STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335806	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springvale Nursing & Rehabilitation Center	67 Springvale Road Croton on Hudson, NY 10520

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 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** 49372 Based on record review and interviews conducted during an abbreviated survey (NY00340395, NY00339018) the facility did not ensure comprehensive care plans included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment or discharge plans for 2 out of 3 (Resident #2, Resident #4) residents reviewed for discharge planning. Specifically, Resident #2 had no discharge care plan initiated for the resident on admission and they were discharged from the facility on 4/1/2024. Resident #4 was discharged from the facility on 4/15/2024 and there was no documented evidence of a discharge care plan initiated on admission for the resident. Findings include: The facility care planning/process and care conference dated 7/2017 and last revised 7/3/2023 documented an interdisciplinary baseline care plan will be initiated upon admission by the admitting nurse and competed within 48 hours. Social service, dietician, therapy and activities will also initiate a baseline care plan with 48 hours. The resident centered care plan will include the development of discharge planning focusing on mutually agreed upon and attainable resident discharge goals that prepare residents to be an active partner in post discharge care, in effective transitions, and to assist in reduction of factors leading to preventable hospital readmissions. Documented each care plan need/problem must have a goal and interventions to address the need of the resident. The facility discharge planning-interdisciplinary discharge summary and discharge plan of care dated 8/10/2021 and last revised 4/9/2024 documented discharge planning is a service and process that, with resident participation, identifies and evaluates the resident's needs and assists them in moving from one environment to another. A discharge plan of care will indicate education and training necessary for the resident to be discharged safely. 1)Resident #2 was admitted to the facility on [DATE] with diagnosis including but not limited to Alzheimer's disease, Dementia, and muscle weakness. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Admission Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 7/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). Resident #2 had limited range of motion in both upper extremities and required maximal assistance with eating and bed mobility and was dependent for toileting and transfers. The Resident was always incontinent of bladder and bowel, had a stage 3 pressure ulcer and 2 deep tissue injuries requiring skin/wound care. There was no documented evidence of a social service discharge planning care plan being initiated upon Resident #2's admission. There was no documented evidence of an interdisciplinary team meeting being held regarding the resident's discharge prior to their departure from the facility. Review of a social worker progress note dated 3/25/2024 documented Resident #2's family requested discharge with the managed long term care company. Documented Resident #2's case manager confirmed the resident had 69 hours weekly of home care service which will be supplemented by help from the family with a discharge date of [DATE]. Review of Resident #2's admission/discharge/transfer report dated 4/1/2024 at 11:30AM documented a scheduled discharge to an unspecified location. Review of Resident #2's admission/discharge/transfer report dated 4/1/2024 at 2:30 PM documented Resident #2 will be discharged home. Additionally, review of an elimination bowel incontinence care plan dated 3/7/2024 documented the resident is incontinent of bowel requiring incontinence care. There was no documented interventions noted on the care plan. Review of an elimination urinary incontinence care plan dated 3/7/2024 documented Resident #2 was incontinent of bladder function. There are no documented interventions noted on the care plan. Review of a skin integrity presence of skin breakdown care plan dated 3/7/2024 documented the resident had skin breakdown as evidenced by a sacral area stage 3 pressure ulcer and bilateral heel deep tissue injuries. There were no documented interventions noted on the care plan. 2)Resident # 4 was readmitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including but not limited to disorientation, muscle weakness and other lack of coordination. A 5-day Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Innterview for Mental (BIMS score of 13/15 associated with intact cognition.The resident required supervision for eating and bed mobility, moderate assistance for toileting and maximal assistance for transfers. There was no documented evidence of a social service discharge planning care plan being initiated upon the resident admission. There was no documented evidence of an interdisciplinary team meeting being held regarding the resident's discharge prior to their departure from the facility. (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 a social worker progress note dated 4/12/2024 documented the resident received a Notice of Medicare Non-Coverage with last coverage date 4/14/2024 and the resident does not want to appeal and wants to be discharged Monday 4/15/2024. Resident's sister will transport home. Review of the admission/discharge/transfer report dated 4/15/2024 at 12:00 AM documented Resident #4 is scheduled for discharge to resident's home. Review of the admission/discharge/transfer report dated 4/15/2024 at 11:54 PM documented Resident #4 was discharged home. During an interview on 6/25/2024 at 1:05 PM, the Director of Nursing stated before discharge they conduct a discharge care plan meeting with the social worker, the resident, the family, rehab therapy department, and the interdisciplinary team including the Nurse Practitioner. The social worker is responsible for initiating the care plan and setting up the discharge planning meeting. During a telephone interview on 7/2/2024 at 9:50 AM the social worker stated the discharge care plans are initiated at least a week ahead of discharge, and a discharge care plan meeting is scheduled with the interdisciplinary team. The social worker stated if a Notice of Medicare Non-Coverage is received then the meeting would have to be rescheduled due to 48-hour notification regarding Notice of Medicare Non-Coverage. The social worker stated discharge care plans are initiated upon admission. The Social worker stated discharge care plans for Residents #2 & #4 were initiated. The Social Worker could not provide copies of the care plans upon request during the site visit. A follow up phone call to the social worker was placed on 7/9/2024 and no call back received. 10 NYCRR 415.11(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00340395, NY00339018) the facility did not ensure that the resident environment remained free of accident hazards and that each resident received adequate supervision and assistance devices to prevent accidents for 3 (Resident #3, Resident #4, Resident #5) out of 3 residents reviewed for accidents. Specifically, Resident #3 who had a history of falls had a total of 3 falls in a month (3/3/2024, 3/19/2024, 3/24/2024) and a 4th fall on 4/3/2024. Resident #3 sustained acute left femoral neck fracture with slight varus angulation. There was no documented evidence of timely updates/interventions after each fall to prevent reoccurrence. The resident's fall risk care plan was not updated after each fall and no new interventions were put in place. Findings include: The facility Falls Prevention and Management policy dated 3/1/2016 and last revised 1/12/2023 documented the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Determining casual factors leading to a resident fall is necessary to provide consistent intervention to help further occurrences. A Fall Risk Evaluation will determine fall risk factors. Fall evaluation will be completed on admission/readmission, quarterly, annually, with significant changes and post fall event. An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. Resident #3 admitted to the facility on [DATE] with diagnosis including but not limited to Dementia, Alzheimer's disease, and chronic pain. An Admission Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 06/15 (BIMS, used to determine attention, orientation, and ability to recall information) score of associated with severe cognition impairment, required maximal assistance for eating and is dependent for toileting, transfers and bed mobility. Uses wheelchair for locomotion. Review of a risk for falls care plan dated 2/28/2024 documented interventions: nursing/ rehab as ordered, maintain individual toileting schedule, floor mat, anticipate resident's needs, transfer with Hoyer lift and escort resident to activities. There was no other updates or new interventions after the fall on 3/3/2024, 3/19/2024, 3/24/2024. Review of an Activities of Daily Living Care Plan dated 2/28/2024 documented the resident has a self-care deficit as evidenced by bed mobility, transfer, walk in room, walk in corridor, dressing, eating, toileting, personal hygiene, bathing and locomotion on an off unit. There were no documented interventions noted on the daily living care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physical therapy evaluation dated 2/29/2024 documented Resident #3 is alert and oriented x1 and the resident is full weight bearing on bilateral lower extremities. Resident #3 is bedbound and required extensive assistance with mobility. The resident current status was documented as follows: requires 100% physical assistance x2 for bed mobility, full weight bearing to lower extremities but unable to stand. Resident #3 was a high risk for fall and exhibited poor balance. Review of an accident/incident report dated 3/24/2024 documented the resident was observed on the floor mat on the right side of the bed. The report documented the resident's vital signs were stable, no overt sign and symptoms of injury, bruising or open areas, and the resident was unable to give details as to why they got up without assistance. The certified nurse assistant statement documented the resident was last seen when they fed them lunch at 1 pm, and the resident did not have a floor mat in place and there were no side rails on the resident's bed. Review of an accident/incident report dated 4/3/2024 documented the resident was observed on floor next to their bed on their right side at 1:10 PM. The Registered Nurse assessment documented the resident had no apparent injury and redness to right hip. The Nurse Practitioner was notified, and an x-ray of the right hip was ordered. Immediate intervention to prevent further occurrence included to have resident spend more time in the dayroom with staff and recreation. Review of x-ray results dated 4/4/24 of left hip unilateral, with pelvis documented findings of an acute fracture of the left femoral neck, with slight varus angulation. A right hip replacement is in place. The remainder of the bony pelvis is unremarkable. Soft tissues are unremarkable. Impression acute left femoral neck fracture. During an interview on 6/26/2024 at 1:20 PM, Certified Nurse Assistant #1 stated when they arrived on their shift, they were informed Resident #3 was on the floor. Certified Nurse assistant #1 stated they got Certified Nurse Assistant #2 to assist them to get Resident #3 dressed and placed them in the wheelchair. Certified nurse assistant #1 stated they went down the hall to dispose of the linen, while Certified Nurse Assistant #2 took Resident #3 to the dining room. Certified Nurse Assistant #2 then called out to them and stated Resident #3 was on the floor again. Certified Nurse Assistant #1 stated this incident occurred in the morning around 9 AM. Certified nurse assistant #1 stated Resident could not stand up on their own and could barely turn from side to side in bed on their own. Certified nurse assistant #1 stated Resident #3 was fidgety and sometimes would scoot their self-down in their wheelchair and that morning the resident was very fidgety. Certified nurse assistant #1 stated Resident #3 did have a floor mat. During an interview on 6/26/2024 at 1:40 PM Registered Nurse Manager/Supervisor #1 stated Resident #3 did not have side rails, because they did not meet the criteria to have them. They stated a resident need to be able to cognitively understand that the side rails are used for mobility to have them, and Resident #3 could not do that. During an interview on 6/26/2024 at 3:30 PM the Director of Nursing stated Resident #3 had an intervention implemented to engage the resident and get them out of their room, because majority of their falls were in their room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facility administrator on 6/26/24 at 4:35PM the administrator stated they have now instituted a new protocol in the facility around march or April 2024. After a fall, a quality assurance form will be completed by each department and the interdisciplinary team will review weekly. Each department will document what intervention each discipline is implementing to prevent the falls. The completed form will be kept in the Director of Nursing's office. The Administrator stated Resident #3's falls occurred before this new protocol was instituted. There were no specific interventions documented on the care plan to prevent falls. 10 NYCRR 415.12(h)(2)