| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335845 | A. Building<br>B. Wing | 11/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Northeast Ctr for Rehabilitation and Brain Injury | 300 Grant Avenue<br>Lake Katrine, NY 12449 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>45478<br><br>Based on record review and staff interview during an abbreviated survey (#NY00326982), the facility did not ensure 2 of 4 residents (Residents # 1 and 4) reviewed, had the right to be free from abuse and neglect. Specifically, on 7/8/23 Resident #1 and Resident #4 had a verbal altercation and were separated. Later that day they had a resident-to-resident altercation involving Resident #1 punching Resident #4 in the face, which resulted in Resident #1 being injured with a bleeding lip.<br><br>Findings include:<br><br>The Policy and Procedure (P&P) Abuse dated 11/1/13 documented abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.<br><br>Resident #1 was admitted to facility 10/27/22 with diagnoses including cerebral vascular attack, anxiety disorder, psychotic disorder, and flaccid hemiplegia.<br><br>The quarterly Minimum Data Set (MDS), an assessment tool, dated 9/29/23 documented Resident #1 had moderate impairment in cognition. The MDS further documented Resident #1 needed extensive assist of 2 for transfer, extensive assist of 1 for bed mobility. Resident #1 was able to eat independently with set up. Resident #1 required supervision for toileting.<br><br>Resident #1's Behavior Care Plan initiated on 4/29/23 documented the resident had potential for behavior such as self-injury: swings legs out while in the wheelchair, grabbed onto rail on the wall and would attempt to flip chair over, crawled out of bed onto floor and mat, pulling on tubing and was at risk for victimization. The interventions documented on 4/29/23 were to provide a 1 to 1 as needed, reproach as needed, observe for signs of intent to harm self or others, monitor behaviors and update physician as needed, avoid over stimulation, take to another location, and if appropriate delay care until resident is calmed down and reproachable. New intervention added 7/8/23 documented keep resident separate from peer.<br><br>Resident #4 was admitted to facility 4/27/15 with diagnoses including psychotic disorder and mood disorder due to known physiological condition, unspecified.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The quarterly Minimum Data Set (MDS) an assessment tool dated 7/27/23 documented the resident had a brief interview of mental status (BIMS) score of 12 that indicated modified independence in cognition. The MDS further documented Resident #4 displayed physical aggression 1 to 3 days and verbal aggression 4 to 6 days. Resident #4 was independent in bed mobility, transfer and toileting and needed supervision and set up for eating.<br><br>Resident #4's Behavior Care Plan initiated on 10/13/22 documented the resident was at risk for victimization, resident deemed not to have sexual capacity; easily manipulated by male peers, verbal aggression towards staff and peers for example yelling, cursing, name calling, physical aggression toward staff and peers for example kicking, hitting, spitting, punching, and chasing staff. The interventions documented on 10/13/22, were resident will be offered a private room as available, increased supervision as ordered, provide 1 to 1 as needed, reproach as needed, observe for signs of intent to harm self or others, avoid over stimulation, take to another location, monitor behaviors as ordered and update physician as needed. New intervention added 7/8/23 documented to keep resident separate from peer.<br><br>The facility accident/incident report dated 7/8/23 documented Resident #1 found with mouth bleeding related to unwitnessed punch from peer. Actions taken: Residents separated for 72 hours; Resident moved to different unit. Resident harmed related to verbal altercation. Resident was found by staff to have been bleeding from his mouth after having a peer call for help, staff came to check what was happening and found Resident #1 bleeding from the mouth. When asked what happened Resident #1 replied peer punched him several times. Code Rainbow was called. Resident #1 had unmeasurable laceration to inner bottom lip. It was recommended to keep resident separate from peer for 72 hours, move Resident #1 to new unit secondary to reoccurring friction between 2 peers. Abuse mistreatment and neglect was ruled out.<br><br>The certified nurse aide (CNA) #1 statement dated 7/8/23 documented CNA #1 was passing dinner trays on the south side of the unit, when a resident yelled help. CNA #1 ran down to the north side and saw Resident #1 bleeding from his bottom lip. Resident #1 stated he was punched several times by Resident #4. CNA #1 wheeled resident to their room to remove the threat, while the Resident #4 remained at the table. The staff responded to code rainbow.<br><br>Resident #4 statement dated 7/8/23 documented Resident #1 called them a derogatory name and they (Resident)#4 did not do anything to Resident #1.<br><br>Nursing evaluation care plan note dated 7/12/23 documented Resident #1 was in common area as usual calling out help. Peer (Resident #4) began to taunt Resident #1 and they began to argue. The two were separated but then some how back near each other. Later on, in the day same peer (Resident #4) and Resident #1 were arguing and this writer upon from returning from break noted that a code rainbow was called involving Resident #1 being struck by peer (Resident #4) leaving his lip bleeding. Resident #1 was transferred off the unit.<br><br>Code List documented calling a Code Rainbow is used for a behavior.<br><br>There was no documented evidence of psychiatry follow up following altercation 7/8/23.<br><br>The nursing note dated 7/9/23 documented resident right lip swollen.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The psychiatry consult dated 7/14/23 documented Resident #4 seen for follow up, per nursing there have been recent explosions and Resident #4 has reported hearing people talking in her room. Resident #4 complained about other residents at the table ridiculing Resident #4 while they were sitting quietly at the table.<br><br>The psychiatry consult dated 8/18/23 documented staff reported Resident #1 has behavioral issues such as constant yelling, screaming, and disruptive behavior. Resident was initially calm, after introduction and then started yelling and screaming and disruptive behavior and cursing at undersigned. Resident was uncooperative. The plan is to Seroquel 25 mg. 3 times a day.<br><br>Interview with Registered Nurse Unit Manager (RNUM) #3 on 10/31/23 at 3:47 PM, (RNUM) #3, stated she was the unit manager for NRP2 before being moved to NRP5. Resident #1 was punched in the face after having a verbal altercation with Resident #4. (RNUM) #3 stated Resident #1 had a lot of verbal outbursts. Resident #1 used inappropriate language and sexual comments and gestures towards residents. (RNUM) #3 stated the incident occurred on the weekend. (RNUM) #3 stated resident was moved after the incident 7/8/23. (RNUM) #3 stated Resident #1 thinks people are trying to hurt him. Often calls girlfriend and says they are beating resident up, they are mean to Resident #1.<br><br>Interview with Nurse Practitioner (NP) #2 on 11/2/23 at 1:48 PM, (NP) #2 stated they usually assess the resident the next day following any incident. (NP) #2 stated if they did not write a note, it was not reported to (NP) #2. (NP) #2 stated even though the incident occurred on a weekend they would have received a call about it. (NP) #2 stated he did not have any recollection of being called. (NP) #2 stated that there were no nursing notes that stated NP and/or MD was informed.<br><br>Interview with Director of Nursing (DON) on 11/2/23 at 1:58 PM, DON stated behavior monitoring included providing a 1 to 1, or doing 25-minute checks, with a Community Support Services (CSS) representative, CSS representative will go to each unit and document on check list that the resident is safe. DON stated the nurse can move the resident's room at their discretion based on medical need, census, and a variety of concerns.<br><br>Interview with Administrator on 11/2/23 at 3:25 PM, Administrator stated abuse was ruled out because the 2 residents' statements were inconsistent. Administrator stated Resident #1 stated they bit their lip, but Resident #1 could not stick to one statement. Administrator stated the Director of Nursing did not want to report it because of the inconsistencies in the story. Administrator stated they did not review all the notes and did not believe that the Resident #1 was struck by another resident. Administrator stated Resident #1 was not on a close visual observation and was not being monitored more than every 15 min. Incident was not observed. Administrator stated she felt it was a thorough investigation. Administrator stated she would overrule the situation if they felt that it needed to be called in to the Department of Health.<br><br>Interview with Assistant Administrator on 11/2/23 at 4:05 PM, after reviewing the behavior care plans Assistant Administrator stated a one to one could have been used and was not sure why it was not.<br><br>10 NYCRR 415.4(b)(1)(i) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>45478<br><br>Based on record review and interviews during abbreviated survey (NY00326982), the facility did not ensure that all alleged violations involving abuse were reported no later than 24 hours if the events that cause the allegation did not involve abuse and did not result in serious bodily injury, to other officials (including to the State Survey Agency) in accordance with State law through established procedures for 1 (Resident #1 ) of 4 residents reviewed for abuse and neglect. Specifically, the facility did not report allegations of resident-to-resident abuse involving Resident #1 and Resident #4.<br><br>Findings include:<br><br>Resident #1 was admitted to facility 10/27/22 with the following diagnoses: cerebral vascular attack, anxiety disorder, psychotic disorder, and flaccid hemiplegia. The quarterly Minimum Data Set (MDS) an assessment tool dated 9/29/23 documented resident has moderate impairment in cognition. The MDS further documented resident needs extensive assist of 2 for transfer, extensive assist of 1 for bed mobility. Resident was able to eat independently with set up. Resident requires supervision for toileting.<br><br>The facility accident/incident report dated 7/8/23 documented Resident #1 found with mouth bleeding related to unwitnessed punch from peer. Actions taken: Residents separated for 72 hours; Resident moved to different unit. Resident harmed related to verbal altercation. Resident was found by staff to have been bleeding from his mouth after having a peer call for help, staff came to check what was happening and found Resident #1 bleeding from the mouth. When asked what happened Resident #1 replied peer punched him several times. Resident #1 had unmeasurable laceration to inner bottom lip. It was recommended to keep resident separate from peer for 72 hours, move Resident #1 to new unit secondary to reoccurring friction between 2 peers. Abuse mistreatment and neglect was ruled out.<br><br>The New York State Department of Health (DOH) was not contacted regarding the resident-to-resident altercation involving Resident #1 and Resident #4 with injury to Resident #1's lip.<br><br>Interview with Nurse Practitioner (NP) #2 on 11/2/23 at 1:48 PM, (NP) #2 stated they usually assess the resident the next day following any incident. (NP) #2 stated if they did not write a note, it was not reported to (NP) #2. (NP) #2 stated even though the incident occurred on a weekend they would have received a call about it. (NP) #2 stated he did not have any recollection of being called. (NP) #2 stated that there were no nursing notes that stated NP and/or MD was informed.<br><br>Interview with Administrator on 11/2/23 at 3:25 PM, Administrator stated abuse was ruled out because the 2 residents' statements were inconsistent. Administrator stated Resident #1 stated they bit their lip, but Resident #1 could not stick to one statement. The Administrator stated the Director of Nursing did not want to report it because of the inconsistencies in the story. Administrator stated they did not review all the notes and did not believe that the Resident #1 was struck by another resident. Administrator stated Resident #1 was not on a close visual observation and was not being monitored more than every 15 minutes. Incident was not observed. The Administrator stated she felt it was a thorough investigation and did not need to be reported.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10 NYCRR 415.4(b)(2) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666<br><br>Based on observation, record reviews and staff interviews on an abbreviated survey (NY00326982), the facility did not ensure that necessary monitoring was performed to maintain weight and prevent loss for 1 (Resident #1) of 3 residents reviewed for nutrition. Specifically, Resident #1, who had a history of weight fluctuations since 1/23, had MD orders for monthly weights but were not carried out as prescribed.<br><br>The findings are:<br><br>Resident #1 is a [AGE] year-old admitted to facility 10/27/22 with the following diagnoses: Cerebral Vascular Accident (CVA), Psychotic Disorder, obstructive and reflux uropathy. The quarterly Minimum Data Set (MDS) an assessment tool dated 9/29/23 documented resident has moderate impairment in cognition. The MDS further documented resident needs extensive assist of 2 for transfer, extensive assist of 1 for bed mobility. Resident was able to eat independently with set up. No dental issues.<br><br>The nursing care plan for Nutrition dated 10/27/22 document's goal; Resident will attain/maintain optimal nutritional status and has goal monitor weight per MD orders.<br><br>Physician orders dated 10/27/22 document monthly weights and were reordered after each readmission from the hospital. On 4/28/23 the physician ordered a ground, no added salt diet, double portions.<br><br>Individual orders documented as weigh now were noted on 8/17/23, 8/31/23, 9/11/23, 10/4/23.<br><br>Weights were documented:<br><br>1/5/23 189.9<br><br>2/6/23 166<br><br>3/3/23 168.4<br><br>6/8/23 163.6<br><br>7/11/23 168.2<br><br>There were no documented weights for April, May, August September, and October 2023. There was no documentation the resident refused weights.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/31/23 10:26AM with the Dietician Tech who stated they looked over the monthly weight obtained from the Certified Nurses Assistant and did the calculations for loss/gain and entered the number into the resident record. The Dietician Tech stated they made observations of the Resident at meals and found the resident fed himself, had a good appetite and ate 75-100% of meals. They stated there were problems with missing weights and sent messages to the Unit Managers and placed a weigh now order in the record for weights to be performed that day. This was done on August 17, August 31, September 11 and October 5. There was no response to the request. The Dietician Tech stated they spoke with the Registered Nurse Unit Manager (RNUM) #2 about obtaining the weights and the RNUM said they would do that but it did not happen. Weights were discussed at morning meeting, and they voiced their concern about weights not being done. The Dietician Tech stated they felt they were doing as much as possible by communicating the need for weights with the staff.<br><br>During an interview with Certified Nurses Assistant #1 11/2/23 10:53AM they stated the resident was in a Broda chair and could be pushed on to a scale. They were not aware that the resident refused weights. If there was a problem obtaining a weight, they would let the nurse know.<br><br>During an interview with CNA#2 11/2/23 10:53 AM resident weights have to be done by the 10th of the month. If not in the facility on 10th then will be weighed as soon as they return to unit. They will let the next shift know they could not get weight. Lastly, they will let nurses know if they can't get the weight.<br><br>During an interview with the Administrator 11/1/23 at 4:45PM who stated they were aware the resident refused a lot of things and heard from staff they refused weights but was aware there was no documentation.<br><br>During an interview with The Nurse Practitioner NP#1 11/2/23 10:03AM they stated was they were not aware the resident did not have a weight since July. They stated they were not informed by any staff there was a problem with weights.<br><br>10NYCRR 415.12 |