| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335549 | A. Building<br>B. Wing | 05/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Warren Center for Rehabilitation and Nursing | 42 Gurney Lane<br>Queensbury, NY 12804 |

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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>47140<br><br>Based on record review and interviews during an abbreviated survey (Case # NY00331618), the facility failed to ensure residents were free from neglect. Specifically, Certified Nurse Aide #1 did not follow Resident #3's care plan which included that the resident required physical assistance from two nursing staff to safely complete bed mobility. On 1/15/2024, Certified Nurse Aide #1 attempted to roll the resident while they were in bed without assistance from another nursing staff member. Subsequently, the resident fell on to the floor and sustained fractures to both of their legs. This resulted in actual harm that was not immediate jeopardy for Resident #3.<br><br>This is evidenced by:<br><br>The Policy and Procedure titled Abuse, last revised December 2022, documented the facility prohibited the mistreatment, neglect, abuse of residents/patients, and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends, and residents of the facility. The facility prohibited any exploitation of the mentally and physically disabled resident in the facility. The facility had designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.<br><br>Resident #3 was admitted to the facility with diagnoses of hemiplegia and hemiparesis (muscle weakness or paralysis) affecting left non-dominant side, conversion disorder with seizures or convulsions (a medical condition where the body muscles contract and relax rapidly resulting in uncontrolled shaking) and spastic hemiplegic cerebral palsy (a neurological condition that can present as issues with muscle tone, posture and/or a movement disorder). The Minimum Data Set (an assessment tool) dated 1/12/2024, documented the resident could be understood and could understand others with intact cognition for decisions of daily living.<br><br>The Activities of Daily Living Care Plan, initiated 9/20/2019, documented Resident #3 was dependent on physical assistance from two or more staff to perform transfers, bed mobility (rolling from their left to right side), bathing, toileting, and dressing. The resident was documented as unable to use their own strength for any part of bed mobility. Two or more staff were required to use their own strength to lift or hold the resident's body, arms, and legs during the entire activity.<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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The Facility Investigation dated 1/16/2024 documented Resident #3 required the assistance of two nursing staff to roll the resident in bed from side to side. Upon investigation, it was identified that on 1/15/2024 at approximately 6:45 PM, Certified Nurse Aide #1 failed to follow Resident #3's care plan while attempting to roll the resident in bed without the assistance of another staff. While attempting to roll the resident, the resident's left leg began to slide off the bed then the resident's whole body slid to the floor. Resident #3 was assessed by Registered Nurse #2 following the incident and documented the resident had no pain or discomfort at the time. According to the facility's investigation report, Resident #3 reported pain the following morning on 1/16/2024 at approximately 5:30 AM and was assessed by Registered Nurse Unit Manager #1; the physician was notified, and the resident was transferred to the hospital for further evaluation. Hospital records were obtained which revealed the resident had sustained fractures in both legs.<br><br>An Investigation Statement dated 1/15/2024 documented that Certified Nurse Aide #1 acknowledged they were aware Resident #3's care plan included the resident required two staff to perform care, however, they thought they were capable of providing the care by themself.<br><br>A Radiology Report dated 1/16/2024 documented Resident #3 had a non-displaced fracture of the fibular head (a broken calf bone where the pieces remain aligned and do not move far enough out of place to create a gap) (top of a bone in the lower leg) of their right leg and a femoral diaphyseal (fracture (a break in the thigh bone near its center) and non-displaced fracture of posterior aspect medical distal femoral condyle (base of the femur behind the knee) of their left leg.<br><br>During an interview on 5/20/2024 at 11:30 AM, Resident #3 stated Certified Nurse Aide #1 attempted to turn them by themself. They stated they told Certified Nurse Aide #1 they were not positioned correctly in order to be turned. They stated they noticed their left leg was completely off the bed and then all of sudden they were on the floor. They stated they were frustrated with Certified Nurse Aide #1 because they warned them this would happen. They broke both their legs during the fall and required surgery. They stated both legs had since healed, and they felt safe at the facility. They stated the facility had made sure there were two staff providing their care when they returned from the hospital following the incident.<br><br>During an interview on 5/31/2024 at 1:10 PM, Director of Nursing #1 stated Certified Nurse Aide #1 had received education and completed a return demonstration of how to access resident care plans prior to the incident. They stated the facility was sufficiently staffed when Certified Nurse Aide #1 attempted to provide care to Resident #3 without assistance and they elected to try to do the care on their own. They stated Resident #3 was immediately assessed after they fell on to the floor and initially, the resident reported to be without pain. They stated the on-call physician was notified at the time of the fall and no orders were given to transport the resident to the hospital at that time. They stated the resident was lifted to their bed with a mechanical lift and monitored. They stated the following morning, the resident reported having pain and the on-call physician was notified and gave the order for the resident to be transported to the hospital. They contacted the hospital to follow-up on the resident's condition and were notified the resident had sustained fractures. They stated that facility-wide education was conducted to ensure that all staff could identify how to check the resident's care plan and which residents required the assistance of two staff in order to complete care.<br><br>10 New York Codes, Rules, and Regulations 415.4(b)<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on the following corrective actions taken as of 1/16/2024, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey:<br><br>Certified Nurse Aide #1 was immediately suspended and subsequently terminated following the facility investigation.<br><br>A Nursing In-service titled Comprehensive Care Plan and Kardex Usage was conducted on 1/16/2024 for nursing and therapy staff which included a hand-out, discussion and return demonstration. The in-service was signed off as completed by nursing and therapy staff across all shifts. The facility ran a report of all residents in the building who required the assistance of two staff to perform bed mobility and conducted an audit to ensure staff could identify which residents required two-person assistance.<br><br>95% of facility staff were educated on abuse, neglect and mistreatment related to neglect of care. |