STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Center for Rehabilitation and Nursing	42 Gurney Lane 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews during an abbreviated survey (Case #s NY00337932 and NY00340604), the facility did not ensure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 3 (Resident #s 1, 2, and 3) of 3 residents reviewed. Specifically, the facility did not ensure it revised the residents' care plan to include A) Resident #1's five (5) falls that occurred from 1/09/2024 to 4/25/2024, B) Resident #2's incident of alleged sexual abuse that occurred on 4/18/2024, and C) Resident #3's fall that occurred on 4/7/2024. This is evidenced by: The Policy and Procedure titled, Care Plans - Comprehensive, last revised 10/2019, documented assessments of residents were ongoing and care plans were revised as information about the residents and the residents' condition change. Resident #1: Resident #1 was admitted to the facility with history of falling, malignant neoplasm (cancer) of prostate, and dementia with behavioral disturbance. The Minimum Data Set (an assessment tool) dated 4/17/2024, documented the resident had moderate cognitive impairment. The resident had clear speech, was understood, and usually understood others. Review of the, 1 LN: Initial Event Documentation, (assessment documentation) for Resident #1 documented the resident had a fall on 1/9/2024, 1/25/2024, 2/26/2024, 4/19/2024, and 4/25/2024. Interventions initiated to decrease the risk of falls documented non-skid socks on 1/25/2024, 2/26/2024, 4/19/2024, and 4/25/2024. Review of the comprehensive care plan for Risk for Falls/Has Had an Actual Fall, last revised 5/2/2024, did not document any falls. Care plan interventions/tasks did not document non-skid socks. Resident #2: Resident #2 was admitted to the facility with diagnoses of moderate dementia with mood disturbance, recurrent major depressive disorder, and developmental disorder of scholastic skills. The Minimum Data Set, dated dated dated [DATE], documented the resident had moderate cognitive impairment. The resident had clear speech, was understood, and understood others. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the, 1 LN: Initial Event Documentation, for Resident #2 documented a resident-to-resident incident of inappropriate sexual contact by Resident #2 on 4/18/2024. Review of the, Full QA Report, (incident report) for Resident #2 dated 4/18/2024 at 5:15 PM, documented a resident-to-resident incident. Actions documented the care plan was updated, monitor for further behaviors, and enhanced monitoring. Review of the comprehensive care plan for Exhibits Behavior Symptoms such as inappropriate touching of staff and residents, last revised 3/14/2024, did not document the resident-to-resident incident that occurred on 4/18/2024. Care plan interventions/tasks did not document to monitor for further behavior and enhanced monitoring was not documented. Resident #3: Resident #3 was admitted to the facility with diagnoses of iron deficiency anemia secondary to blood loss, gastrointestinal hemorrhage, and history of falling. The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment. The resident had clear speech, was usually understood, and usually understood others. Review of the, 1 LN: Initial Event Documentation, for Resident #3 documented the resident had a fall on 4/07/2024. Interventions initiated to decrease the risk of falls documented keep front wheeled walker at bedside within reach of the resident. Review of the comprehensive care plan for, Has Had an Actual Fall, last revised 3/24/2024, did not document any falls. Care plan interventions/tasks did not document to keep front wheeled walker at bedside within reach of the resident. During an interview on 6/14/2024 at 12:29 PM, Assistant Director of Nursing #1 stated that when a resident falls or has any other incident, the Registered Nurse assesses the resident and documents the assessment on the, 1 LN: Initial Event Documentation. They stated interventions were initiated at the time of the assessment and then documented on the care plan. During an interview on 6/14/2024 at 2:47 PM, Registered Nurse Manager #1 stated residents were assessed by the Registered Nurse whenever they fell or had any other incident. The nurse then documents the assessment on the 1 LN: Initial Event Documentation. They stated the nurse that does the assessment and initiates interventions should be documenting the interventions on the care plan under interventions/tasks. They stated they were the nurse manager for Resident #s 1, 2, and 3 and ultimately responsible for their care planning. They stated it was not the facility's practice to document the date of each fall on the care plan focus and stated the details of the fall assessment were documented on the, 1 LN: Initial Event Documentation. 10 New York Codes Rules and Regulations 415.11(c)(2)(i-iii)