

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Chautauqua Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10836 Temple Road Dunkirk, NY 14048	
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 - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49438</p> <p>Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00337078) the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #1) of 3 residents reviewed. Specifically, Resident #1 was left alone in the bathroom while attached to a sit to stand lift and had a fall that resulted in a bruise to the side of their head.</p> <p>The finding is:</p> <p>The policy and procedure titled, Accident/Incident Investigation and Prevention, revised on 6/2023, stated the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.</p> <p>The policy and procedure titled Interdisciplinary Care Planning, revised on 4/15/2024, stated the comprehensive care plan and Kardex (guide used by staff to provide care) must always be current and accurately reflect the resident's status. The Care plan/Kardex must always be reviewed by staff prior to initiating resident care. Additionally, Care Plans are accessible in electronic format to any person involved in care of the resident. Direct care staff has easy accessibility on the touch screen should they require access to the comprehensive Care Plan.</p> <p>Resident #1 had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness of one side of body) affecting right dominant side, malignant neoplasm (a fast-growing cancer) of the brain, and vascular dementia. The Minimum Data Set (a resident assessment tool) dated 2/15/24 documented Resident #1 was cognitively intact was understood and understands.</p> <p>The comprehensive care plan dated 8/16/21 documented Resident #1 was at risk for falls related to cognition, mobility, and right sided weakness. An intervention was added on 3/9/22 stating Resident #1 must be supervised by staff while on the toilet.</p> <p>Additionally, the comprehensive care plan had an intervention dated 10/4/22 that Resident #1 required a sit to stand lift with 2 persons assist for all transfers</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335485
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The current Kardex with a print date of 7/25/24 still reflected the safety interventions (that were in place at the time of the fall) to include the resident must be supervised by staff while on the toilet and required a sit to stand lift with 2 persons assist for all transfers.</p> <p>Review of ACTS Complaint/Incident Investigation Report dated 3/6/24 at 3:10 PM documented Resident #1 was found lying on the floor in their bathroom between the toilet and wall, had the sling from sit to stand lift around their waist, only attached on one side. Certified Nurse Aide #1's statement documented they entered the bathroom and found the resident lying on the floor in their urine, resident was alone in the bathroom upon entering.</p> <p>During a revie completed on 8/12/24 of Safe Patient Handling Standing Lift Skills Competency dated 3/13/24 documented Certified Nursing Assistant #1 was educated by Registered Nurse #1 on locking breaks and using a second assist during transfers. This education was provided to Certified Nursing Assistant #1 when a break in care plan was identified after Resident #1's fall.</p> <p>The Nurse Progress Note dated 3/6/24 at 6:45 PM, written by Registered Nurse #3, documented Resident #1 was complaining they were unable to move their right knee, and had pain in their right hip and knee. The doctor was notified, and Resident #1 was transported to the ER (emergency room) for evaluation.</p> <p>The Hospital Discharge summary dated 3/6/24 at 10:12 PM documented Resident #1 was seen in the emergency room after a fall. Resident #1 was diagnosed and discharged with a subgaleal hematoma (an accumulation of blood within the layers of soft tissue of the head between the connective tissue and membrane tissue that covers the surface of the skull) and hip pain.</p> <p>During an interview on 7/25/24 at 10:08 AM, Licensed Practical Nurse #1 stated that on 3/6/24 a certified nursing aide came and got them because Resident #1 was found on the floor. Registered Nurse #1 was then called and came to assess the resident.</p> <p>During an interview on 7/25/24 at 10:48 AM, Certified Nursing Assistant #1 stated that on 3/6/24 they assisted Resident #1 onto the toilet using the sit to stand lift. They then handed the resident their call bell, closed the door and exited the resident's room. When they returned to answer the call bell, Resident #1's belt was unbuckled, and they were lying half on the floor. Certified Nursing Assistant #1 stated they were not aware that Resident #1 had a care plan intervention in place to be supervised while on the toilet at the time of the fall. Certified Nursing Assistant #1 stated they don't check care plans very often. They stated they we're re-educated on the incident by Registered Nurse #1 and were educated on how to properly use the sit to stand lift.</p> <p>During a telephone interview on 7/25/24 at 10:57 AM, Registered Nurse #2 stated they recalled the incident and assessed Resident #1 Resident #1 in the bathroom and then again once they were in bed.</p> <p>During an interview on 7/25/24 at 11:45 AM, Licensed Practical Nurse #2 (former Unit Manager) stated they were alerted to the resident falling and went down to assess the situation. They stated Registered Nurse #1 was already in the room, so they started the investigation. Licensed Practical Nurse #2 stated when a resident needs to be supervised that means the resident must be within eyesight of the staff.</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 - Few</p>	<p>During an interview on 7/25/24 at 12:40 PM, Resident #1 stated they were put onto the toilet with the sit to stand lift and left there by themselves. They were attempting to grab a urinal that was on the railing and could not reach it. Resident #1 stated they then unhooked the belt on the lift and attempted to reach further causing them to fall off the toilet. Resident #1 stated they were able to grab the call bell and ring it. Two aides then came into the room and found them on the floor.</p> <p>During an interview on 7/25/24 at 1:59 PM, the Director of Nursing stated they would expect Certified Nursing Assistants to check the Kardex prior to providing care to a resident. They should be checking the Kardex's daily. The Director of Nursing stated supervision to them would be within eyesight or ear shot. The Director of Nursing stated that if there was a break in care plan there could be injury or possible death to a resident. The Director of Nursing stated that if a break in care plan was found, they would expect education to be provided to that staff member.</p> <p>During an interview on 7/26/24 at 9:49 AM, Registered Nurse #1 (Educator Inservice Coordinator) stated they expected certified nurse aides prior to read the care plan prior to providing care to a resident and if they don't know what they're doing, to ask for help. Registered Nurse #1 stated certified nurse aides were taught to check care plans daily though their expectation would be for the certified nurse aides to check the care plans at least once a week for any changes. Registered Nurse #1 stated it was important for staff to check the care plans regularly because it spells out how to provide care for that resident. If they were not checking them regularly then breaks in care plan could occur resulting in abuse, falls, accidents, and indents. Registered Nurse #1 stated Certified Nurse Aide #1 was educated on 3/13/24 for failure to lock breaks and not using a second assist for this incident, this was a break in Resident #1's care plan.</p> <p>10NYCRR 415.12(h)(1)</p>		