| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335436 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Jamaica Hospital Nursing Home CO Inc | 89-40 135th Street<br>Jamaica, NY 11418 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the Recertification and Complaint Survey (NY00352512) conducted from 02/18/2025 to 02/25/2025, the facility did not ensure a resident received adequate supervision and assistance devices consistent with resident's needs, goals, and care plan to prevent accidents. This was evident for one (1) (Resident #26) of 38 total sampled residents. Specifically, Resident #26 required total assistance of two (2) staff using mechanical lift for transfers as documented in the Comprehensive Care Plan. On 08/26/2024, Resident #26 was noted with ecchymosis (medical term for bruise) on the right leg. X-ray report revealed fractures of tibia (inner and larger of the two bones of the lower leg) and fibula (the outer and usually smaller of the two bones between the knee and the ankle). Investigation revealed Certified Nursing Assistant #1 transferred Resident #26 without assistance and pivoted the Resident from chair to bed. In addition, interview with Certified Nursing Assistants #3 and #4 revealed they had not used a mechanical lift during transfers prior to Resident #26 sustaining fractures. This resulted in actual harm to Resident #26 that was not Immediate Jeopardy.<br><br>The findings include:<br><br>The facility policy titled Prevention of Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property with a revised date of 01/2023 documented it was the policy of the facility to develop and implement written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents. Additionally, it was the policy of the facility to ensure appropriate investigation and follow-up of all allegations of mistreatment, neglect, abuse, exploitation, and misappropriation of resident's property.<br><br>The facility policy titled Certified Nursing Assistant Accountability Record with a revised date of 01/2023 documented that the purpose of the policy was to ensure that Certified Nursing Assistants are instructed in all areas of Activities of Daily Living and to direct them to provide care and accurately document.<br><br>Resident #26 had diagnoses that included Cerebrovascular Accident (medical term for stroke, interruption in the flow of blood to cells in the brain), Non-Alzheimer's Dementia (memory impairment in the elderly), Hemiplegia (one sided weakness of the face, arm, and leg).<br><br>The Minimum Data Set assessment (a standardized, comprehensive assessment tool) dated 07/19/2024 documented that Resident #26 had severely impaired cognitive skills for daily decision making and was totally dependent on staff for all activities of daily living.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A Comprehensive Care Plan for Activities of Daily Living was initiated for Resident #26 on 07/17/2024. The care plan interventions included total assistance of two (2) for transfers with the use of a mechanical lift device.<br><br>The Resident Certified Nursing Assistant Documentation History Detail (overview of tasks and assignments completed by the Certified Nursing Assistants) documented that Resident #26 was transferred by two (2) staff with no documentation that a mechanical lift was used on 08/20/2024 7:00 AM - 3:00 PM, 08/21/2024 7:00 AM - 3:00 PM, 08/22/2024 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM, 08/23/2024 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM, 08/24/2024 7:00 AM - 3:00 PM, and 08/25/2024 3:00 PM - 11:00 PM.<br><br>Furthermore, Certified Nursing Assistant #1 documented in the Resident Certified Nursing Assistant Documentation History Detail that Resident #26 was transferred by pivot(a type of transfer that involves bearing weight on one or both legs and spinning to move their bottom from one surface to another) with 2-person assist on 08/19/2024 3:00 PM - 11:00 PM, 08/21/2024 3:00 PM - 11:00 PM and 08/24/2024 3:00 PM - 11:00 PM.<br><br>A nurse's progress note dated 08/26/2024 at 2:19 PM by Registered Nurse #2 documented Resident #26 was observed with discoloration on the right shin and right foot. Resident #26 was contracted (tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) due to right hemiparesis. An X-ray (a photographic or digital imaging of the body) was ordered by the physician, and pain medication was administered as ordered.<br><br>A physician's progress note by the Medical Director dated 08/26/2024 at 9:51 PM documented Resident #26 was noted with right leg in contracture position with ecchymosis, swelling to leg and movement restriction due to pain and tenderness, unknown injury mechanism. An X-ray was noted with fracture of tibia, osteoporotic bones noted. Based on the findings, the resident was transferred to the emergency room for further evaluation and management.<br><br>The facility Investigative Summary Report dated 08/28/2024 completed by Assistant Director of Nursing #2 documented on 08/26/2024 during the morning tour, Resident #26 was observed with right leg edema and bluish purplish discoloration of the right foot. Resident had severe cognitive impairment and cannot give account. An X-ray revealed non-displaced spiral tibial shaft, distal fibula fracture (broken leg), and disuse osteopenia (localized loss of bone due to decreased use). Resident #26 was transferred to the emergency room for further evaluation on 08/26/2024 and returned on 08/27/2024. Assigned Certified Nursing Assistants, who provided care for the past 72 hours prior to the incident were interviewed and they denied fall or trauma to the site of injury. Certified Nursing Assistant #1 stated they transferred Resident #26 to bed without assistance and without a lifting device. The Summary Report concluded that the investigation revealed during re-enactment that injury may have been sustained during the process of transfer.<br><br>The hospital Discharge summary dated [DATE] documented Resident #26's primary diagnosis was closed fracture of right tibia and fibula. Resident was admitted under orthopedic surgery. Non-operative management was decided by the resident and the family. A cast was applied, and Resident was discharged back to the nursing home.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 02/25/2025 at 11:02 AM, Physical Therapist #1 was interviewed and stated Resident #26 required a mechanical lift for transfer since their assessment on 09/14/2022. They stated Resident #26 had no change in functional status and had always required two (2) staff assistance and mechanical lift during transfers.<br><br>On 02/21/2025 at 10:13 AM, Certified Nursing Assistant #3, who was assigned to Resident #26 on 08/22/2024 and 08/23/2024 during the 7:00 AM - 3:00 PM shift was interviewed and stated they last transferred Resident #26 out of bed on 08/23/2024 and had not noticed any injury to the Resident. Certified Nursing Assistant #3 stated that prior to Resident #26 sustaining a fracture, they transferred Resident #26 with two (2) staff without using a mechanical lift.<br><br>On 02/21/2025 at 11:00 AM, Certified Nursing Assistant #4 was interviewed and stated they had assisted Certified Nursing Assistant #3 in transferring Resident #26 on 08/23/2024 without using a mechanical lift. They stated they were not aware that Resident #26 required a mechanical lift for transfers.<br><br>On 02/21/2025 at 4:08 PM, Certified Nursing Assistant #1, who was assigned to Resident #26 on 08/24/2024 during the 3:00 PM - 11:00 PM shift, was interviewed and stated they transferred Resident #26 alone on 08/24/2024. They stated they called for help that evening and one of the staff stated Resident #26 was small and could be transferred alone. Certified Nursing Assistant #1 declined to mention the name of the staff they contacted for help. Certified Nursing Assistant #1 stated Resident #26 had been in their assignment and is familiar with their transfer status. They stated they checked the instructions and was aware Resident #26 should be transferred by two (2) staff with mechanical lift.<br><br>On 02/24/2025 at 3:33 PM, Licensed Practical Nurse #1 was interviewed and stated that instructions on how to transfer residents and other plan of care are in the Certified Nursing Assistant Accountability Record. Certified Nursing Assistants must check the accountability record before providing resident care every shift. They stated they give report at the start of shift to let the Certified Nursing Assistants know what is expected of them and remind them to check their accountability record and ask questions or if they need any assistance. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 did not report they needed assistance with Resident #26 and was not assisted by any staff during the shift. Licensed Practical Nurse #1 further stated that they sometimes make rounds if they are less busy with medication administration and documentation, to monitor how Certified Nursing Assistants are giving care to the residents and to provide assistance and directions as needed.<br><br>On 02/21/2025 at 11:10 AM, Registered Nurse #2, was interviewed and stated that Resident #26 was assessed on 08/26/2024 with discoloration and swelling to the right leg and the x-ray report indicated fracture of right tibia and fibula. They stated they initiated the investigation and found out that Certified Nursing Assistant #1 did not follow the care plan when transferring Resident #26.<br><br>On 02/24/2025 at 10:21 AM, Assistant Director of Nursing #2 was interviewed and stated they assessed Resident #26 on 08/26/2024 and the site of injury was consistent as if the injury was sustained during a transfer. They stated Resident #26 has a leg contracture and required mechanical lift for transfers. They stated based on the investigation, Certified Nursing Assistant #1 transferred Resident #26 without assistance from any of the staff, and that caused Resident #26's injury to the right leg.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 02/24/2025 at 10:58 AM, the Medical Director was interviewed and stated they evaluated Resident #26 on 08/26/2024 for leg fractures. They stated Resident #26 had no report of fall and is not able to move themselves in bed and needs help with repositioning. The Medical Director stated Resident #26 had osteoporosis and the leg fracture could have been caused by trying to move the Resident's contracted leg.<br><br>On 02/25/2025 at 11:18 AM, the Director of Nursing was interviewed and stated Resident #26's injury might have occurred when Certified Nursing Assistant #1 transferred Resident #26 without help from another staff. The Director of Nursing stated, during the investigation, Certified Nursing Assistant #1 re-enacted the transfer. Certified Nursing Assistant demonstrated that Resident #26 was lifted from under both armpits and was pivoted from chair to bed which could have caused the leg fracture.<br><br>10 NYCRR 415.12(h)(2) |