STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335588	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Chittenango	331 Russell Street Chittenango, NY 13037

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. 46276 Based on record review and interviews during the abbreviated survey (NY00297623), the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and resident choices for 1 of 1 resident (Resident #5) reviewed. Specifically, Resident #5 had an unwitnessed fall, complained of pain the following morning, an x-ray was ordered, the x-ray was completed 10 hours after the resident complained of pain, and results were received 14 hours after they were ordered. Subsequently, the resident was hospitalized and was diagnosed with a right hip fracture. Additionally, the resident was not medicated for complaints of pain. Findings include: The facility policy, Falls Prevention Program, last reviewed 1/2024, documented residents must be assessed in a timely manner for potential causes of falls. The physician would identify medical conditions affecting fall risk and the staff would evaluate and document falls that occurred while the individual was in the facility; for example, when and where they happened and any observations of the event. The Interdisciplinary Team, with the physician's guidance, would follow-up on any associated injury until the resident was stable and delayed complications had been ruled out or resolved. Delayed complications such as late fractures or major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. Resident #5 had diagnoses including pneumonia, chronic obstructive pulmonary disease (lung disease), and muscle weakness. The 5/25/2022 admission assessment documented the resident had moderate cognitive impairment; required partial/moderate assistance of 1 for toileting and sitting to stand position; substantial/maximum assistance of 1 for sitting to standing, chair to bed transfers, toileting transfers; had no previous falls; and had no pain. The Comprehensive Care Plan initiated 5/25/2022 documented Resident #5 was at risk for falls related to limited mobility, weakness, and a history of falls. Interventions included a clutter-free environment; call bell in reach; a safe environment; educate family and resident on what to do if a fall occurs; physical therapy evaluation and treatment; and re-educate on safety precautions when needed. (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	A 5/25/2022 at 10:55 PM Licensed Practical Nurse #9 nursing progress documented Resident #5 was discovered on the floor during last room checks near the far wall. All changes in condition were reviewed with the on-call medical professional. The resident did not present with pain. There was no documented evidence of the results of the telephone assessment review by the on-call medical provider. There were no documented nursing notes from 5/25/2022 at 10:55 PM until 5/26/2022 at 9:38 AM. A 5/25/2022 at 10:55 PM Licensed Practical Nurse #9 fall risk evaluation documented a recent fall, the resident had a history of 1-2 falls over the last 6 months, was confined to a chair, was disoriented, and exhibited loss of balance with standing. The resident was evaluated at a high fall risk. A 5/25/2022 at 10:55 PM handwritten (black ink) Accident/Incident Report completed by Licensed Practical Nurse #9 documented the resident was on the floor near the wall, away from the bed during last checks. The resident stated they were looking for a family member. The level of injury was marked as none apparent in black ink. The level of injury was marked as major injury with a fractured right hip (in blue ink). Additional signatures and titles were illegible and signed on 5/26/2022. On 5/26/2022 at 9:27 AM, Assistant Director of Nursing #12 Interdisciplinary Team Meeting progress note documented a meeting was held for Resident #5. The resident's 5/25/2022 fall and physical and occupational services for the resident were discussed. A 5/26/2022 at 9:38 AM Assistant Director of Nursing #12 assessment documented the resident had a fall on 5/25/2022 at 10:55 PM. The resident was choosing not to ambulate or move their right lower extremity due to pain. The resident could not lift the leg on their own which they were previously able to do. The resident stated the pain was in their femur (thigh bone) and the right hip. There was point tenderness to the femur and hip area. The right upper leg was swollen, and there was no bruising or redness. The physician was notified and ordered X-Rays. A 5/26/2022 at 2:08 PM Licensed Practical Nurse #4 progress note documented the resident demonstrated or verbalized controlled pain levels with current interventions. The resident's right lower extremity range of motion was within normal limits. The note did not document the resident's previous fall, complaints of right leg pain, or orders for an X-ray. A 5/26/2022 at 5:10 PM Physical Therapy evaluation by Physical Therapist #17 documented the resident was seen for an initial evaluation and refused to get out of bed due to right hip pain. A 5/26/2022 at 9:35 PM Licensed Practical Nurse #21 progress note documented the resident demonstrated no signs or symptoms or verbalization of pain or discomfort. The resident's right lower extremity range of motion was within normal limits. The note did not document the resident's previous fall, complaints of right leg/hip pain, or if the X-rays were completed. The 5/26/2022 24 hour report sheet documented the resident was a new admit and was Day 1 of a fall. The 7:00 AM-3:00 PM shift documented awaiting right hip/femur X-ray. The 3:00 PM-11:00 PM shift documented X-ray completed awaiting results. The 11:00 PM-7:00 AM shift documented right hip fracture and right femur fracture. A 5/26/2022 X-ray company's order detail log documented: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 12:16 PM, an X-ray order for Resident #5 was entered (two and one half hours after the X-ray was ordered). - at 6:36 PM the order was dispatched (6 hours after order was entered) - at 7:33 PM, the X-ray order was completed (7 hours after the order was entered). - at 11:16 PM, the X-ray results were uploaded to the facility (almost 4 hours from the X-ray completion). - at 1:29 AM, a verbal report of the resident's X-ray results was given to the facility (15 hours after the X-rays were ordered). The 5/26/2022 X-ray report documented impressions were an acute fracture of the right hip and right femur at the intertrochanteric region (where hip and thigh meet). A 5/27/2022 at 12:16 AM Registered Nurse Supervisor #10 progress note documented the resident's X-ray results were faxed to the facility at 11:17 PM with results of an acute fracture to the right hip. The resident was in extreme pain, more so with movement and the on-call physician was phoned. An order for narcotic pain-relieving medication was obtained, oxycodone 5 milligrams to be given by oral route twice a day for 3 days. The first dose would be taken from the facility's automatic medication dispenser. -At 2:50 AM, Registered Nurse Supervisor #10 documented the resident's X-ray results additionally showed a fracture to the right proximal (closer to center of body) femur at the intertrochanteric region. The 5/2022 Medication Administration Record documented: - extra strength Tylenol 500 milligrams, give 2 tablets by mouth every 6 hours as needed for pain or fever. There was no documented evidence the resident received the Tylenol from 5/25/2022-5/27/2022 when they were discharged to the hospital. - oxycodone 5 milligram capsule, give 1 capsule by mouth every 12 hours as needed for moderate to severe pain. The oxycodone was not documented as administered on 5/27/2022. - the resident's pain level was documented as 0 on all shifts on 5/26/2022 despite registered nurse and physical therapy progress note documenting the resident was in pain. A 5/27/2022 at 7:09 AM Licensed Practical Nurse Unit Manager #3 progress note documented the resident had a change in condition, a fracture to their right hip after a fall on 5/25/2022 and at 7:21 AM, and Physician Assistant #11 was notified. Physician Assistant #11 recommended to send the resident to the emergency room for evaluation. A 5/27/2022 at 7:54 AM Licensed Practical Nurse Unit Manager #3 progress note documented the resident was sent to the hospital via ambulance and the resident's representative was notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/27/2022 hospital emergency room progress note documented Resident #5 arrived at the emergency room at 8:28 AM, had a right hip fracture and their right leg was shortened and externally rotated (in an outward position away from the midline of the body). During an interview on 10/23/2024 at 9:20 AM, Licensed Practical Nurse #9 stated they used to work on the evening and overnight shifts as an agency nurse and did not recall Resident #5. They stated there was not a Registered Nurse Supervisor in the building most of the time they worked. The registered nurses were on-call. If a resident fell , they called the on-call registered nurse who would walk them through an assessment over the phone. The on-call registered nurse asked them to check the resident's arms and legs for injuries. Licensed Practical Nurse #9 stated when the phone assessment was completed, they filled out the accident/incident form. In-person assessments were often delayed as it depended on who the staff was. They were not comfortable filling out the assessment forms as it was beyond their scope of practice. It was not uncommon for a resident's hospital transfer to be delayed. X-ray results were often delayed depending on who the nurse was who obtained the order. During an interview on 10/25/2024 at 11:05 AM, the X-ray company's Operations Manager stated X-rays resulted based on their order input, whether they were placed as routine or as stat (emergent). Resident #5's x-rays orders were received on 5/26/2022 at 12:16 PM as a routine order. They stated on 5/26/2022 at 11:15 PM, the resident's x-ray results were uploaded to the resident's electronical medical records and faxed to the facility at 11:16 PM. During an interview on 10/28/2024 at 11:07AM, Licensed Practical Nurse Unit Manager #3 stated they did not remember the resident and looked up information in the resident's chart. The resident had a fall and suffered a fractured hip, and they sent them to the hospital the morning of 5/27/2022. They stated if a resident had a fall on the off-shifts (3:00 PM-11:00 PM or 11:00 PM to 7:00AM), an on-call registered nurse completed the assessment. Back in 2022 the staff were given calendars to notify them who was on-call. They stated Resident #5's x-rays were not done timely and there were problems in the past with results being delayed. They stated the resident should have been sent to the hospital immediately when the x-rays resulted instead of calling the medical provider for medication. Licensed Practical Nurse Unit Manager #3 stated the resident's transfer to the hospital was not done in a timely manner. During an interview on 10/29/2024 at 2:51 PM, Physician Assistant #16 stated they no longer worked at the facility and did not have access to Resident #5's records. They would occasionally take on-call assignments for the facility as a courtesy. They did not recall receiving a phone call regarding a resident with a hip fracture. Physician Assistant #16 stated if they received a phone call from an off-shift nurse relaying a resident had a fall and results were a fractured hip they would have recommended immediate stabilization and immobilization of the hip, calling 911, and notifying the resident's health care proxy as it was important to send them to the hospital immediately for a surgical consult. Administering a narcotic pain relieving medication only would not be appropriate. A delay in treatment could result in complications such as blood clots or extreme pain. Physician Assistant #16 stated if the resident's transfer to the hospital was 2 days after the fracture occurred, it was not appropriate. This could result in undue pain and suffering for the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 2:18 PM, Registered Nurse #14 stated they no longer worked for the facility, and they were the former Director of Nursing. Registered Nurse #14 stated they did not recall Resident #5 or the incident. They would often be on-call day at night and staff would call them if a resident fell . The Licensed Practical Nurse Supervisor or unit nurse would call, and a registered nurse would have to go into the facility. Phone assessments were done over the phone occasionally if the resident was a high fall risk and care planned as such. If a resident required x-rays and the x-rays were delayed it was unacceptable. They did not think it was appropriate for Resident #5's x-rays to have resulted late or their transfer to the hospital 2 days after a fall. During an interview on 11/4/2024 at 3:35 PM, Registered Nurse #12 stated they were the former Assistant Director of Nursing. Their duties included filling out incident reports if a resident had a fall. If a resident fell during the off shifts, there was supposed to be a Registered Nurse Supervisor available to perform an assessment. They were unsure if assessments were done over the phone or if a registered nurse was in the building at night. Registered Nurse #12 stated they did not recall the resident or the incident. If a resident fell and x-rays were ordered, the x-ray company was portable and the results were often delayed, sometimes up to 1-2 days. Registered Nurse #12 stated If they performed a fall assessment and the resident complained of pain, the criteria for sending a resident to the hospital would be extreme pain, swelling and/or symptoms of limited range of motion. 10 NYCRR 415.12