STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335672	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Health Services Inc	690 West German Street Herkimer, NY 13350

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. 37385 Based on record review and interview during the abbreviated survey (NY00337472), the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 3 residents (Resident #3) reviewed. Specifically, Resident #3 sustained a head injury from a fall and neurological checks were not performed during the time the resident awaited transport to the hospital. Findings include: The Head Trauma Protocol reviewed 3/2007, documented: - the Registered Nurse Supervisor was responsible for notifying the physician of any resident with head trauma and to follow-up as warranted. - Neurological checks were to be performed per the instructions. The Registered Nurse was to obtain the physician's order to perform neurological checks per the policy (refer to Neurological Check policy). The Neurological Check policy reviewed 3/2007 documented: - any incident involving the head that resulted in an injury would initiate a monitoring schedule for neurological checks. The schedule was to be maintained for a minimum of 24 hours. Following the initial Registered Nurse assessment, monitoring and neurological assessments could be conducted by licensed nursing personnel. - If the medical provider was not in attendance, the Registered Nurse Supervisor was responsible for notifying the physician of a possible head injury and the assessment of the resident. - A neurological assessment was to be completed and documented every 15 minutes for the first hour. If the assessment was within normal limits and there was no evidence of changes, continue with assessment, monitoring and documentation every 30 minutes for the next hour. (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	- The neurological assessment would include but not limited to vital signs, orientation/level of consciousness, pupil check, change in vision or speech, monitoring for nausea and vomiting, seizure activity, assessment of sensory function, change in behavior, checking motor function (ask resident to grip/release hands, push their arms against you, extend and flex both feet against resistance), and complaints of headache. - Documentation in the nursing notes was to include response to and tolerance of assessments and the presence or absence of parameters. Documentation on the neurological check flow sheet was to be completed with each assessment. The sheet was maintained with the corresponding month's medication administration records. Resident #3 had diagnoses including dementia and anxiety disorder. The 1/6/2024 Minimum Data Set assessment documented the resident had moderate cognitive impairment and required supervision for transfers. The resident had no falls since the last assessment. The 3/24/2024 at 4:30 AM Licensed Practical Nurse #16's progress note was documented as a late entry and noted the resident was found on the floor and the Supervisor was notified. Vital signs and neurological checks were done. The resident had a large bump above and next to their left eye with a small cut and a large bump on the side of their knee. The resident was sent to the hospital. The 3/24/2024 Incident Report completed by Registered Nurse Supervisor #15 documented: - at 4:40 AM, the resident was observed by staff to be on the floor in their room near their bed. - The resident had a large hematoma (collection of blood under the skin) to the left forehead and left side of the eye that measured 5 inches by 2 inches, and a hematoma with severe pain to the touch on the lower thigh that measured 2.5 inches by 2.5 inches. - The fall was unwitnessed. - The physician was notified at 5:00 AM and the resident was to be sent to the hospital for evaluation and treatment. -There was no documentation of neurological checks being completed. The resident's blood pressure, pulse, and respirations were noted on the incident report. The 3/24/2024 at 6:07 AM Registered Nurse Supervisor #15's progress note documented the resident was observed lying on their back next to the bed. They had a large hematoma to the left forehead extending down the left side of their eye measuring 5 inches by 2 inches and a hematoma to the left lower thigh area measuring 2.5 inches by 2.5 inches that was very painful to touch. Range of motion on all 4 extremities was at baseline. Neurological checks were at baseline. Ice was applied and acetaminophen was given. The on-call medical provider was notified and gave a new order was received to transfer the resident to the hospital for evaluation and treatment. Emergency Medical Services was called, and the resident left the facility via stretcher without incident. The Emergency Medical Service Patient Care Record documented they arrived to the resident at 6:46 AM. The resident had a fall out of bed, had a bump on their head, and possible hematoma and leg fracture. The resident was transported to the hospital and arrived at 7:21 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence of neurological checks every 15 minutes for the first hour and every 30 minutes the next hour, following the initial assessment (approximately 5:00 AM) until emergency services arrived at 6:46 AM. During an interview on 5/15/2024 at 4:18 PM, Registered Nurse Supervisor #15 stated on 3/24/2024, they were called to the unit to assess Resident #3 following a fall. They called the physician and received the order to send the resident to the hospital and then called the resident's representative at approximately 5:15 AM for hospital of choice. The Supervisor called the Emergency Medical Services company directly. The Supervisor stated after that they went to the office to print the transfer paperwork and brought it to the unit, then returned to their office to do end of shift tasks. Registered Nurse Supervisor #15 was called back to the unit (unsure of the time) due to increased swelling of the area on the resident's head. They reassessed the resident at that time and directed staff to monitor the resident. They then returned to the office and was not made aware that Emergency Medical Services had not arrived to transport the resident. Approximately 45 minutes later, the Supervisor was on the unit and observed the resident was still in their room. They immediately called Emergency Medical Services again and they arrived shortly after. During an interview with Licensed Practical Nurse #16 on 5/23/2024 at 7:43 AM, they stated after a fall with head injury, neurological checks were done for 24 hours. They were to be recorded on a paper neurological flow sheet for 24 hours. The Licensed Practical Nurse was not sure of the time intervals to complete the neurological checks and would refer to the neurological check sheet. When Resident #3 fell , Registered Nurse Supervisor #15 responded to the unit and did an initial assessment and neurological check. Licensed Practical Nurse #16 stated they monitored the resident while waiting for Emergency Medical Services to arrive and did not complete a neurological check flow sheet due to the resident being sent to the hospital. They stated they documented neurological checks in the progress notes and on the incident report. During the time they waited for Emergency Medical Services, they did not notify the Registered Nurse Supervisor when they did not arrive but when the Supervisor came back to the unit, the Licensed Practical Nurse stated Emergency Medical Services had not arrived and the Supervisor called them again. During an interview with the Director of Nursing on 5/23/2024 at 11:52 AM, they stated post-fall protocol for residents who hit their head included initiation of neurological checks immediately. Neurological checks should be completed and documented every 15 minutes for the first hour, every 30 minutes for the next hour, and then every hour, and ongoing increments for a full 24 hours. If the resident was being sent to the hospital, the neurological checks should be completed per the protocol until Emergency Medical Services arrived. Neurological checks included vital signs, pupil reactions, hand grips, sensory function, and mobility/gait and should be fully documented for each increment of time according to the neurological flow sheet. The Registered Nurse who completed the initial assessment should document the first neurological assessment and subsequently, it could be the Registered Nurse or unit nurse. Documentation of the neurological assessment in progress notes without any details was acceptable as long the assessment was fully documented on the neurological flow sheet. If there was no flowsheet, the Director of Nursing expected the assessment to be documented in the progress note. The Director of Nursing was not aware that there were no neurological checks in the resident's record and stated it should have been documented to ensure monitoring of the resident's condition prior to emergency services arrived. 10 NYCRR 415.12