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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER: Wayne Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 3530 Wayne Avenue Bronx, NY 10467	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on observations, record review and interviews conducted during the Recertification Survey from 01/13/2025 to 01/21/20245, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was evident for 1 (Resident #187) of 35 total sampled residents. Specifically, Resident #187 did not receive monitoring and maintenance of the peripheral intravenous site for the infusion of fluids and antibiotics. The finding is: The facility's policy and procedure titled Administration, Monitoring and Maintenance of Intravenous Therapy, undated, documented that the facility shall have a system in place for the administration, monitoring and maintenance of Intravenous therapy. Intravenous tubings shall be labeled with the date and time change. The Intravenous site and dressing shall be labeled with the date and time the needle/catheter was inserted, the gauge of the needle/catheter, and the date and time the dressing was changed. The nurse or physician who changes a dressing after the initial insertion must relabeled the dressing with the date of the initial insertion and needle gauge, and the date the dressing was changed. All must be documented on the medical record. The nurse must notify the physician to change the peripheral intravenous needle/catheter or heparin lock after 3 days (72 hours). Transparent dressings shall be changed and relabeled every 72 hours as per procedure. At the time of the dressing change the insertion site is to be observed for signs of phlebitis, infection, or infiltration and the insertion site cleansed per procedure. Resident #187 was admitted with diagnoses that include Hypertension and Peripheral Vascular Disease The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #187 had severely impaired cognition skills for daily decision making. On 01/15/25 at 11:16 AM, Resident #187 was observed in bed with an undated dressing covering a left upper extremity peripheral intravenous catheter. On 01/15/25 at 02:52 PM, Resident #187 was observed in bed with an undated dressing covering a left upper extremity peripheral intravenous catheter. On 01/16/25 at 12:18 PM, Resident #187 was observed in bed with an undated dressing covering a left upper extremity peripheral intravenous catheter. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/25 at 1:10PM Resident #187 was observed in bed with an undated dressing covering a left upper extremity peripheral intravenous catheter in the presence of Registered Nurse #4, the unit manager. The Physician Order dated 01/11/2025 at 5:29PM, documented for the administration of Dextrose 5% and 0. 45% Sodium Chloride intravenous solution to be infused at 60 cubic centimeters per hour for 72 hours. The Physician Order dated 01/11/2025 at 5:31PM, documented for the administration of Zosyn 3.375 grams/50mililiters in Dextrose intravenous piggyback every 8 hours for 5 days. The Physician Order dated 01/16/2025 at 2:21PM, documented for the treatment of the Peripheral Intravenous Line: Dressing Change Now for 1 treatment then every 3 days and as needed. The Resident Medication Administration Record dated January 2025 documented that Resident #187 received administrations of Zosyn 3.375 grams/50ml in Dextrose intravenous 01/11/2025 thru 01/16/2025. The Resident Medication Administration Record dated January 2025 documented that Resident #187 peripheral intravenous line dressing change treatment was initially performed on 01/16/2025. The Care Plan Activity report dated 01/11/2025, documented that the first dose of Zosyn was administered intravenously 01/11/2025. The Care Plan Activity report dated 01/16/2025, documented that the peripheral intravenous line was removed 01/16/2025. Prior to 01/16/2025, There is no documented evidence that the peripheral intravenous line dressings were changed nor is there documented evidence that the peripheral intravenous insertion site was assessed. On 01/16/25 at 1:20PM Registered Nurse #4, the unit manager, was Interviewed and stated that the intravenous infusion through the left peripheral line was started on 01/11/2024 for resident #187, but until today the dressing at the insertion site had not been changed. Registered Nurse #4 also stated that the nurse who inserted the peripheral intravenous line was responsible to date the dressing and that the dressing is to be changed and dated every 72 hours per the policy and procedure. Registered Nurse #4 also stated that the intravenous medication was infused three times a day and no one observed that the dressing was not dated and had not been changed. The dressing change should have been documented in the progress notes and the order for the dressing changes should have been entered at the initiation of the IV medication, but neither are in the computer system. Registered Nurse #4 further stated that it is their responsibility to round daily and assess that the Intravenous dressings are changed, dated and that the documentation and orders are entered into the electronic medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/17/25 at 10:09 AM, The Director of Nursing was interviewed and stated that regarding peripheral intravenous lines, the insertion site is rotated every 3 days and that collaborates with the dressing change so essentially the dressing should be changed every 3 days. The Director of Nursing also stated that the ideal practice is to date the dressing when it is changed and enter that date in the Treatment Activity Record with documentation of the insertion site assessment. The physician should be made aware if there is difficulty with the insertion and the physician order be for dressing changes then should be changed to every 5 days. The Director of Nursing further stated that outside of the nurse who changes the dressing, the nurse manager should be looking for evidence of this during their daily rounds and when they run the Treatment Activity Report at the end of each day. 10NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on observation, record review interviews, and record review conducted during the recertification and complaints (NY00342658) survey from 01/13/2025 to 01/21/2025, the facility did not ensure a resident remained free of accident hazards. This was evident for 1 (Resident #290) of 3 residents reviewed for accidents out of 38 sampled residents. Specifically, Resident #290 fell out of bed and sustained a 2.5 cm skin tear to the forehead during care when one staff provided care without a second staff member. The Findings are: The facility policy and procedure titled Accident Prevention Reporting and Investigation, last revised June 6, 2021, documented that the purpose is to provide an environment free from accident hazards for the safety of the residents and staff. Identify the cause of an accident and obtain appropriate care for the injury. Resident #290 was admitted to the facility with diagnoses that include Hemiplegia or Hemiparesis, Respiratory Failure, and Dependence on respirator [ventilator] status. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #290's cognition as severely impaired and never/rarely made decisions. The resident was dependent and requires one person assistance with personal care and two persons for bed mobility. The Comprehensive Care Plan for Falls/Injury, initiated on 12/31/2020 and last revised on 05/19/2024, documented that while certified nursing assistant #3 was providing care, the unit nurse was alerted that the resident had fallen out of bed. The Resident Nursing Instruction for Certified Nurse Aid dated 09/25/2023 documented that Resident #290 is dependent and requires two-person assistance for bed mobility and one-person assistance for personal hygiene. The Certified Nursing Assistant (CNA) Documentation History Detail dated 05/01/2024 to 05/31/2024 documented personal hygiene support provided one-person physical assistance. The Nursing Note dated 05/20/2024 at 3:37 PM documented that on 05/19/2024 at 9:40 AM, certified nursing assistant # 3 called the writer's attention to Resident #290's room. The writer immediately went to the room and found out the resident was on the floor. Upon assessment, Resident #290 was conscious and alert; a skin tear was noted on the left side of the forehead with slight swelling measuring 2.5cm x 1.0cm. The area was cleansed with normal saline, and Steri strips were applied. The nursing supervisor was made aware, and the physician and the family were notified. The facility Resident Incident/Accident Report dated 05/19/2024 at 9:40 AM documented that Certified Nursing Assistant # 3 stated that while giving care to Resident #290, the resident was turned to the left side, and the resident got agitated and fell out of bed. The resident was unable to state what had happened. Resident # 290 sustained a 2.5 cm x 1 cm abrasion and skin tear to the forehead. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Summary of Occurrence concluded that Certified Nursing Assistant #3 did not intentionally harm Resident #290. However, given the circumstances and information gathered, the incident met the criteria of Department of Health incident reporting for not following the plan of care. On 01/17/2025 at 3:14 PM, Certified Nursing Assistant #3 was interviewed and stated that I was providing care for Resident #290, who was on a ventilator. I turned the resident, and the resident started shaking and then fell . It was only me taking care of the resident. I do not know if they changed it now, but when I looked at the computer, it was one person's assistant for care. I did not get the time to call someone to assist me when the resident became agitated and was shaking. I went to inform the nurse immediately. The nurse and the manager came to see the resident before we put the resident back to bed. On 01/16/2025 at 2:54 PM, Registered Nurse #3 was interviewed and stated that certified nursing assistant #3 called that Resident #290 was on the floor. I assessed the resident; the resident had a small abrasion on the forehead. I called the supervisor and reported to the doctor. We transferred the resident back to bed after the assessment. On 01/21/2025 at 11:40 AM, the Director of Nursing was interviewed and stated that Resident #290 fell during care. They investigated the fall and concluded that there was no intentional harm, but the incident met the criteria for Department of Health reporting for not following the plan of care. Certified Nursing Assistant # 3 was sent home immediately and was suspended for three days. Certified Nursing Assistant # 3 was educated upon return. Resident #290 requires two-person assistance for bed mobility and one person for personal hygiene. Certified Nursing Assistant # 3 was providing care and tried to turn the resident, but the resident became agitated and fell . They will increase the staff for personal hygiene to coincide with the care for bed mobility. 10 NYCRR 415.12(h)(1)