STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335760	A. Building B. Wing	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Heritage House Nursing and Rehabilitation Ctr	2920 Tibbits Avenue Troy, NY 12180

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33538 Based on record review and interviews during an abbreviated survey (Case # NY00316856), the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse, to the Administrator of the facility and to the State Survey Agency for 1 (Resident #1) of 5 residents reviewed. Specifically, an allegation of physical abuse reported by Resident #1 on 5/15/2023 was not reported to the New York State Department of Health after the allegation was made. This is evidenced by: Resident #1: Resident #1 was admitted to the facility with diagnoses of dementia, squamous cell carcinoma (skin cancer), and anemia (condition of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissue). The Minimum Data Set (an assessment tool) dated 5/18/2023, documented the resident could be understood, could understand others, and had intact cognition for decisions of daily living. The facility's Abuse, Prevention and Investigation Policy, dated 7/27/2023, documented a report to the New York State Department of Health must be made immediately, but no later than 2 hours after forming the suspicion that an allegation meets the following criteria: Serious bodily injury occurred and/or there is suspicion that abuse has occurred. The Statement Form dated 5/15/2023 at 7:10 AM signed by Certified Nurse Aide #2 documented Resident #1 reported the staff that got them dressed that morning was rough and mean causing a bruise on their right arm. The Investigation Summary Form dated 5/15/2023 documented the resident reported to two (2) daytime Certified Nurse Aides that the overnight aide was mean and rough and the bruise on their right arm was caused by the aide. The Conclusion documented the facts in this investigation did not support the allegation of abuse. The section of the form titled Department of Health Notification was blank. The form was signed by Administrator #2 on 5/16/2023. A review of ASPEN Complaints/Incidents Tracking System revealed no reports were submitted by the facility regarding the incident that occurred on 5/15/2023. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/15/2023 at 1:52 PM, Assistant Director of Nursing #1 stated it was an allegation of abuse and should have been reported to the Department of Health immediately; and that there was nothing in the file to indicate the incident was reported. During an interview on 2/15/2023 at 2:05 PM, Administrator #1 stated the incident was suspected abuse and should have been reported within two hours. 10 New York Codes, Rules and Regulations 415.4(b)(2)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on record review and interviews during an abbreviated survey (Case #'s NY00310829, NY00311751, NY00316856, and NY00319018), the facility did not ensure all alleged violations of abuse, neglect, or mistreatment, including injuries of unknown source were thoroughly investigated for 5 (Residents #1, 2, 3, 4, and 5) of 5 residents reviewed. Specifically, the facility did not conduct a thorough investigation when Resident #1 alleged abuse on 5/15/2023 by a Certified Nurse Aide. For Resident #2, the facility did not conduct a thorough investigation to determine the cause of a fracture (bone break) identified on 2/28/2023. For Resident #3, the facility investigation began 5 days after the resident's unwitnessed fall and did not identify the cause or corrective actions to prevent re-occurrence. For Residents #4 and 5, facility investigations did not identify non-adherence to the residents' care plans as contributing factors; additionally, the facility investigations did not include appropriate corrective actions to prevent reoccurrence. This is evidenced by: The facility policy titled Abuse Prevention and Investigation Policy, effective 6/27/2023, documented the following: - Nursing Supervisor/Nurse Manager shall initiate the investigation on the shift in which the incident was observed, the report was first received, or when abuse was suspected. - Any staff members who may have knowledge of the incident including the alleged perpetrator shall be interviewed and asked to write a written statement. - Anyone else who could potentially be a witness or who may have knowledge of circumstances shall be interviewed. If allegations involve a specific staff member, alert residents who have been cared for by that individual should be interviewed to ascertain if there were care concerns which should be addressed. A thorough investigation includes the following: - A record of interviews - An explanation of evidence reviewed. - The conclusion reached with a discussion of its basis, and any changes made to care plans or processes. The facility shall make any necessary changes to care plans, policies, procedures, and staff education as identified as a result of the investigation. Resident #1: (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted to the facility with diagnoses of dementia, squamous cell carcinoma (skin cancer), and anemia (condition of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissue). The Minimum Data Set (an assessment tool) dated 5/18/2023, documented the resident could be understood, could understand others, and had intact cognition for decisions of daily living. Witness statements dated 5/15/2023 from Certified Nurse Aides #2 and #5 documented the resident reported the overnight Certified Nurse Aide was rough and caused a bruise to their right forearm. An Investigation Summary Form dated 5/15/2023 documented the resident reported to the Certified Nurse Aide on the day shift that an overnight Certified Nurse aide was rough during early morning care causing a bruise on the right arm. The Record Review and Conclusion section of the form documented the facts in this investigation did not support the allegation of abuse as defined by the regulations. Steps to prevent reoccurrence, staff was counseled regarding being rushed with care and how that could be perceived negatively by residents. Staff had no disciplinary history. The investigation did not include interviews and/or witness statements from any staff working at the time the incident occurred and there were no resident interviews regarding care provided by the accused staff. The Investigation Summary did not include a possible cause of the bruise sustained by the resident or steps to prevent reoccurrence of injury for this resident. Resident #2: Resident #2 was admitted to the facility with diagnoses of hemiplegia (paralysis of partial or total body function on one side of the body) following cerebral infarction (stroke that disrupted blood flow to the brain), apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked), and mild cognitive impairment. The Minimum Data Set, dated dated dated [DATE], documented the resident could sometimes be understood, could sometimes understand others and had moderately impaired cognition for decisions of daily living. An Investigation Summary Form dated 2/28/2023 documented that Resident #2 reported ankle pain and swelling. Mobile X-ray dated 2/28/2023 revealed left ankle fracture (bone break). The Record Review and Conclusion section of the form documented the facts in this investigation did not support the allegation of abuse as defined in the regulations. The Investigation Summary did not include a possible cause of the fracture sustained or steps to prevent reoccurrence of injury for this resident. Resident #3: Resident #3 was admitted to the facility with diagnoses of chronic kidney disease, bilateral osteoarthritis of hip (arthritis in both hips), severe protein calories malnutrition. The Minimum Data Set, dated dated dated [DATE], documented the resident could be understood, could understand others and had moderately impaired cognition for decisions of daily living. A Progress Note dated 2/07/2023 written by a Registered Nurse documented the resident was observed laying on the floor in their room at 6:05 PM; the resident did not know what happened; Registered Nurse assessment found no injury. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Investigation Summary Form dated 2/13/2023 documented that the resident was noted to have severe pain with bruising on right posterior thigh. The resident sustained an unwitnessed fall on 2/7/2023. Resident #3 was diagnosed with a right thighbone fracture (bone break) on 2/13/2023. The Record Review and Conclusion section of the form documented the facts in this investigation did not support the allegation of abuse as defined in the regulations. The Investigation Summary did not include a possible cause of the fracture sustained or steps to prevent reoccurrence of injury for this resident. During an interview on 2/15/2024 at 2:06 PM, Administrator #1 stated there should have been a conclusion statement in the investigation with possible cause of injury and what would be done to prevent it from happening again. Administrator #1 stated there should have been documented interviews with all staff and residents who were potentially involved or were witness to what happened. During an interview on 2/21/2024 at 2:50 PM, Assistant Director of Nursing #1 stated the facility's investigation folder for NY00319018 was not helpful since it did not have information related to the care plan changes or whether the care plan was implemented. Assistant Director of Nursing #1 further stated that facility investigations were not being completed properly by the former Director of Nursing; the investigations did not contain what happened to cause the resident's injuries or what should have been done to prevent reoccurrence. 10 New York Codes, Rules and Regulations 415.4(b)(3)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on record review and interviews during an abbreviated survey (Case #'s NY00311751 and NY00316856), the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 (Residents # 1 and 2) of 5 residents reviewed. Specifically, for Resident #1, the facility did not ensure an immediate and thorough assessment of the resident's injury alleged to be caused by abuse. For Resident #2, the facility did not ensure an assessment of new onset pain resulting in delay of treatment for a fracture (bone break). This is evidenced by: The facility Policy titled Abuse Prevention and Investigation, effective 6/27/2023, documented, when abuse is suspected or alleged, resident safety must be a priority. All required documentation, assessments, treatments must be completed as appropriate by facility staff. The resident shall be assessed and any necessary care provided. The facility Policy titled Change in Condition, effective 2/2020 documented, as a resident's condition changes the licensed nurse will consult with the resident immediately. The attending physician will be notified immediately as indicated by the significance of the change and need for medical intervention. Resident #1 Resident #1 was admitted to the facility with diagnoses of dementia, squamous cell carcinoma (skin cancer) , and anemia (condition of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissue). The Minimum Data Set (an assessment tool) dated 5/18/2023, documented the resident could be understood, could understand others, and had intact cognition for decisions of daily living. An Investigation Summary Form dated 5/15/2023 documented the resident reported to a Certified Nurse Aide on the day shift that an overnight Certified Nurse aide was rough during early morning care causing a bruise on the right arm. The form did not contain documentation of a Registered Nurse assessment of the resident's injury. Witness statements dated 5/15/2023 at 7:10 AM from Certified Nurse Aides #2 and #5 documented the resident reported the overnight Certified Nurse Aide was rough and caused a bruise to the right forearm. Review of Resident #1's medical record revealed it did not contain documentation of a Registered Nurse assessment of the resident's injury. Medical Provider Note dated 5/15/2023 at 12:51 PM documented the resident was seen for reports of bruising on right arm. The note documented Resident #1 had bruising on right forearm and bicep area, no open wounds, no evidence of injury, and excellent range of motion on the arm. Medical Provider #1 did not document an assessment that included a description of the bruise that was alleged by the resident to be the result of abuse by a staff. (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 2/15/2024 at 1:52 PM, Assistant Director of Nursing #1 stated the documentation completed by the Nurse Practitioner did not document an assessment of the bruise, such as the bruise's size, shape, color, or characteristics like a handprint. Assistant Director of Nursing #1 further stated that such parameters should be documented in the assessment, and that the investigation summary form did not address risk factors for bruising. Assistant Director of Nursing #1 stated that there was no nursing assessment of the injury following the allegation and there should have been; any reported incident required an immediate evaluation and assessment by a Registered Nurse. Resident #2 Resident #2 was admitted to the facility with diagnoses of hemiplegia (paralysis of partial or total body function on one side of the body) following cerebral infarction (stroke that disrupted blood flow to the brain), apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked), and mild cognitive impairment. The Minimum Data Set, dated dated dated [DATE], documented the resident could sometimes be understood, could sometimes understand others and had moderately impaired cognition for decisions of daily living. A Progress Note dated 2/25/2023 documented the resident complained of pain in left leg and the resident was added to the doctor book for assessment. A Progress Note dated 2/26/2023 documented resident received medication for left foot and ankle pain, Nurse Supervisor notified. A Progress Note dated 2/27/2023 documented resident complained of left ankle pain and looked swollen, put in doctor's book. A Progress Note dated 2/28/2023 documented resident's family brought to nurse; the resident was yelling in pain, left ankle swollen. Doctor was notified and x-ray was ordered. A Progress Note dated 2/28/2023 documented Doctor and family were made aware of left foot fracture (bone break). The medical record did not contain documentation of a nursing assessment or of a medical provider assessment of the resident's new onset foot and ankle pain. During an interview on 2/15/2024 at 1:52 PM, Assistant Director of Nursing #1 stated any new onset pain complaints should have been reported to the Nurse Manager or Supervisor and should have been assessed immediately. They further stated that this resident should not have complained of pain for 3 days without being looked at. During an interview on 2/26/2024 at 12:20 PM, Registered Nurse #2 stated that any concerns that are immediate should not have been placed in the Doctor's Book, especially if a resident was suddenly wheezing, short of breath, or fell and the staff member thinks there may be any injury, the Doctor should be contacted. (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 2/26/2024 at 12:42 PM, Physician #1 stated they would check the Doctor Book as soon as they got to the unit, address the requests and talk to the nurses. Physician #1 stated it was their own expectation that if there was an emergent issue, such as a resident with shortness of breath or in needing an x-ray, that they (the Physician) or the on-call provider were called about the emergent issue rather than placing it in the book. 10 New York Codes, Rules and Regulations 415.12