

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Elderwood at Ticonderoga		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Adirondack Drive Ticonderoga, NY 12883	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47140</p> <p>Based on record review and interviews during a recertification and abbreviated survey (Case #NY00307330), the facility did not ensure that a thorough and accurate investigation was conducted after an injury of an unknown origin was observed for one (Resident #48) out of three residents reviewed for incident investigations. Specifically, when Resident #48 was observed with bruising to their right eye on 12/07/2022 which was of an unknown origin, the facility did not conduct an investigation.</p> <p>This is evidenced by:</p> <p>Resident #48 was admitted to the facility with diagnoses of unspecified dementia, dysphagia (difficulty swallowing) and cognitive communication deficit. The Minimum Data Set (an assessment tool) dated 4/30/2024, documented the resident had severe cognitive impairment for decisions of daily living, could usually be understood and could usually understand others.</p> <p>The Policy and Procedure titled Abuse Prevention, Identification, Investigation, Protection and Reporting, last revised 4/30/2024, documented upon identification of an observed act or outcomes of abuse, mistreatment, a suspicious injury, a sudden or unexplained change in behaviors or expressions of fear, feelings of guilt or shame that could be an indication of abuse, mistreatment, neglect, exploitation or misappropriation of resident property, all staff members were required to report the observation immediately to their direct supervisor, the Director of Nursing or the Administrator so an investigation could begin. The investigation was to include identification and interview of all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation. A complete and thorough documentation of the investigation should be maintained.</p> <p>A Nursing Progress Note dated 12/07/2022 documented that nursing staff attempted to update Resident #48's family member regarding bruising to their right eye but was unable to reach them and had left a message to return the call.</p> <p>On 7/11/2024, review of the facility's Electronic Medical Record did not reveal a nursing assessment or progress notes which documented the bruising Resident #48's eye.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Elderwood at Ticonderoga		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Adirondack Drive Ticonderoga, NY 12883	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Incident Report dated 12/07/2022 was completed by Registered Nurse #3 on 7/15/2024. The Incident Report documented that an area of ecchymosis (discoloration of the skin due to the breaking of blood vessels) was noted in the corner of resident's right eye and the resident was unable to state what happened to them. The report noted that the location of the injury could have been self-inflicted while the resident was putting on their glasses. The report documented no witnesses found.</p> <p>A Nursing Documentation Note dated 12/07/2022 marked as Late Entry was entered on 7/15/2024 at 8:51 AM by Registered Nurse #3 documented that a small ecchymosis area was noted in the corner of the resident's right eye. The resident was unable to state how the injury occurred and denied pain or discomfort. The note documented that the Nurse Manager tried to call the resident's family member.</p> <p>During an interview on 7/15/2024 at 11:00 AM, Nursing Home Administrator #1 stated they had tried to locate an investigation into bruising of unknown origin to Resident #48's face and was unable to find evidence that investigation was conducted. They stated that an Incident Report was completed that morning based on Registered Nurse #3's recollection of what had occurred at the time.</p> <p>During an interview on 7/15/2024 at 12:40 PM, Registered Nurse #3 stated they had completed an Incident Report earlier that day based on their recollection of the bruising to Resident #48's eye in December 2022, however, that it was difficult to recall all the details of the incident given that how long it had been since it occurred. They stated they had assessed the resident at the time but did not document their assessment. They stated that if anyone had touched (Resident #48) they would have yelled out, therefore they did not think the injury could have been caused by any potential abuse. They stated they assumed the other nurse on the unit who was working at the time had documented about the resident's bruising. They stated nursing assessments should always be documented. They stated from what they recalled, the resident had a very small bruise on their right eye which looked older and was faded. They stated they thought the bruise could have been caused by the resident's glasses and also the resident had a behavior of laying their head on tables, but the resident could not say what had happened to them. They stated they did not believe an investigation of the injury was conducted. They stated when a resident was observed with an injury of an unknown origin, an investigation should be initiated immediately to determine what may have caused the injury and rule out abuse. They stated that investigation of the incident could include taking statements from staff on various shifts who or interviewing any alert and oriented residents who may have witnessed something. They stated that injuries of unknown origin should be reported within two hours.</p> <p>During an interview on 7/15/2024 at 1:05 PM, Director of Nursing #1 stated injuries of an unknown origin should be investigated immediately if the resident was not able to state what happened to them. They stated a nursing assessment of any injuries should be completed and documented in the Electronic Medical Record. They stated that the intent of the investigation was to try to determine a root cause of the injury in order to implement interventions to try to prevent recurrence and to rule out that abuse that could have occurred. They stated they would conduct interviews, review the residents record, and any camera footage that may have captured what occurred.</p> <p>10 New York Codes, Rules and Regulations 415.4(b)(3)</p>		