| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335537 | A. Building<br>B. Wing | 03/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Rutland Nursing Home, Inc | 585 Schenectady Ave<br>Brooklyn, NY 11203 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 40565<br><br>Based on record review and interview conducted during the Recertification and Complaint Survey (NY00369624 and NY00354365) conducted from 03/24/2025 to 03/31/2025, the facility did not ensure residents received adequate supervision and assistance devices consistent with resident's needs, goals, and care plan to prevent accidents. This was evident for 2 (Residents #108 and #260) of 2 residents investigated for Accidents out of 39 total sampled residents. Specifically, (1) Resident #108 fell and hit the back of head causing injury to left eye orbital while being transferred to bed by 2 Certified Nursing Assistants, and 2. (2) Resident #260 who required a harness while out of the crib and in a wheelchair was removed from wheelchair with harness and placed in a Gerichair without any harness causing Resident #260 to move and fall to the floor.<br><br>The findings include:<br><br>1. Resident #108 has diagnoses that included Cerebrovascular Disease (medical term for stroke, interruption in the flow of blood to cells in the brain), Non-Alzheimer's Dementia (memory impairment in the elderly), and Hemiplegia (one sided weakness of the face, arm, and leg).<br><br>The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #108 had severely impaired cognitive skills for daily decision making and was totally dependent on staff for all Activities of Daily Living.<br><br>The Comprehensive Care Plan for Fall dated 04/2023 documented that Resident #108 had a history of falls, or at risk for fall or injury. Goals included that Resident will be free of falls/injury, minimize risks of falls/injury (personal-environmental). Interventions included provide on-going assessment of risk factors, orient frequently; refer to Rehab for Occupational/Physical Therapies, and teach transfer techniques.<br><br>The Nursing Progress note dated 1/20/25 documented that Resident #108 fell and hit the back of their head on the floor while being transferred to bed by 2 Certified Nursing Assistants.<br><br>The Physician's order dated 01/02/2025 documented transfer resident to hospital status post fall.<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 - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The document titled Investigative Incident Report dated 01/21/2025 documented that on 1/20/25 during the evening shift (5:15pm), two Certified Nursing Assistants were transferring Resident #108 from the chair to bed using Hoyer lift when resident fell . Resident #108 was transferred to hospital Emergency Department for further evaluation. On 1/21/25 at approximately 2:00 pm, Director of Nursing was notified that resident sustained an acute fracture of the left orbit.<br><br>The Resident Incident/Accident - Supervisor's Investigation Report dated 1/26/2025 documented that the contributing Factor to Resident #108's fall and injury was poor transferring technique and use of equipment.<br><br>The Axial Computed Tomography (CT) images (X-Ray photograph) results dated 01/21/2025 documented that Resident #108 had Periorbital soft tissue (tissue surrounding left eye) swelling and laceration on the left side; intra-orbital emphysema (fluid) on the left side; Acute comminuted fractures of the lateral wall of the left orbit; Fracture extends into the frontal skull on the left side.<br><br>On 03/27/2025 at 03:31 PM, Certified Nursing Assistant #3 was interviewed and stated that they were assisting the Certified Nursing Assistant assigned to Resident #108 with transferring Resident #108 with the Hoyer lift on the day of incident. Resident #108 was in a Geri-chair and the Hoyer lift canvas sling had already been placed underneath Resident #108 by the previous shift. Certified Nursing Assistant #3 also stated the sling was checked by the two Certified Nursing Assistants transferring the resident, and hooked up to the Hoyer lift, and Resident #108 was moved up in the chair and chair placed close to the bed. Resident #108 slid down to the floor while being transferred, and their head was hanging off of the sling and resting on the floor while their body was on the bed. Certified Nursing Assistant #3 stated that Resident #108 was not fidgeting during the transfer and the sliding movement to the floor happened very fast. Certified Nursing Assistant #3 was unable to explain or demonstrate how the Hoyer lift canvas sling was placed under Resident #108 when the fall occurred. Certified Nursing Assistant #3 stated that they had in-service on the use of the Hoyer lift before the accident and after the accident occurred but could not explain the instruction given on placement of Hoyer Lift canvas sling.<br><br>On 03/27/2025 at 03:36 PM, Certified Nursing Assistant #4 was interviewed and stated that they were on one-to-one observation with another resident on the unit when Resident #108 was reportedly fell off from Hoyer. Certified Nursing Assistant #4 stated that they were told that Resident #108 fell from the Hoyer lift during transfer but was not present in the room when the incident occurred. Certified Nursing Assistant further stated that they were given training on the use of the Hoyer lift before the accident and shortly after the incident but could not remember the instruction given on the placement of the Hoyer lift pad.<br><br>On 03/28/2025 at 09:42 AM, Certified Nursing Assistant #5 was interviewed and stated that the representative of the company that supplied the Hoyer lift came to give in-service, but no demonstration was given, they just talked them through it and gave them a website to watch the video. Certified Nursing Assistant #5 stated that no specific instruction was given on whether to cross the strap, but they will normally cross it to ensure resident is properly fixed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/28/202525 at 10:07 AM, Certified Nursing Assistant #6 was interviewed and stated that they have been given in-service on the use of Hoyer lift but cannot remember if they were specifically educated how to place the sling, they know if the resident is small the sling's straps should be crossed to prevent resident coming off. Certified Nursing Assistant #6 stated that they were educated that the Hoyer lift should always be used with two staff assist.<br><br>On 03/27/2025at 03:45 PM, Licensed Practical Nurse #3 was interviewed and stated that they were on the floor on the day of the accident but did not witness Resident #108's fall. Licensed Practical Nurse #3 also stated that when they were called to the room, Resident #108 was observed hanging on the Hoyer lift canvas sling with their head on the floor. Licensed Practical Nurse #3 stated that they thought the strap was not crossed when Resident #108 was hooked to the Hoyer lift, but the pad should have been crossed. Licensed Practical Nurse #3 also stated that they have since been instructed that the strap should be crossed when transferring resident.<br><br>On 03/27/2025 at 03:58 PM, Licensed Practical Nurse #4 was interviewed and stated that two Certified Nursing Assistants were in the room transferring the resident when one of them came to notify them that Resident #108 was hanging from the Hoyer Lift. Licensed Practical Nurse #4 also stated that when they entered Resident #108's room, they observed that one of their feet was in the canvas, and the rest of Resident #108's body was on the floor. Licensed Practical Nurse #4 further stated that Certified Nursing Assistant #3 reported that Resident #108 slipped off the canvas. Licensed Practical Nurse #4 stated that the Hoyer lift canvas sling was not crossed under the legs of Resident #108 which could have caused Resident #108 to slip off the sling easily. Licensed Practical Nurse #4 also stated that when the staff was initially given training on the use of the sling, they were told not to cross the straps under the resident's leg, but after the incident they were told to cross it to prevent residents from sliding off.<br><br>The Certified Nursing Assistant assigned to Resident #108 is no longer employed at the facility and attempts to contact them on 03/27/2025 at 04:10 PM and on 03/28/25 at 08:58 AM were unsuccessful.<br><br>On 03/28/2025 at 09:00 AM, Registered Nurse #3 was interviewed and stated that they got the call that Resident #108 fell , went in to check and observed Resident #108 lying on their back on the floor. Registered Nurse #3 also stated that the Certified Nursing Assistants reported that Resident #108 slipped out of Hoyer lift canvas sling and fell on the floor. Registered Nurse #3 further stated that they did not know what instructional training was given to the Certified Nursing Assistants regarding placement of Hoyer lift canvas slings during transfer of residents.<br><br>On 03/28/2025 at 09:13 AM, the Staff Development Coordinator was interviewed and stated that when the facility got the new Hoyer lift, the company that supplied the equipment came in to educate the staff. The Staff Development Coordinator also stated they educated the staff before they started using the equipment and they continue to educate staff thereafter, and on an annual basis and periodically check for competency and staff are re-inserviced when there is an incident. The Staff Development Coordinator further stated that from the report given and return demonstration by the assigned staff, Resident #108 was not placed properly on the Hoyer lift canvas sling, which caused Resident #108 to fall off the sling during transfer. The Staff Development Coordinator stated that staff were adequately educated on proper placement of canvas sling and use of Hoyer lift before and after the accident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/28/2025 at 11:56 AM, the Senior Associate Director of Nursing was interviewed and stated that they have an educator doing periodic in-service to staff on the use of equipment, Managers are on the floor to monitor that staff are competent, and if any staff is noted not to be competent they are given re- inservice. The Senior Associate Director of Nursing also stated that some staff are not comfortable even with the in-service, and they try to re-educate the staff several times. The Senior Associate Director further stated that based on return demonstration by the involved Certified Nursing Assistants during the investigation, Resident #108 fell backward indicating the resident was not properly placed on the sling and staff did not securely control the resident's body on the sling, using poor transfer technique.<br><br>On 03/31/2025 at 11:29 AM, the Director of Nursing was interviewed and stated it is users' error that caused Resident #108 to fall off the Hoyer lift, and they think that the Certified Nursing Assistants did not properly support the top half of Resident #108's body during the transfer. The Director of Nursing also stated that all Certified Nursing Assistants were given training by the equipment vendor and the facility educator as part of their orientation, and the incident could have been avoided if the Certified Nursing Assistants used appropriate technique to support the resident during the transfer. The Director of Nursing further stated that based on the report that Resident #108 fell from the top of the canvas sling, the lack of support caused the fall.<br><br>On 03/31/2025 at 12:09 PM, the Administrator was interviewed and stated upon review of the investigation with the clinical team, they found out that the Hoyer lift was not malfunctioning, and it was the one of the Certified Nursing Assistants that did not properly support Resident #108 during transfer that caused the fall. The Administrator stated that the Certified Nursing Assistants should have followed the training received and as a result one of the Certified Nursing Assistants was terminated, and the other one was suspended.<br><br>41709<br><br>Resident #260 has diagnoses that include Down Syndrome, Failure To Thrive, and Pulmonary Hypertension.<br><br>The Annual Minimum Data Set assessment dated [DATE] documented that Resident #260 was severely cognitively impaired and required dependent care for all Activities of Daily Living. The Minimum Data set further documented Resident #260 have no fall history.<br><br>During multiple observations from 03/26/2025 at 09:03 AM to 03/31/2025 at 09:00 AM, Resident #260 was observed in constant motion, moving arm and legs, and always making sounds. Resident #260 observed seated in multiple locations such as wheelchair, in crib, in a wheelchair in the hallways, receiving feeding and was never at rest.<br><br>The Comprehensive Care Plan titled Falls/Injury Actual dated initiated 3/12/2024 and last reviewed 9/09/2024 had interventions that included provide ongoing assessment of risk factors, investigate falls, assess judgement/mental status and provide supervision in accordance with needs. Refer to Physical therapy/Occupational Therapy. Resident in crib.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Nursing progress notes dated 9/12/2024 documented Resident #260 is alert and responsive to tactile stimuli. Received out of bed to wheelchair at 7:00am, sleeping on and off with no signs of acute distress. The schoolteacher later reported that the resident accidentally fell off the recliner chair in the playroom while they were doing an activity with Resident #260 and another resident. Resident #260 was assessed with no visible injury, and the doctor and the unit manager notified. Resident was assessed and recommended transfer to the hospital Brookdale for Computed Tomography scan of the head, the resident fell on the right side of head in addition to history of intracranial pressure and shunt. Resident had no loss of consciousness, and the resident remained playful with the staff. Monitoring continued until resident was transferred to Brookdale at 1:40 PM for Computed Tomography scan.<br><br>The Nursing progress note dated 9/12/2024 at 10:30 PM documented Resident #260 was awake and responsive returned from the Emergency Department via ambulance accompanied by two Emergency Medical Attendant and Certified Nursing Assistant. Body check done, seen and evaluated by Medical Doctor, orders in place. Status post fall evaluation, resume diet, medications and feeding as per Medical Doctor's order.<br><br>The Computer Tomography Scan of head results dated 9/12/2024 documented scan of the head without contrast, no evidence of fracture or occlusion, no evidence of mass, midline shift or intracranial hemorrhage, or large territory infarction. Result unremarkable.<br><br>The Nursing progress note dated 09/13/2024 at 4:30 am documented Resident #260 was lethargic, difficulty to arouse, placed on oxygen via Nasal canula Oxygen. Doctor called and made aware continue to monitor closely. Resident #260 resting calmly.<br><br>The Resident Profile/Certified Nursing Assistant Accountability instructions dated 9/2024 documented Resident #260 required total dependent assistance for dressing, elimination, personal hygiene, eating, transfers, oral care, and out of bed in chair with seatbelt.<br><br>The Resident Profile/Certified Nursing Assistant Accountability Record dated 8/2024 documented Resident #260 always required wheelchair seat belt and harness.<br><br>The Nursing Fall Risk evaluations dated 9/16/2024 and 10/25/2024 documented Resident #260 was high risk with a score of 15.<br><br>The Facility Incident Report Summary dated 9/12/2024 documented that on 9/12/2024, Resident #260 was in class when the teacher reported to nursing that Resident #260 fell from armchair to right side, and Resident #260 was examined by medical doctor and was unremarkable. Resident #260 was transferred to hospital for evaluation where a Computer Tomography scan was done and found the shunt was in place with no hydrocephalus.<br><br>Medical progress notes dated 8/9/2024 documented that Resident #260 experienced an episode of altered mental status and sudden respiratory distress suspicious of shunt malfunction.<br><br>Medical admission note dated 1/20/2025 documented resident had Ventricular Peritoneal Shunt revision on 8/29/2024 and latest revision on 9/13/2024.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A statement dated 9/12/2024 written by the Teacher documented that student Resident #260 was sitting on an armchair with another student while learning math numbers. The Teacher documented that they often serve Residents in small group of two to incorporate some social skills. Resident #260 was in the wheelchair and teacher took Resident #260 out of wheelchair and placed Resident #260 in the armchair at about 10:00 am in the playroom. Resident #260 was sitting on an armchair with another student while learning math numbers, which teacher often do to serve residents in small group of two to incorporate some social skills. As they worked with the residents, they noticed another resident was very active and needed to be moved. They picked up that resident to shift onto another chair, and as soon as they did this, Resident #260 moved in the armchair and fell out of the chair to the floor. They immediately picked up Resident #260 and comforted Resident #260. At that point another staff walked by and the nurse came.<br><br>The Teacher involved in the incident was not currently working at the facility and was not available for interview.<br><br>On 03/27/2025 at 09:24 AM, the Speech Therapist was interviewed and stated that they were walking by the playroom when they heard a loud thud and saw Resident #260 on the floor. The Speech Therapist also stated that they saw the teacher pick Resident #260 up from the floor and place Resident #260 back in the chair. The Speech Therapist further stated that Resident #260 was in the Geri chair and was not secured in the chair. The Speech Therapist stated they immediately reported the incident to the nurse on the unit.<br><br>On 03/27/2025 at 09:33 AM, Registered Nurse #6 was interviewed and stated that on the day of the incident was passing by the playroom, going to the back of the school area and noticed that the Teacher was in the playroom with two residents, including Resident #260. Registered Nurse #6 also stated they saw the Teacher standing next to the Ger-chair trying to pick up Resident #260 and told the Teacher to be careful because the Resident #260 was not in wheelchair and is very active. Registered Nurse #6 further stated that approximately two minutes later the Speech Therapist reported that Resident #260 fell to the floor. Registered Nurse #6 stated that when they went into the playroom Resident #260 was in the Teacher's arms, and the Teacher was cradling and soothing Resident #260 who was not crying. Nurse #6 stated that Resident #260 was not crying, and the Teacher stated that Resident #260 fell out of the chair. Registered Nurse #6 stated that they immediately assessed Resident #260.<br><br>On 03/27/2025 at 09:40 AM, Registered Nurse #7 was interviewed and stated that they were informed about the incident regarding Resident #260 and immediately assessed them and found no injury, crying and or other signs of distress at the time. Registered Nurse #7 also stated that they immediately reported to the Medical Doctor, Nurse Manager and Director of Nursing. Registered Nurse #7 further stated that Resident #260 was closely monitored and later that day started crying and had changes in their vital signs. Registered Nurse #7 stated that Resident #260 was sent out to the hospital and return to the unit in no distress, was monitored by staff. Later at night Resident #260 was lethargic, and eventually had respiratory distress, and was taken to the hospital where their Ventricular Peritoneal Shunt was revised due to increased intracranial pressure. Registered Nurse #7 also stated that Resident #260 is super active, full of energy and when taken out of the crib they must be placed in a wheelchair with harness restraints because of their constant movement.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/27/2025 at 09:44 AM, the Pediatric Medical Doctor was interviewed and stated that they examined Resident #260 at the time of the fall and Resident #260 had no visible injury, their vital signs were stable at the time, and they ordered that Resident #260 be transferred to the hospital secondary to a history of Ventricular Peritoneal Shunt. The Pediatric Medical Doctor also stated the Ventricular Peritoneal Shunt is used to treat hydrocephalus, a condition where excessive fluid builds up in the brain, and the shunt is used to drain the excess fluid in the abdomen of resident #260. The Pediatric Medical Doctor further stated they did document all that occurred in the chart including involving the medical examiner to look at the case and they all concluded the fall did not contribute to the later increase in intracranial pressure, leading to replacing the Ventricular Peritoneal Shunt on 9/13/2024 a day after the fall. The Pediatric Medical Doctor stated this was concluded because in the past Resident #260 had the same condition without falls and without trauma.<br><br>On 03/28/2025 at 03:45 PM, the Director of Nursing was interviewed and stated that it was not appropriate for the teacher to transfer Resident #260 from the specialized wheelchair to the armchair that Resident #260 was placed in because Resident #260 is a very active resident and moves constantly. The Director of Nursing also stated that the teachers are trained in working with residents and the Teacher should have known that Resident #260 needed to be placed in the wheelchair with the seatbelt or they needed to stay close to Resident #260. The Director of Nursing further stated that this fall could have been prevented if Resident #260 was not removed from their wheelchair. The Director of Nursing stated that the teacher is not available as they are on Medical Leave.<br><br>On 03/31/2025 at 09:02 AM, the Senior Director of Nursing for Pediatrics and Young Adults was interviewed and stated that Resident #260 is very active and depends on staff to meet all their needs. The Senior Director of Nursing for Pediatrics and Young Adults stated that prior to this incident, the Teacher was allowed to take residents from the bedroom to classroom or playroom, and the Teacher usually works one to one or in groups with the residents. The Senior Director of Nursing for Pediatrics and Young Adults stated that Resident #260 would have been safe with the teacher if on one to one supervision, and the accident could probably have been avoided if the teacher did not take the Resident #260 out of the wheelchair.<br><br>10 NYCRR 415.12(h)(2) |