resident from behind. Registered Nurse Supervisor #13 came down the hall and stood off to the side, then behind the group, as the other staff members slid the resident down the hallway as the resident remained rigid and struggled with staff. They placed the resident in a chair across from the nurses' station outside the dining room and all four staff members (Certified Nurse Aides #8, #12, and #14, and Licensed Practical Nurse #15) struggled with the resident to get them to sit in the chair while Registered Nurse Supervisor #13 observed. The certified nurse aides went to the dining room, the licensed practical nurse went to the nursing cart, and the registered nurse supervisor went to the nurses' station.</p> <p>- At 5:55 PM Certified Nurse Aide #8 brought an overbed table to the resident, the resident pushed the table away and got up and walked down the hallway into another resident's room and shut the door.</p> <p>During an interview on 9/25/2024 at 1:49 PM, the Director of Nursing stated Certified Nurse Aides #8 and #12 were bringing the resident out to eat dinner as the dementia unit had a lot of residents the Unit Manager preferred to come out of their rooms to eat. The Director of Nursing stated after watching the video they saw the certified nurse aides were rough with the resident and had pulled the resident out of their room. Certified Nurse Aides #8 and #12 received written education on what happened if a resident refused assistance. The resident could not be forced, and if the resident still said no, they should inform the charge nurse and document on the refusal. The Supervisor stated they went to assist with the resident to avoid the resident from falling. The supervisor did not realize the resident had been dragged out their room by Certified Nurse Aides #8 and #12. There was no education provided to the staff members who came to assist because they thought the resident was falling. If a resident was combative and looked like they were going to fall, they should be lowered to the floor. The incident was discovered because Licensed Practical Nurse #15 submitted a report that they had been bitten by the resident, so the Director of Nursing watched the surveillance footage and saw the incident with Certified Nurse Aides #8 and #12</p> <p>During an interview on 9/25/2024 at 2:23 PM, Certified Nurse Aide #8 stated on 9/6/2024 the resident had not had any medications and had not eaten so they brought the resident out for dinner and to get their medication. The Nurse Manager told the certified nurse aides they had to bring residents out for meals. Resident #4 was care planned to be supervised for meals so they could not eat in their room. They stated they stood the resident in their room and the resident started to push them back and forth in the hallway, so they sat the resident down on a couch. They were trying to figure out if they should sit the resident there or bring the resident to the nurses' station. They did not want to get in trouble, so they brought the resident to sit near the nurses' station to eat so the resident would be supervised with their meal. They stated the resident likely did not want to get off the couch, but they got the resident up, and had to call for assistance because the resident was trying to sit on the floor in the hallway. As a group they helped the resident walk down the hallway and sit down in a chair near the nurses' station.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/26/24 at 1:29 PM, Licensed Practical Nurse #15 stated they were behind the nurses' station with the registered nurse when they heard a yell for help. The resident was between two aides and was very aggressive, rocking back and forth. They and another aide went down the hallway and the registered nurse followed. They stated Resident #4 was very upset, so they decided to sit the resident down in a chair; there were four staff members walking the resident at one point. The chair was across from the nurses' station down the hallway. When they got the resident to the chair, the resident bit them on the hand and scratched Certified Nurse Aide #14. They were going to get the resident a snack or a drink, but the resident got right back up and left. They stated they did not know why the certified nurse aides were assisting the resident down the hallway as they did not work on the dementia unit a lot. Registered Nurse Supervisor #13 oversaw the situation but did not say much. They stated they normally would have walked away from a resident that agitated but at that point the resident was attempting to throw themselves down, so it was decided to get the resident to a safe place.</p> <p>During an interview on 9/26/2024 at 3:15 PM, Registered Nurse Supervisor #13 stated they were an agency nurse. They stated they were sitting at the nurses' station and there was a certified nurse aide and a licensed practical nurse nearby. They heard a yell for help and thought they saw the resident falling and the two certified nurse aides holding the resident up. The resident took a few steps then resisted walking. There were five staff members with the resident, four of them were assisting the resident (Certified Nurse Aides #8, #12, and #14, and Licensed Practical Nurse #15). The resident walked to the chair next to the nurses' station but was resistive. They got the resident to a chair across from the nurses' station. They completed an incident report as the resident had bitten Licensed Practical Nurse #15 and scratched Certified Nurse Aide #8. They were unaware that Certified Nurse Aides #8 and #12 had pulled the resident out of their room when the resident did not want to go to dinner.</p> <p>2) Resident #5 had diagnoses including dementia with behaviors, Lewy body dementia (a specific type of dementia), and agitation. The 7/22/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, delusions, and hallucinations, rejected care, had physical, verbal, and other behavioral symptoms, and required setup or was independent for all activities of daily living except dressing and personal hygiene.</p> <p>The Comprehensive Care Plan initiated 1/30/2024 documented the resident had altered mood and behaviors related to history of past behaviors and history of becoming aggressive and being a victim of aggression. The resident did not like loud, crowded situations. Outcomes included staff would try to minimize things that triggered behaviors. Interventions included do not argue with the resident, as it increased agitation; do not touch without permission; approach in a calm, positive manner; redirect when demonstrating inappropriate behaviors; and do not overreact or confront, respond calmly and firmly.</p> <p>The Resident Preference and Function (care instructions) dated 9/18/2024 documented the resident was independent with ambulation, was able to communicate clearly but forgot and became frustrated, required 30- minute checks for safety and behaviors, the resident did not like being touched without their permission, had a history of being aggressive and being a victim of aggression.</p> <p>9/9/2024 physician's order documented COVID-19, influenza, and respiratory syncytial virus nasopharyngeal (nose) swab.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility incident report documented on 9/9/2024 at 10:00 AM Resident #5 had an incident with another resident when they threw a can of soda. The soda hit the other resident on the side of the head.</p> <p>- Resident #5 sustained a skin tear on their left hand between the first and second finger. They were triangle shaped and sized about 1.5 by 1.5 centimeters, 1 by 1 centimeters, and 0.5 by 0.5 centimeters.</p> <p>- During an interdisciplinary review of the event on 9/10/2024 by Registered Nurse Unit Manager/Supervisor #20, the resident-to-resident event was triggered by Registered Nurse #9 who had swabbed the resident for COVID-19 at 9:45 AM with arm support around the resident's neck and head. Certified Nurse Aide #8 held the resident while the resident was swabbed twice.</p> <p>- A statement by Social Work Assistant #10 on 9/10/2024 at 12:23 PM documented Resident #5 threw a can of soda in the direction of another resident in reaction to agitation by Registered Nurse #9 who tried to intervene. Resident #5 remained upset with Registered Nurse #9 for the remainder of the day as evidenced by observation from staff.</p> <p>- A statement by Registered Nurse #9 entered by the Quality Assurance Director on 9/11/2024 documented they were swabbing residents for COVID-19. Resident #5 was agitated, yelling, and attempting to grab the unopened swabs on their cart. They redirected the resident not to do that and removed the cart from the resident's reach. They thought the resident would be uncooperative and combative for the nasal swab, so they had Certified Nurse Aide #8 hold the resident's hands and they put their arms around the resident, not in front of their neck, to swab the resident quickly.</p> <p>- A statement by Certified Nurse Aide #8 entered by Registered Nurse Unit Manager/Supervisor #20 on 9/12/2024 at 2:20 PM documented Resident #5 had come over to hold Certified Nurse Aide #8's hands. Registered Nurse #9 told them to hold on and swabbed Resident #5 which upset the resident. Registered Nurse #9 ended up taking the resident back to their room.</p> <p>- A statement by the Director of Quality Assurance on 9/13/2024 at 10:51 AM documented Registered Nurse #9 was removed from the schedule pending investigation. Registered Nurse #9 watched the surveillance video and was educated prior to returning to work on a resident's right to refuse, documentation of refusals, communication with the chain of command when a resident refused, and alternative approaches. All nursing staff would be educated on a resident's right to refuse, documentation of refusals, communication with the chain of command when a resident refused, and alternative approaches.</p> <p>The incident was not reported to the New York State Department of Health until 9/11/2024 at 4:15 PM.</p> <p>There was no documented evidence of education or disciplinary action for Certified Nurse Aide #8.</p> <p>The facility's surveillance video from the nursing unit was reviewed for 9/9/2024 from 9:49 AM through 10:30 AM:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- From 9:56 AM to 9:57 AM, Resident #5 was ambulating independently in the hall, approached Registered Nurse #9's treatment cart, and attempted to take an object off the top of the cart. Registered Nurse #9 attempted to push the resident's hands from the cart and took the container when the resident attempted to grab it. Registered Nurse #5 pushed the cart away from the resident and around to the other side of the nurses' station.</p> <p>- At 9:57 AM, Resident #5 took Certified Nurse Aide #8's arm while the certified nurse aide was walking with another resident and began talking to them.</p> <p>- From 9:57 AM to 9:58 AM, Registered Nurse #9 walked from the opposite side of the nurse's station, approached the resident and Certified Nurse Aide #8, and opened a swab. They opened one swab while Certified Nurse Aide #8 held the resident's hands. Registered Nurse #9 put their left arm around the resident's left side of their neck with their hand along the side of the resident's jaw as the resident attempted to resist and obtained a swab with their right hand. Certified Nurse Aide #8 held both resident's hands and wrists while the resident attempted to struggle away from Registered Nurse #9. The resident attempted to release themselves from Certified Nurse Aide #8. Certified Nurse Aide #8 let go of the resident's hands and the resident attempted to swing at Registered Nurse #9 and Certified Nurse Aide #8 took the resident's left elbow to hold them back and proceeded to lead the resident down the hall for a short distance.</p> <p>- From 9:58 AM to 10:01 AM, Resident #5 approached the nurse's station desk, picked up a can of soda, and walked around to the other side. They started to interact with another resident in a wheelchair. Registered Nurse #9 came out from behind the nurses' station to intervene and reached their hand out toward Resident #5 who smacked it away. Resident #5 threw a can of soda in the nurses' direction which appeared to glance off the side of the other's resident's head who was wearing a helmet. Registered Nurse #9 attempted to take Resident #5, who began to struggle, away from the nurse's station. Registered Nurse #9 had one hand on the resident's arm/elbow and the other arm behind the resident and began to pull the resident away. Resident #5 was struggling against Registered Nurse #9 as they were led away. Registered Nurse #9 had one hand under the resident's armpit and one on their elbow area. Resident #5 grabbed onto the mobility bar on the wall with their right hand. Registered Nurse #9 attempted to pull the resident off the bar by their other arm, and the resident would not move. Registered Nurse #9 released the resident's fingers from the bar and the resident grabbed the bar again with their other hand. Registered Nurse #9 continued to struggle with Resident #5 and attempted to release the resident's hand as they grabbed the bar. Certified Nurse Aide #8 came and assisted with removing the resident from the rail. Registered Nurse #9 and Certified Nurse Aide #8 walked the resident down the rest of the hallway holding onto the resident's arms.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/25/24 at 1:49 PM, the Director of Nursing stated Resident #5 was angry all day, and they attempted to figure out why, so they pulled the surveillance footage to see what had happened that day. They had noticed in the video that Registered Nurse #9 had obtained a swab from the resident by grabbing the resident and swabbing their nose with the assistance of Certified Nurse Aide #8. Certified Nurse Aide #8 held the resident's hand so the resident would feel safe during the swab. Registered Nurse #9 did not hold the resident tightly but did hold them in place during the swab. The resident was upset after this incident. Certified Nurse Aide #8 did not receive any education as the certified nurse aide did not do any restraining, when the resident moved her hand, the certified nurse aide let go; the certified nurse aide did not try to hold the resident's hand. They did not talk to Certified Nurse Aide #8 about reporting a resident being restrained by a staff member. Registered Nurse #9 told them they did not realize they had been restraining the resident ; they thought they were just obtaining a swab on a resident that would be difficult to swab. They were unsure of why the incident was not reported to the Department of Health until 9/11/2024. They were unsure of how Resident #5 obtained the skin tear in their hand.</p> <p>During an interview on 9/25/24 at 2:23 PM, Certified Nurse Aide #8 stated Resident #5 had been yelling at everyone that day. They didn't know what set the resident off that day, but they were not themselves. Resident #5 had approached them and grabbed their hands. Registered Nurse #9 came over and stated they were going to swab the resident. They stated Registered Nurse #9 went to the side of the resident, completed the swab, and the resident got mad at the nurse. They did not remember if Registered Nurse #9 held the resident. They stated the nurse did not inform the resident before the swab was completed. They remembered Registered Nurse #9 brought the resident to their room and they went to go complete care for another resident.</p> <p>During an interview on 9/26/24 at 2:39 PM, Registered Nurse #9 stated they were moved from the Dementia Unit after they held a resident while doing a COVID-19 swab. Due to them holding a resident, it was considered abuse. They stated on 9/9/2024 before they swabbed Resident #5, the resident was angry and was yelling and had tried to grab their unopened kits from the cart. They moved their cart to the other side of the nurses' station. Resident #5 had an order to be swabbed as they were exposed to COVID-19. The resident was standing with Certified Nurse Aide #8, so they asked Certified Nurse Aide #8 to hold the resident's arm, so they did not swing out or hurt themselves. They wanted to get the swab done quickly because they knew the resident was not cooperative and had a history of yelling and combative behavior. They put their arm behind the resident, grabbed the resident's chin, and did the COVID-19 swab with the other hand. The resident said stop and they did not want it done. Registered Nurse #9 stated they felt the swab needed to be done so they did it. After they swabbed the resident, the resident yelled at another resident, so they attempted to intervene. They stated Resident #5 threw a soda can at another resident, so they stood in front of Resident #5 and pulled the two residents apart. They stated they brought the resident to their room by holding their hand and arms. They wanted to get the resident to a safe place. The resident had a lot of behaviors the rest of the day. They stated they held other residents to get COVID-19 swabs that morning. They stated they were educated about the incident the next day and were informed they would be removed from the floor. They worked Thursday 9/12/2024 and Friday 9/13/2024 but were suspended for one day on Monday 9/16/2024 for their involvement in the incident.</p> <p>3) Resident #1 had diagnoses including Alzheimer's dementia, schizoaffective disorder, and Parkinson's disease (a progressive neurological disease). The 8/16/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had fluctuating disorganized thinking, had verbal, physical, and other behavioral symptoms, and was dependent for care except eating and oral hygiene.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The 8/26/2024 Resident Preference and Function care plan documented the resident was dependent for toileting and transfers and required substantial/maximum assistance for bed mobility and dressing. The resident always required two caregivers and was to be given something to hold during transfers and care. The resident had a history of verbal aggression, physical aggression, and sexually inappropriate comments.</p> <p>The 9/11/2024 facility incident report documented staff were made aware of an incident that occurred at 6:15 PM. Registered Nurse Supervisor #2 was notified by Certified Nurse Aide #5 (no documentation of the time of notification) that Certified Nurse Aide #6 was rough with handling and caring for Resident #1 while putting them to bed. Certified Nurse Aide #6 made derogatory comments, intimidating remarks, belittled the resident about their genitalia, and called the resident an [expletive] and a [expletive]. Certified Nurse Aide #6 did not deny the event and was educated about abuse and the consequences. Registered Nurse Supervisor #2 attempted to interview Resident #1, but the resident did not remember the incident. The Administrator and Director of Nursing were notified at 7:38 PM and Registered Nurse Supervisor #2 was instructed to send Certified Nurse Aide #6 home. Certified Nurse Aide #6 was escorted by Registered Nurse Supervisor #2 to the lobby and Certified Nurse Aide #6 exited the building (no time documented).</p> <p>- A statement from Certified Nurse Aide #5 documented on 9/11/2024 at 6:15 PM they witnessed Certified Nurse Aide #6 being rough with Resident #1 during care which included pulling on the resident, slapping the resident's chest, calling the resident names, screaming in the resident's face, and making fun of the resident's genitalia. The statement did not include who Certified Nurse Aide #5 reported the incident to, or the time.</p> <p>- Certified Nurse Aide #6 was interviewed by Registered Nurse Supervisor #2 and stated they were sorry and did not deny the accusation.</p> <p>- Certified Nurse Aide #6 was sent home on 9/11/2024 pending investigation per the direction of the Director of Nursing.</p> <p>The incident report did not include a statement from Licensed Practical Nurse #7.</p> <p>The facility's surveillance video from Resident #1's nursing unit on 9/11/2024 from 6:23 PM through 8:35 PM was reviewed:</p> <p>- At 6:32 PM Certified Nurse Aide #5 and Certified Nurse Aide #6 exited Resident #1's room.</p> <p>- At 6:33 PM Certified Nurse Aide #6 went back into Resident #1's room, exited the room with the mechanical lift and entered another resident room with Certified Nurse Aide #5.</p> <p>- At 7:03 PM, Certified Nurse #5 was speaking with Licensed Practical Nurse #7 at the medication cart at the end of the hallway near the elevators.</p> <p>- At 7:05 PM, Licensed Practical Nurse #7 went towards the elevators and made a phone call and went back to their medication cart.</p> <p>- At 7:15 PM, Certified Nurse Aide #6 left the floor.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- At 7:26 PM, Certified Nurse Aide #5 left the floor.</li> <li>- At 7:42 PM, Certified Nurse Aide #6 was at the nursing station then walked into a resident room.</li> <li>- At 8:10 PM, Certified Nurse Aide #6 left the floor with their jacket on.</li> <li>- At 8:20 PM, Certified Nurse Aide # 6 returned to the floor and walked down the hallway.</li> <li>- At 8:21 PM, Certified Nurse Aide #6 carried a slipper to a resident's room.</li> <li>- At 8:22 PM, Certified Nurse Aide #6 assisted an unidentified resident near the nursing station to sit in a chair.</li> <li>- At 8:24 PM, Certified Nurse Aide #6 walked down the hallway with an unidentified certified nurse aide to a resident's room. The two certified nurse aides were in the alcove between two resident rooms out of view of the camera, then they walked back to the nursing station.</li> <li>- At 8:24 PM Certified Nurse Aide #6 remained at the nursing station until Registered Nurse Supervisor #2 came to the floor at 8:33 PM and took Certified Nurse Aide #6 into the breakroom behind the nursing station.</li> </ul> <p>Certified Nurse Aide #6's timecard documented they clocked out at 8:35 PM on 9/11/2024 and they did not work any other shifts past 9/11/2024.</p> <p>There was no documented evidence Certified Nurse Aide #6 was immediately removed from resident access after the allegation of abuse.</p> <p>The 9/12/2024 Employee Performance Appraisal form documented Certified Nurse Aide #6 was suspended pending investigation on 9/12/24. The investigation was completed, Certified Nurse Aide #6's actions were confirmed abuse, therefore, their employment was terminated.</p> <p>The 9/12/2024 at 3:00 PM Registered Nurse #9 Skin Risk Assessment Scale documented the resident had two points of purple bruising observed on their right arm and one bruise on their left arm.</p> <p>During an interview on 9/24/24 at 12:11 PM, Registered Nurse Supervisor #2 stated at approximately 6:15 PM on 9/11/2024, Licensed Practical Nurse #7 messaged them and stated that there was a complaint made. They had Licensed Practical Nurse #7 send Certified Nurse Aide #5 to the Supervisor's office on the first floor. Certified Nurse Aide #5 informed them they were in Resident #1's room with Certified Nurse Aide #6, providing care and Certified Nurse Aide #6 was behaving inappropriately. They asked Certified Nurse Aide #5 to write a statement and then sent the certified nurse aide back upstairs and asked Licensed Practical Nurse #7 to send down Certifie [TRUNCATED]</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052</b></p> <p>Based on observation, record review, and interviews during the abbreviated (NY00348034, NY00353814, NY00354138) surveys, the facility did not ensure a resident who displays or is diagnosed with dementia receives the appropriate treatment and services to attain and or maintain their highest practicable physical, mental, and psychosocial well-being for 3 of 16 residents (Residents #4, #5, and #16) reviewed. Specifically, Residents #4, #5, and #16 had diagnoses of dementia and resided on the dementia unit in the facility and were not cared for in a dementia-informed manner. Resident #4 was forced to ambulate against their will by several staff members after refusing to go to the dining room; Resident #5 was physically restrained by a registered nurse and a certified nurse aide while a nasal swab was obtained; and Resident #16's care plan was not followed which resulted in a fall with a skin tear. Refer to F 600.</p> <p>Findings include:</p> <p>The facility policy, GEMS Stages of Dementia Classification, created 11/2023, documented the GEMS Model was a framework for understanding and caring for individuals with the diagnosis of dementia. The model used gemstones as a reference for each stage of dementia, such as sapphire, diamond, emerald, amber, ruby, and pearl. The purpose was to diminish negative stereotypes associated with dementia and to create a more positive dementia care culture. The GEMS State Model was the standardized method of identifying an individual's stage in the dementia process at the facility. The GEMS State Model provided a means of quickly identifying interventions and approaches best suited to the resident, allow the staff who did not have easy access to the resident charts to identify the stage of dementia for the resident, and to continue to educate staff on all stages of dementia. The GEM care plan would appear on the resident's function and preference which was placed in a binder at the nurses' station on the first floor.</p> <p>1) Resident #4 had diagnoses including dementia with behavioral disturbance, anxiety disorder, and disorder of bone density and structure. The 6/24/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, physical and verbal behavioral symptoms directed toward others 1-3 of 7 days, behavioral symptoms not directed toward others 1-3 of 7 days, did not reject care, and was independent with transfers and ambulation.</p> <p>The 9/16/2024 Resident Preference and Function care plan documented the resident was independent with ambulation and was to be encouraged to use their four wheeled walker. The resident must eat in the dining room with supervision. The resident ate in a regular chair with a low table when in their room where the resident preferred to eat. Encourage to the resident to eat in the dining room as the resident threw food in the toilet.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility incident report initiated by Registered Nurse Unit Manager/Supervisor #20 on 9/9/2024 at 1:53 PM, documented on 9/6/2024 at 5:52 PM Resident #4 was observed on video ambulating out of their bedroom with resistance. The resident had 2 certified nurse aides on both sides of their arms, sliding the feet of the resident down the hallway. The resident sat on a loveseat in the mid-hallway and the staff stood across the hall waiting for the resident. Within 1 minute the 2 staff went to get the resident up and the resident resisted and slid their feet to tell staff not to ambulate at that time. The resident stopped and other staff came to assist the 2 certified nurse aides. The licensed practical nurse, another certified nurse aide, and the supervisor came to assist. The 2 certified nurse aides (unidentified) were sliding the resident down the hallway.</p> <p>The facility's surveillance video from the nursing unit on 9/6/2024 from 5:49 PM through 6:15 PM was reviewed:</p> <ul style="list-style-type: none"> <li>- From 5:51 PM to 5:52 PM, Certified Nurse Aides #8 and #12 each had one arm holding above the resident's elbow and one arm holding the resident's wrists, while the resident struggled and resisted. The resident was firmly placed on a couch in the hallway.</li> <li>- At 5:53 PM, Certified Nurse Aides #8 and #12 using both arms, attempted to pull the resident off the couch by their arms while the resident swatted out at them and resisted until they forcibly pulled the resident off the couch into a standing position.</li> <li>- From 5:53 PM to 5:54 PM, Certified Nurse Aides #8 and #12 pulled the resident down the hallway by their arms as the resident struggled and fought and planted their feet, causing their feet to slide against the floor as they were pulled. Certified Nurse Aide #8 attempted to move the resident forward and the resident grabbed onto the railing to stop their movement. Certified Nurse Aide #14 and Licensed Practical Nurse #15 came to assist and got on either side of the resident and held the resident's arms while Certified Nurse Aide #8 and #12 held the resident from behind. Registered Nurse Supervisor #13 came down the hall and stood off to the side, then behind the group, as the other staff members slid the resident down the hallway as the resident remained rigid and struggling with staff. They placed the resident in a chair across from the nurses' station outside the dining room and all four staff members (Certified Nurse Aides #8, #12, and #14 and Licensed Practical Nurse #15) struggled with the resident to get them to sit in the chair while Registered Nurse Supervisor #13 observed. The certified nurse aides headed toward the dining room, the licensed practical nurse to the nursing cart, and the registered nurse supervisor to the nurses' station.</li> </ul> <p>During an interview on 9/25/2024 at 2:23 PM, Certified Nurse Aide #8 stated the Nurse Manager told the certified nurse aides they had to bring residents out for meals. Certified Nurse Aide #8 stated they were told the residents on the unit did not know how to refuse. Resident #4 was care planned to be supervised for meals so they could not eat in their room. They stated they stood the resident in their room and the resident started to push them back and forth in the hallway, so they sat the resident down on a couch. They were trying to figure out if they should sit the resident there or bring the resident to the nurses' station, so they brought the resident to sit near the nurses' station to eat so they were supervised. They stated the resident likely did not want to get off the couch, but they got the resident up, and had to call for assistance because the resident was trying to sit on the floor in the hallway. As a group they helped the resident walk down the hallway and sit down in a chair near the nurses' station. Certified Nurse Aide #8 stated they had been previously educated on the Teepa Snow (a specialized dementia care program) program for the dementia unit.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) Resident #5 had diagnoses including dementia with behaviors and agitation. The 7/22/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, delusions, and hallucinations, rejected care, had physical, verbal, and other behavioral symptoms, and was independent after setup for most activities of daily living.</p> <p>The 9/18/2024 Resident Preference and Function care card documented the resident was independent with ambulation, was able to communicate clearly but would forget and become frustrated, required 30-minute checks for safety and behaviors, did not like being touched without their permission, and had a history of being aggressive and being a victim of aggression.</p> <p>9/9/2024 physician's order documented a COVID-19, influenza, and respiratory syncytial virus nasopharyngeal (nose) swab was to be collected.</p> <p>The facility's surveillance video from the nursing unit was reviewed for 9/9/2024 from 9:49 AM through 10:30 AM:</p> <ul style="list-style-type: none"> <li>- At 9:51 AM, Registered Nurse #9 swabbed an unidentified resident sitting in a chair in front of the nurses' station with the assistance of another unidentified staff member while the resident fought against the swab.</li> <li>- At 9:54 AM, Registered Nurse #9 swabbed an unidentified resident sitting in a chair in front of the nurses' station with their arm braced on the resident's chest while the resident attempted to move their head away from the swab.</li> <li>- At 9:56 AM, Registered Nurse #9 went to the side of a resident from behind, put their arm around the back of the resident's neck and shoulders and swabbed the resident as they tried to move their head away.</li> <li>- From 9:57 AM to 9:58 AM, Registered Nurse #9 put their arm around Resident #5's left side of their neck with their hand along the side of the resident's jaw. They secured the resident's head/neck between their forearm and shoulder to hold the resident and went around the right side of the resident to swab their nose. Certified Nurse Aide #8 had a visible hold of the resident's hands and wrist area while the resident struggled away from Registered Nurse #9. The resident attempted to get their arms released as well from the certified nurse aides' grip. When the swab was done, the certified nurse aide let go of the resident's hands as they struggled, and the resident attempted to swing out at the registered nurse but was halted by Certified Nurse Aide #8 who took the resident's arm at the elbow and held them back. The resident was visibly agitated and shaking their first at Registered Nurse #9. Certified Nurse Aide #8 attempted to get the resident to follow them down the hallway, but the resident refused.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/26/24 at 2:39 PM, Registered Nurse #9 stated before they swabbed Resident #5 on 9/9/2024, the resident looked angry and was yelling. The resident looked dangerous and had tried to grab the unopened kits off the treatment cart. Registered Nurse #9 stated they had moved the cart to the other side of the nurses' station out of the resident's reach. The resident was standing with Certified Nurse Aide #8, so they asked Certified Nurse Aide #8 to hold the resident's arm because they did not want the resident to swing out or hurt themselves. Registered Nurse #9 stated they wanted to get the swab done quickly because they knew the resident was not cooperative and had a history of yelling and combative behavior. They put their arm behind the resident, grabbed the resident's chin, and did the COVID-19 swab with the other hand. The resident had stated stop and that that they did not want to do it, but Registered Nurse #9 felt it needed to be done so they did it. The resident was yelling at another resident, so they attempted to intervene. Resident #5 threw a soda can, so they stood in front of Resident #5 and pulled the residents apart. They brought Resident #5 to their room by holding the resident's hand and arms. They stated they wanted to get the resident to safe place, like their room. The resident had a lot of behaviors the rest of the day.</p> <p>3) Resident #16 had diagnoses including Alzheimer's disease, osteoporosis, and cardiac arrhythmia. The 8/19/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, continuous inattention and disorganized thinking, physical and verbal behaviors for 1 to 3 of 7 days that significantly interfered with the resident's care and activity participation, required substantial to maximum assistance for dressing, partial to moderate assistance for transfers, and supervision to touching assistance for ambulating 150 feet with a walker.</p> <p>The 7/8/2024 Resident Preference and Function documented the resident required supervision to touching assistance with a two wheeled walker, was substantial to maximum assist of one person into the bathroom with red toilet seat, and attempt to toilet the resident when they were initiating movement/ready to get up and walk. Fall precautions included frequent visual checks of 30 minutes, to keep their walker or assistive device with the resident, to wear hipsters, and to wear shoes when out of bed. Behavior interventions included to allow the resident to feel in charge and have active part of their care, walk with the resident on the unit as resident will rest when they're tired, and ensure they have a chair before allowing the resident to sit as the resident had poor safety awareness. Resident's GEMS color was amber (mid-stage to late-stage dementia). Interventions included to be careful of over of under stimulation, to limit noise and touch, and to make the environment safe for exploring.</p> <p>The 7/11/2024 incident report documented:</p> <p>- Resident #16 had an unwitnessed fall with 0.5-centimeter skin tear to their right elbow and a red mark on their right shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The 7/12/2024 statement by Registered Nurse/Nurse Manager #20 documented the resident was supervision to touching with their walker. Resident #16 was given their medications by Licensed Practical Nurse #25 at 7:03 PM and then the resident was using the handrails in the hallway. At 7:07 PM, Certified Nurse Aide #26 brought Resident #16 into the bathroom for toileting and gave the resident their walker to ambulate. Certified Nurse Aide #26 left the bathroom and brought a scoot chair to the other side of the hallway. The resident ambulated out of the bathroom at 7:20 PM and ambulated to resident room [ROOM NUMBER]. The resident left the walker outside room [ROOM NUMBER] and ambulated into resident room [ROOM NUMBER]. Another resident noticed Resident #16 immediately and notified staff the resident was on the floor. Certified Nurse Aide #26 was educated by Registered Nurse Supervisor #19 at 6:22 PM regarding the resident's transfer status prior to the fall.</p> <p>The 7/22/2024 Employee Performance Appraisal documented education was provided to Certified Nurse Aide #26 for failure to follow policy. On 7/11/2024, Certified Nurse Aide #26 took Resident #15 to the bathroom and left the resident. The resident left the bathroom, wandered to another resident room, and fell . The resident was not safe to be left alone. Certified Nurse Aide #26 did not follow the resident's plan of care of the resident being substantial to maximal assist in the bathroom. Certified Nurse Aide #26 was re-educated on the resident's plan of care and documentation in the resident's record.</p> <p>During a telephone interview on 10/07/2024 at 4:05 PM, the Administrator stated they became aware of an issue at the facility with abuse related issues around 9/15/2024 or 9/16/2024. They had five incidents in two weeks with different issues which included some residents refusing care. A resident had the right to refuse care but there was a fine line between care, abuse, and neglect. These incidents had different issues and encompassed several nuances including abuse and neglect. The interdisciplinary team, which included department heads and Unit Managers, reviewed incidents regularly. While reviewing these incidents, questions were raised, and it was decided they would come up with staff education and training for the abuse follow up. The staff education was designed but had not been implemented yet because it took longer than planned to complete. The process for identifying trends was determined by the interdisciplinary team that met monthly, and by the Quality Assurance Committee which met monthly. Each case was reviewed for repeating issues. Even though the facility had a dementia unit, there were residents with dementia on all four units. When a resident with dementia needed more care, they were moved from the dementia unit to one of the other floors, often the fourth floor. The education that was planned was geared toward dementia communication. Staff working on the dementia floor had been given special training in Teepa Snow 1 which addressed that. The dementia care unit staff would be receiving Teepa Snow 2 instruction which was more in depth and helped them communicate and understand dementia better. The plan was for the entire facility to get Teepa Snow 1 education, but this had not yet been implemented.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 10/9/2024 at 9:57 AM, Certified Nurse Aide #26 stated they were an agency certified nurse aide and they no longer worked at the facility. They stated they were informed that if Resident #16 had to use the bathroom, they had to use the hallway one and if they wanted to have a nap, they had to use the couch as they could not be in their room alone due to falls. They stated the resident required supervision for walking with their walker. They stated when they started at the facility, they were told supervision for Resident #15 meant they had to check on the resident every 15 minutes, they had to know where the resident was and if they had their walker with them. They stated they received education over the phone in which they were informed the resident was supervision and that supervision meant the staff had to be right next to the resident. They stated they did not receive specialized training for the dementia unit or how to address the dementia specific behaviors.</p> <p>During a phone interview on 10/9/2024 at 12:55 PM, Registered Nurse/Nurse Manager #20 stated the staff on the dementia unit goes through the Teepa Snow training and they should know how to communicate and communicate in different ways and motions as well as get residents with dementia to engage. They stated all the staff should be trained to work on the dementia unit and the facility was working to make sure travelers had training as well. The training was yearly. Each resident had a specific care plan but on the dementia unit, the care plans were kept in a binder at the nurses' station on the dementia unit as opposed to in the residents' closet on other units.</p> <p>During a phone interview on 10/10/2024 at 11:24 AM, the Director of Nursing stated they had not identified any patterns with their incidents; they all involved different staff members. They stated they believed part of the issue was that a lack of education. They stated they had not been educated with the Teepa Snow program but had asked to be educated during the next training course. They stated they used something different for dementia training in the state they were from. They stated they did not know if the Teepa Snow program provided any specific education to the staff on the dementia unit on how to handle refusals, behaviors, or dementia specific issues but the staff on the regular floors are taught to reapproach.</p> <p>10NYCRR 415.12</p>		

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  10/10/2024
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	

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>48052</p> <p>Based on record review and interviews during the abbreviated survey (NY00341596, NY00353814, NY00354138, and NY00354190) the facility did not ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the administration failed to ensure policies and procedures were properly identified, communicated, and consistently implemented for abuse and dementia care. The administration was not aware of the extent of the deficient practices and Immediate Jeopardy was identified on 9/25/2024 in the area of abuse (refer to F 600).</p> <p>Findings include:</p> <p>The facility policy, Quality Assessment and Performance Improvement Plan, revised 9/2023, documented the program was intended to identify and prioritize problems and opportunities based on performance indicator data and resident and staff input that reflected organizational processes, functions, and services provided to residents. The program would identify corrective actions necessary to address gaps in systems, and then these actions were evaluated for effectiveness. The program was established around the premise of safety, quality, rights, choice, and respect.</p> <p>The facility policy, Administrator Policy [Residential Healthcare Facility], reviewed 3/2022, documented the purpose of the Administrator was to be a focal point for information while developing a hierarchy within the Residential Health Care Facility and establishing a responsible party for management of the facility. An Administrator, licensed by the State of New York, would be appointed by the Chief Executive Officer and would be responsible for the management and oversight of the facility. The Administrator would report to the Chief Executive Officer. The facility department heads, contractors, and consultants reported directly to the Administrator. The Administrator ensured that all policies, procedures, mandated regulations, and quality of resident care were followed to the highest possible standards.</p> <p>The 3/20/2014 facility Director of Nursing Service job description documented the position involved responsibility for planning, directing, and supervising activities as they applied to nursing services. Their supervision and direction were to be exercised over all nursing home facility nursing services personnel. They conferred with facility administrator and other administrative and professional personnel to assist in establishing and reviewing policies, programs and procedures effecting patient care. They were also responsible for evaluating the quality and quantity of the nursing services rendered in the facility and for making changes as necessary to meet State and Federal requirements.</p> <p>Freedom from Abuse, Neglect, and Exploitation Refer to citation text under F600.</p> <p>Residents #1, #2, #4, and #5 were not free from verbal, physical, and mental abuse. The facility's failure to ensure residents were free from abuse placed all 123 residents at risk for serious injury, serious harm, serious impairment, or death. This resulted in Immediate Jeopardy to resident health and safety.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/24/2024 at 1:23 PM, the Director of Nursing stated for incidents of abuse they educated the involved staff immediately. They planned to have a long-term care day where they educated the staff. The facility had an abuse course which was very good, and they requested the education to be done for all staff. During a follow up phone interview on 10/10/2024 at 11:24 AM, the Director of Nursing stated they had not identified any patterns with the abuse incidents, and they all involved different staff members. They stated they believed part of the issue was a lack of education. They stated they had not been educated with the Teepa Snow (a specialized dementia care program) program since they started in August 2024, but had asked to be educated on the next course date.</p> <p>During an interview on 9/24/2024 at 3:00 PM, the Director of Quality Assurance stated they put together an education due to the facility having four incidents that were related. They stated they combined their efforts for education on physical, verbal, emotional abuse, and residents' rights.</p> <p>During an interview on 9/24/2024 at 4:42 PM, the Administrator stated they identified a trend of reportable incidents in the facility, so they had tasked their three Teepa Snow trained staff (including the Activities Director and the Director of Social Services), to research and put together a training for all staff. The training had not been approved and implemented yet. They stated they had focused on implementing the plan of correction and education from their last recertification survey first.</p> <p>During a follow-up telephone interview on 10/07/2024 at 4:05 PM, the Administrator stated they became aware of an issue at the facility with abuse related issues around 9/15/2024 or 9/16/2024. They had five incidents in two weeks with different issues which included some residents refusing care. A resident had the right to refuse care but there was a fine line between care, abuse, and neglect. These incidents had different issues and encompassed several nuances including abuse and neglect. The interdisciplinary team, which included department heads and Unit Managers, reviewed incidents regularly. While reviewing these incidents, questions were raised, and it was decided they would come up with staff education and training for the abuse follow up. The staff education was designed but had not been implemented yet because it took longer than planned to complete. The process for identifying trends was determined by the interdisciplinary team that met monthly, and by the Quality Assurance Committee which met monthly. Each case was reviewed for repeating issues. Even though the facility had a dementia unit, there were residents with dementia on all four units. When a resident with dementia needed more care, they were moved from the dementia unit to one of the other floors, often the fourth floor. The education that was planned was geared toward dementia communication. Staff working on the dementia floor had been given special training in Teepa Snow 1 which addressed that. The dementia care unit staff would be receiving Teepa Snow 2 instruction which was more in depth and helped them communicate and understand dementia better. The plan was for the entire facility to get Teepa Snow 1 education, but this had not yet been implemented.</p> <p>(continued on next page)</p>		

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F 0835  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>During an interview on 10/9/2024 at 1:20 PM, the Medical Director stated they had not been consulted by the Chief Executive Officer regarding the issues with abuse the facility had recently had but they had initiated a conversation briefly with the Administrator and Director of Nursing to propose their own solution of being more present on the floors of the facility. They did not believe there was enough administrative presence on the nursing home unit floors, or these issues would not have occurred. They stated the previous Chief Operating Officer had a philosophy where the staff are presumed innocent until proven guilty, so they were not allowed to remove staff from the floor until the investigation had been concluded and the staff found to have been guilty of the allegation. They also believed the issue was lack of education as the traveling nurse staff were not as educated the same as those directly employed by the facility. They stated they were educated when they started, but not well enough or these issues would not have happened.</p> <p>10 NYCRR 483.70(i)</p>		