STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335607	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation Nursing Center	2806 George Street Eden, NY 14057

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47750 Based on observation, interview, and record review conducted during the Standard survey completed on [DATE], the facility did not ensure the system developed for advanced directives was implemented in a manner that was consistent with residents' wishes for one (Resident #8) of one resident reviewed for advanced directives. Specifically, the facility did not ensure Resident #8's advanced directives identifier was consistent with the resident's wishes and provider's orders. The finding is: The policy and procedure titled Advanced Directives effective [DATE] documented advanced directives will be respected in accordance with state law and facility policy. The facility will verify the presence of advance directives or the resident's wishes regarding CPR (cardio-pulmonary resuscitation - artificial ventilation and chest compressions). Additionally, the policy and procedure documented, each resident's advanced directives will be distinguished using at least two resuscitative identifiers; identifiers will be maintained up to date and consistent. The policy and procedure documented the facility will utilize the following resuscitative identifiers to ensure resident's wishes are honored: arm band (red: do not resuscitate, blue: full code (the provision of emergency measures including artificial ventilation and chest compression in the absence of breathing and/or heart rate), electronic medical record order, and MOLST (medical orders for live saving treatment) book. Resident #8 had diagnoses including fracture of the sixth cervical vertebra (a bone in the neck), dementia, and intracerebral hemorrhage (bleeding within the brain). The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #8 was severely cognitively impaired, was always understood, always understands and their advanced directives included do not resuscitate. The comprehensive care plan initiated on [DATE] documented Resident #8 wished for advanced directives: full code. Interventions included check for name/code status band placement every shift, full code band on wheelchair, MOLST (medical orders for live saving treatment) in place. Review of the Medication Review Report (physicians) dated [DATE] documented Resident #8 had an order initiated on [DATE] for a full code. Review of the facility's advanced directives binder located at the nurse's station on [DATE] revealed there was no MOLST (medical orders for live saving treatment) for Resident #8. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of interdisciplinary Progress Notes dated [DATE] through [DATE] revealed no documentation regarding advanced directives and code status. Review of the physician discharge summary note dated [DATE] documented there were no advanced directives currently available. During an observation on [DATE] at 9:00 AM, Resident #8 was sitting in their wheelchair. The wheelchair had a red band attached to it, labeled with Resident #8's name. During an interview on [DATE] at 10:01 AM, Certified Nurse Aide #3 stated a red bracelet indicated do not resuscitate and a blue bracelet indicated to resuscitate a resident. Certified Nurse Aide #3 stated they would notify a nurse if they found a resident was unresponsive. During a telephone interview on [DATE] at 10:02 AM, Resident #8's family member stated Resident #8 wished to be a full code. Resident #8's family member stated Resident #8's MOLST (medical orders for live saving treatment) was at home, and they forgot to bring it to the facility. During an interview on [DATE] at 10:10 AM, Licensed Practical Nurse #2 stated a resident's code status could be found in the electronic medical record provider's order, a sheet in the narcotic count book, the MOLST (medical orders for live saving treatment) form located in the advanced directive binder, or the arm band either worn by the resident or located on their wheelchair or walker. Licensed Practical Nurse #2 stated blue bands indicated full code status requiring CPR (cardio-pulmonary resuscitation) and red bands indicated do not resuscitate code status. Licensed Practical Nurse #2 stated upon admission the code status band was placed on the resident or their wheelchair by the admitting nurse or sometimes the social worker. Licensed Practical Nurse #2 stated if they had found a resident unresponsive, they would have first looked at the code status band and if it was a blue band, they would have begun CPR (cardio-pulmonary resuscitation). Licensed Practical Nurse #2 stated they would then call for assistance of another staff member to check another location regarding the code status. Licensed Practical Nurse #2 stated if the code status band was red when they found an unresponsive resident, then they would not begin CPR (cardio-pulmonary resuscitation), but they would then double check in another place. During an observation and interview on [DATE] at 10:19 AM, Registered Nurse #1 stated there was a red code status band on Resident #8's wheelchair which indicated Resident #8 would not be resuscitated, if needed. Registered Nurse #1 checked the advance directives binder and stated there was no MOLST (medical orders for live saving treatment) in the advanced directive binder for Resident #8. Registered Nurse #1 checked the electronic medical record and stated Resident #8 had an order for full code which meant CPR (cardio-pulmonary resuscitation) should be performed. Registered Nurse #1 stated the code status band on the wheelchair should be blue to match the order because that was Resident #8's life saving measure that they wanted. Registered Nurse #1 stated if the resident was found unresponsive, staff would not have started CPR (cardio-pulmonary resuscitation) and they would have wasted time looking for the MOLST (medical orders for live saving treatment) and then the order. Registered Nurse #1 stated this could have delayed Resident #8 from receiving CPR (cardio-pulmonary resuscitation) if they needed it. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:45 PM, the Social Worker stated they ensured new admissions had a MOLST (medical orders for live saving treatment) in the advanced directive binder unless they wished to remain a full code. The Social Worker stated they or the Registered Nurse Resident Care Coordinator put the code status bands on the resident or their wheelchairs. The Social Worker stated they thought they could rely on a Registered Nurse to place the correct code status band on a resident, but they should have double checked Resident #8's code status band. The Social Worker stated it was important for the code status band to match the orders and the MOLST (medical orders for live saving treatment) because that was the resident's wishes. The Social Worker stated this type of mistake could result in a resident receiving CPR (cardio-pulmonary resuscitation) when they did not want it, or they might not receive CPR (cardio-pulmonary resuscitation) when they wanted it. During an interview on [DATE] at 3:04 PM, the Director of Nursing stated the Registered Nurse Resident Care Coordinator received residents advanced directives upon admission. The Director of Nursing stated both the Registered Nurse Resident Care Coordinator and the Social Worker checked code bands weekly and documented it on an audit sheet. The Director of Nursing stated it was expected that Resident #8's code status band matched Resident #8's order for full code. 10 NYCRR 400.21

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47750 Based on observation, interview, and record review conducted during the Standard survey completed on 5/8/24, the facility did not ensure that the resident's person-centered care plan was implemented to meet the resident's medical and nursing needs for one (Resident #3) of one resident reviewed for positioning. Specifically, a resident who required extensive assist of two for bed mobility was not provided with their planned positioning devices. The findings are: The policy and procedure titled Quality of Care dated 2/2024 documented that residents will have an individualized plan of care that is consistent with their needs. The plan will be implemented upon admission and revised when indicated. It will include interventions that are to be furnished to attain, maintain, or improve the residents highest practicable physical, mental, and psychosocial well-being. The policy and procedure titled Turning & Positioning dated 10/2022 documented ensure to place any adaptive devises after turning and positioning resident. Some devices may be ordered/care planned strictly based upon as needed of resident as they can tolerate. Some devices may be implemented strictly for resident preference/at their request. Additionally, the policy and procedure documented the following information should be noted in the resident's chart: If resident refuses device/positioning care and why. The policy and procedure titled Edema dated 1/13/2022 documented for chronic edema-the care plan may include interventions such as elevation of affected extremities. Nurse staff will monitor residents with edema regularly to observe the effectiveness of interventions. Additionally, the policy and procedure documented nursing staff will implement preventative measures to reduce the risk of edema development and exacerbation. Resident #3 was admitted with diagnoses of unspecified fracture of right lower leg, periprosthetic fracture around internal prosthetic left knee joint, and congestive heart failure. The Minimum Data Set, dated dated dated [DATE] documented Resident #3 understood/understands and had no cognitive impairments. The Comprehensive Care Plan dated 4/16/24 documented Resident #3 had self-care performance and physical mobility deficits. Interventions included the resident was non ambulatory, required extensive assist of two staff members for bed mobility, and a positioning wedge placed beneath their feet while in bed as tolerated (initiated on 4/22/24). The care plan documented the resident was on diuretic therapy (medication used to help remove excess fluid) therapy and had a history of pressure ulcers. The Kardex (guide used by staff to provide care) dated 4/16/24 documented under Equipment/Safety: Positioning wedge beneath feet while in bed as tolerated. Review of interdisciplinary progress notes dated 4/15/24 to 5/6/24 revealed there was no documented evidence Resident #3 refused and did not tolerate the use of the positioning wedges. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an interdisciplinary progress note dated 4/21/24 completed by RN RCC documented the resident had 2 (+) plus pitting edema to both thighs and 1 (+) plus pitting to their left ankle, the medical doctor was advised, and the resident's Bumex (diuretic) was increased. During an observation on 5/3/24 at 9:18 AM Resident #3 was lying in bed, their left leg had 2 (+) plus pitting edema and the bottom of their left foot was pressed firmly up against the footboard. Resident #3 stated it was extremely painful when their feet were pressed up against the foot board. During an observation and interview on 5/7/24 at 9:37 AM, Resident #3 was lying in bed, the head of bed was elevated approximately 50 degrees, the bottom of their left foot was pressed firmly up against the footboard. Resident #3's left lower extremity had pitting edema, and resident was unable to move their left leg independently. Resident #3 stated staff had not asked or placed the wedges under their feet while they were in bed. During an interview and continuous observation on 5/7/24 at 10:50 AM to 11:06 AM, Resident #3's stated they had not been out of bed, and it was noted their left foot was still pressed up against the footboard. Resident #3 was unable to reposition themself to move their left leg from against the footboard. As Resident #3 attempted to reposition themself they grimaced and stated their leg and foot were really bothering them. During an interview on 5/7/24 at 11:11 AM, Certified Nursing Assistant #1 stated they noticed Resident #3's feet were low (against foot board), so they asked Licensed Practical Nurse #1 to assist with boosting resident. They stated Resident #3 can't sit up at a 90-degree angle in bed because of their fractures and boot, so the resident slides down in bed. Certified Nursing Assistant #1 also stated Resident #3 could get sores on their heels or feet from pressing against the footboard of the bed. During an observation and interview on 5/7/24 at 11:45 AM, in the presence of Certified Nursing Assistant #1 there was no wedge positioned under the resident's lower legs and feet. Certified Nursing Assistant #1 was asked if the resident had any care plan interventions to aide in their positioning. Certified Nursing Assistant #1 stated they would have to look through the Kardex. At this time Certified Nursing Assistant #1 reviewed the Kardex and stated, Oh I see that they are supposed to have a wedge under their feet as tolerated. Resident #3 stated they would allow the wedge to be placed under their feet. Certified Nursing Assistant #1 placed wedge, allowing the residents heels to float. Resident #3 stated they were able to tolerate the wedge. During an interview on 5/7/24 at 1:41 PM, Registered Nurse #1 stated Resident #3 slides down in bed and they try to reposition them. Registered Nurse #1 stated Resident #3 had an intervention to place a positioning wedge under their feet to tolerance. Registered Nurse #1 stated it was important to keep their feet elevated off the footboard because it could cause pain or skin breakdown. During an interview on 5/7/24 at 1:55 PM, the Director of Physical Therapy stated Resident #3 had a lot of swelling and they were working on reducing it with nursing. The Director of Physical Therapy stated they were trying to make sure the resident had adequate pressure relief and Resident #3 had no skin issues at the time, but noticed there was one possibly starting with the left heel. The Director of Physical Therapy stated Resident #3's family had brought in wedges and the wedges were added to the resident's care plan to address pressure relief and the family's request. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/24 at 9:57 AM, the Director of Nursing stated if Resident #3 was in pain from their feet against the foot board they would expect staff to attempt to alleviate the pressure and that stated repositioning would help. 10 NYCRR 415.11 (c)(1)