

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Salem Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 539 Route 22 Purdys, NY 10578	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478</p> <p>Based on observation, interview, and record review conducted during the recertification and abbreviated survey (NY00323734) from 5/9/24 to 5/16/24, the facility did not ensure adequate supervision was provided and that the resident's environment remained as free of accidents hazards as possible for 3 of 7 residents (Residents #89, #72, and #3) reviewed for accidents. Specifically, 1) Resident #89 did not receive 1:1 supervision as per plan of care, resulting in a fall, 2) Resident #72 had multiple oral medications and eye drops (left by nursing) in their room on a dementia unit with twelve residents with wandering behaviors, and 3) Resident #3 had medicated creams (left by nursing) in their room on a dementia unit with twelve residents with wandering behaviors.</p> <p>The findings are:</p> <p>The facility policy and procedure, titled Accident Prevention/Falls last revised 12/15/2023 documented it was the policy of the facility to provide adequate supervision, assistance, and assistive devices to prevent accidents.</p> <p>1. Resident #89 was admitted with diagnoses including but not limited to non-Alzheimer's dementia, anxiety disorder, and mood affective disorder.</p> <p>The Quarterly Minimum Data Set (an assessment tool) dated 8/16/23 documented severely impaired cognition. The resident required 1-person limited assistance with ambulation.</p> <p>The care plan titled Risk for Falls documented on 9/3/23 the resident had a fall and sustained a hematoma (solid swelling of clotted blood) to the left side of the forehead and was sent to the emergency room . The 9/4/23 care plan note documented the resident was placed on 1:1 upon return from the emergency room . The 9/5/23 care plan note documented the resident was to remain on 1:1 observation for 2 more days.</p> <p>The Incident / Accident Report dated 9/5/23 documented, 'resident identified as at risk for incident /accident due to dementia, self-care deficit, history of falls dependent with activities of daily living'. The incident / accident report documented an unwitnessed fall at 10:35 PM.</p> <p>(continued on next page)</p>

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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Salem Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 539 Route 22 Purdys, NY 10578	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/15/24 at 4:25 PM during an interview, the Director of Nursing stated Resident #89 was on 1:1 supervision upon return from the hospital on 9/4/23 after a fall and was supposed to be on 1:1 supervision for 3 days from 9/4/23 to 9/7/23. The Director of Nursing stated that when Resident #89 had another fall on 9/5/23, the resident was on 1:1 supervision, but the certified nurse aide who was providing 1:1 supervision had stepped away from Resident #89. The Director of Nursing stated that the Registered Nurse and Licensed Practical Nurse Supervisor had educated the certified nurse aide who was assigned to provide 1:1 supervision of Resident #89 not to leave Resident #89 unsupervised, and to ask for assistance or relief if needed.</p> <p>On 5/15/24 at 4:30 PM during an interview, Staff #21 (Registered Nurse) who was on duty 9/5/23 at the time of Resident #89 fall stated the certified nurse aide who was assigned to do 1:1 supervision for Resident #89 had stepped away from the resident and when they returned to the resident's room they found the resident on floor of their room. The Registered Nurse stated the certified nurse aide who was assigned to do 1:1 supervision of Resident #89 had been educated to stay with the resident at all times and to ask for assistance or relief if they needed to step away, but the certified nurse aide had not asked for assistance or relief.</p> <p>On 5/16/24 at 8:20 AM during an interview, Staff #13 (Licensed Practical Nurse Supervisor) stated they were on duty on 9/5/2023 on the 3-11 evening shift. They stated the certified nurse aide who was assigned to 1:1 supervision of Resident #89 had stepped out of the resident's room. They stated the certified nurse aide who was assigned to 1:1 supervision of Resident #89 had been educated by them and by the Registered Nurse on duty not to leave the resident unsupervised at any time, and to ask for relief if needed.</p> <p>On 5/16/2024 at 8:30 AM during an interview, Staff #17 (certified nurse aide) who was assigned to 1:1 supervision of Resident #89 stepped out of Resident #89 room. They stated they did not ask another staff for assistance or for relief prior to leaving the room. They stated the registered nurse on duty had explained to them not to leave Resident #89 alone, and to ask for assistance or relief if needed.</p> <p>48847</p> <p>2. The facility policy titled Medication Administration dated 1/02/2019 and reviewed on 03/12/2024 documented the goal was to ensure safe and accurate medication administration, to stay with the resident until medication was swallowed, and to never leave medication at the bedside.</p> <p>Resident #72 was admitted with diagnosis including but not limited to Alzheimer's disease, major depressive disorder, and shared psychotic disorder.</p> <p>The Quarterly Minimum Data Set (resident assessment tool) dated 4/17/23 documented that Resident #72 had severely impaired cognition, required extensive with toileting, limited assistance with transfers, was independent with eating and bed mobility and had no behaviors or rejection of care.</p> <p>The care plan titled Cognitive Patterns; Dementia dated 8/21/21 documented staff will remind resident to maintain daily schedule, offer resident simple choices, provide cues and assistance as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Salem Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 539 Route 22 Purdys, NY 10578	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/09/24 at 10:32 AM, Resident #72 was observed in their room. Two almost full bottles of Latanoprost eye drops were observed on the resident's bed side table. One bottle was filled on 11/7//23 and the other was filled on 3/21/24.</p> <p>On 05/10/24 at 09:57 AM, Resident #72 was observed in their room sitting in a chair. There were two medicine cups containing multiple oral medications, and 2 almost full bottles of Latanoprost eyedrops were observed on the bed side table. Resident #72 stated they didn't know when the medications were put on their table and stated they did not know when to take them. Resident #72 stated they took them when they felt like it. They're only vitamins.</p> <p>On 05/10/24 at 03:28 PM, Resident #72 was observed in their room. One medicine cup with multiple oral medications was observed on the bedside table (Seroquel (antipsychotic) 2.5 mg, Seroquel 12.5 mg, Aldactone (water pill) 25 mg, folic acid (vitamin) 1 mg, Diltiazem (blood pressure medicine) CD 240 ER 24 hr, Lasix (water pill) 40 mg, Eliquis (blood thinner) 5 mg x 2, gabapentin (anticonvulsant) 100 mg, Atorvastatin (cholesterol medication) 20 mg, and Aricept (dementia medication) 5 mg) and Latanoprost (eye drops).</p> <p>On 05/10/24 at 03:35 PM, the Assistant Director of Nursing was observed removing the oral medications from Resident #72's bed side table and at 3:40 PM provided the sureveyor a list with names for the medications that had been removed from the residents room.</p> <p>On 05/10/24 at 04:00 PM, the Assistant Director of Nursing stated they were told by Staff #12 (Licensed Practical Nurse) that the medications were left in the room unattended due to Resident #72 stating they were going to take the medication. The Assistant Director of Nursing stated that it was unacceptable and not good practice for nurses to leave medications unattended at residents' bedside and that Resident #72 was not capable of self-administering medication. The Assistant Director of Nursing stated that the medications found in the Resident #72 room were a mixture of day and evening shift medications and that if a resident refused medications, the nurse should have taken the medications out of the resident's room, written a nurses note, and notified the doctor.</p> <p>During an interview on 05/10/24 at 04:24 PM, Staff #12 (Licensed Practical Nurse) stated they did leave medications in Resident #72's room and that they were aware that medications should never be left unattended. Staff #12 (Licensed Practical Nurse) stated that they should always make sure residents take their medications and if a resident refused, they should report to the charge nurse and document.</p> <p>Review of all Care Plans revealed that there were no care plan in place for self-medication administration.</p> <p>During an interview with on 05/15/24 at 12:25 PM, Staff #22 (Registered Charge Nurse) stated that oral medications should never be left in the residents' rooms because it was a safety hazard and if a resident refused medications, the nurse should re-approach, and if the resident continued to refuse, the nurse should remove medications from the room, document, and make the registered nurse aware. Staff #22 stated that there were a lot of residents who wandered on the unit who may wander into rooms. Staff #22 stated that leaving oral medications in a resident room was a safety issue.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Salem Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 539 Route 22 Purdys, NY 10578	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/16/24 at 10:45 AM, the Director of Nursing stated that it was unsafe to leave medications in a resident's room and that the nurse should have ensured that the resident took the medications. The Director of Nursing stated if the resident refused, the nurse should not have left the medications unattended.</p> <p>During an interview on 05/16/24 at 12:41 PM, the Nurse Practitioner stated they were made aware of oral medications being left unattended in Resident #72's room. The Nurse Practitioner stated Resident #72 was not psychologically intact to self-administer their own medications and would not advise them to administer their own medications. The Nurse Practitioner stated that it was harmful to leave medications in the residents' room because there were residents who wandered. The Nurse Practitioner stated Resident #72 did not know what the medications were and would not know how to consume them.</p> <p>3. Resident #3 was admitted with diagnosis including but not limited to bilateral primary osteoarthritis of knee, polymyalgia rheumatica, and primary osteoarthritis of shoulder.</p> <p>The Comprehensive Minimum Data Set, dated dated dated [DATE] documented that Resident #3 had intact cognition, required moderate assist with toileting, transfers, and bed mobility, and was independent with eating.</p> <p>Review of all Care Plans revealed that there were no care plan in place for self-medication administration.</p> <p>On 05/09/24 at 11:08 AM and 5/10/24 at 10:11 AM Resident #3 was observed in their room. Multiple tubes of medicated creams which included: Clobetasol (steroid), Lotrimin ultra (anti-fungal), hemorrhoidal ointment, miconazole nitrate (anti-fungal) 2% topical cream were observed on their nightstand. Resident #3 stated that the creams were left by the nurse and either the nurse applied the creams, or they applied the creams.</p> <p>On 05/10/24 at 03:14 PM, Resident # 3 was observed with multiple tubes of medicated creams on their nightstand. Resident #3 stated that they were in the process of ordering new creams because the applicator was not sanitary. Resident #3 stated that some of the creams were for gynecological problems and stated that the nurses left the creams in their room.</p> <p>On 05/13/24 at 02:54 PM, Resident #3 was observed in their room. Clobetasol cream was observed on the resident's nightstand dated 4/25/24. Resident #3 stated the nurses previously removed the creams but then gave it back.</p> <p>During an interview on 05/10/24 at 04:00 PM, the Assistant Director of Nursing stated that creams should never be left in a resident's room unless they have an order to self-apply and stated that they were not sure if Resident #3 was able to self-apply creams/ointments.</p> <p>During an interview on 05/10/24 at 04:24 PM, Staff #12 (Licensed Practical Nurse) stated that the creams had been in Resident #3's room for a while and was unsure if there was a physician order to self-apply.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Salem Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 539 Route 22 Purdys, NY 10578	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/13/24 at 02:55 PM, Staff #12 (Licensed Practical Nurse) stated that Resident #3 could not self-apply Clobetasol and that the nurses must apply it. Staff #12 (Licensed Practical Nurse) stated that Resident #3 should not have had that Clobetasol in their room and stated that they thought that it had been removed. Staff #12 (Licensed Practical Nurse) stated that creams should be kept locked away in the treatment cart and stated that oral medications were not safe to keep in residents' room due to residents who wander on the unit.</p> <p>During an interview on 05/16/24 at 10:45 AM, the Director of Nursing stated medications and creams must be stored away in the locked medication and treatment carts.</p> <p>During interview on 05/16/24 at 12:41 PM, the Nurse Practitioner stated that they didn't know that an official self-medication administration assessment was required and was just going off what the nurses told them about the resident being able to apply their own creams. The Nurse Practitioner stated the first time that they assessed Resident #3 to self-apply creams was on 5/14/24, and when they assessed them, they did not want them to be confused with the two creams (Clotrimazole and Clobetasol) because one is to applied to the Resident's face and the other is for the Resident's vaginal area. The Nurse Practitioner stated that when nursing staff showed them the bags with the creams that were left in the resident's room, they were shocked because the resident could get confused about which cream is for which body. The Nurse Practitioner stated the nurses should have been applying the Clobetasol cream and it should not have been left in the room, due to safety concerns.</p> <p>10NYCRR 415.12</p>		