STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	03/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37385 Based on record review and interviews during the abbreviated survey (NY00302340), the facility failed to prevent further potential abuse in response to allegations of abuse, failed to initiate an investigation for 3 days, and failed to report the incident in accordance with State law for 1 of 4 residents (Resident #12) reviewed. Specifically, Resident #12 alleged a certified nurse aide (CNA) was rough during care. The allegation was not addressed at the time it was reported by the resident and the CNA was not removed from having access to residents while the allegation was pending. Findings include: The facility Abuse policy, revised 1/2021 documented: - The shift supervisor/charge nurse was responsible for the immediate initiation of the reporting process upon receipt of the allegation. - Once an allegation of abuse had been made, the supervisor who initially received the report must inform the Administrator/Director of Nursing immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately. - Provide for the immediate safety of the resident/patient, upon identification of suspected abuse, neglect, mistreatment, and/or misappropriation of property. - Immediate suspension of suspected employee(s), pending outcome of the investigation. - Any time an allegation was made involving abuse, neglect, or mistreatment of a resident/patient, which names a specific employee, the employee was suspended until the completion of the investigation. - The employee was not to remain on duty, and was not to be assigned to any other area of the facility Resident #12 had diagnoses including Wernicke's encephalopathy (neurological disease), ataxia (poor muscle control), and major depressive disorder. The 9/22/22 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment, exhibited behavioral symptoms of rejection of care 1 to 3 days during the assessment period, and required extensive assistance of one for activities of daily living (ADLs). (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan (CCP) in effect 9/2022, documented the resident required assistance with ADLs related to impaired balance, Wernicke's Encephalopathy, and pain. Interventions included extensive assistance of one for bed mobility, dressing, and hygiene. The 9/26/22 Investigation Form documented: - On the evening of 9/23/22, Resident #12 alleged that certified nurse aide (CNA) #4 was too rough while providing care. The resident reported pain in both arms, asked the CNA to stop, and the CNA continued anyway. - CNA #34's statement, dated 9/26/22, documented on the evening of 9/23/22, they heard Resident #12 yelling to CNA #4, who was forcing the resident on their side to clean them. CNA #4 yelled to CNA #34 to get them towels. Upon entering the room, CNA #34 observed the resident kicking, yelling, and telling CNA #4 to stop. CNA #34 told CNA #4 to leave the resident if the resident did not want to be changed, walked out, and notified licensed practical nurse (LPN) #33 to get CNA #4 and see what they were doing to the resident. CNA #34 added that Resident #12 was yelling so loudly, another resident came out of their room and CNA #34 was told by another resident that CNA #4 was too rough with them. - A statement signed by licensed practical nurse (LPN) Unit Manager #25 on 9/26/22 documented the resident stated they had diarrhea, the CNA went in to change them, the resident told them no, the CNA was too rough, and the CNA began to change them anyway. The resident stated the CNA twisted their arm and pushed them over. The resident did not know the CNA's name and described them. - The investigation did not include statements from CNA #4 or LPN #33. There was no documented evidence the allegation of abuse was investigated on 9/23/22, the resident was assessed at the time, or accused CNA #4 was removed from resident care pending the investigation. CNA #4's time sheet documented: - On 9/23/22, they clocked in at 3:00 PM and clocked out on 9/24/22 at 7:00 AM; - On 9/24/22, they clocked in at 3:00 PM and clocked out on 9/25/22 at 7:00 AM. During an interview with Resident #12 on 2/15/23 at 12:20 PM, they stated they had an issue when a staff member was rough with them and grabbed their arms during care. They stated they yelled and the CNA did not stop. The resident did not like that CNA and did not know their name. The resident was able to give a description of the CNA. An attempt was made to interview LPN #33 via telephone and a return call was not received prior to exit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 2/28/23 at 3:27 PM, they stated the abuse protocol included removal of staff from work pending completion of the investigation. Any abuse allegations were to be immediately reported to the DON. The DON did not receive a report of alleged abuse on 9/23/22. It was communicated on 9/26/22, at which time an investigation was initiated. The DON expected LPN #33 to have reported to the Supervisor upon receipt of the allegation from Resident #12 and CNA #34, initiate an investigation, and have removed CNA #4 from resident care pending completion of the investigation. CNA #4 should not have continued to work 9/23/22-9/25/22, as the investigation was not conducted until 9/26/22. 10NYCRR 415.4 (b)(2)(3)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on observation, record review and interview during the abbreviated survey (NY00306583), the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 1 of 3 residents (Resident #1) reviewed. Specifically, when Resident #1 developed maroon, blue, black discoloration on their heels, routine monitoring, treatment interventions, and pressure relief were not implemented when recommended to promote healing and the resident's left heel wound progressed to a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle). This resulted in actual harm that was not immediate jeopardy to Resident #1. Findings include: The facility policy Physician-Consultations revised 8/2019 documented a consultant would perform the requested evaluation and provide a consultant's note or report. The attending physician would consider the appropriateness of the consultants' recommendations relative to the resident/patient's current condition, risk factors, existing medication regimen, etc. The attending physician was ultimately responsible for all orders and should remain involved with any aspect of care for which a consultant was involved. As appropriate, the attending physician would approve orders based on consultant recommendations. The facility policy Food and Nutrition assessment dated ,d+[DATE] documented a nutritional assessment, including current nutritional status and risk factors for malnutrition, should be conducted for each resident. The dietitian, with the nursing staff and healthcare practitioners' input, would conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that placed the resident at risk for impaired nutrition. Resident #1 was admitted to the facility with diagnoses including dementia, morbid obesity, and dysphagia (difficulty swallowing). The 7/3/22 Minimum Data Set (MDS) assessment documented the resident had severely impaired cognition, required extensive assistance of 2 with bed mobility, total dependence for transfers, was at risk of pressure ulcers, had no skin impairments, had pressure reducing devices for their chair/bed, and was on a turning and repositioning program. A progress note dated 9/3/22 at 11:00 PM by registered nurse supervisor (RNS) #24 documented they were notified by a licensed practical nurse (LPN) of a circular discoloration to both the resident's heels, with the left heel larger than the right. The left heel was pink/red and dark blue, and the right heel was dark blue/black. The resident's heels were elevated off the bed and the care plan was updated. The impaired skin integrity comprehensive care plan (CCP) initiated 9/4/22 documented on 9/3/22 the resident had discolorations noted to both heels with the left greater than the right. CCP and Kardex (care instructions) interventions included apply protective and preventative skin care and elevate heels off the bed by utilizing a pillow. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An Incident Report dated 9/3/22 at 11:00 PM by RNS #24 documented the resident had a skin issue and was found with bruises to both heels. The telemedicine service on-call nurse practitioner (NP #35) was notified on 9/4/22 at 1:00 AM. The incident report documented the family was not notified because the area was a skin discoloration and not an alteration. The resident's heels were elevated. A progress note entered on 9/7/22 at 7:10 PM by licensed practical nurse (LPN) #12 documented they were notified the resident had soft, red areas on both heels. The left heel had a large intact blister, and the right outer heel had a small dark scab. Skin prep (protective barrier) was applied, the nurse practitioner (NP #9) was notified, and a wound care consult would be obtained. A wound evaluation summary by wound care physician #22 entered on 9/7/22 at 8:12 PM documented the resident had a deep tissue injury (DTI, purple or maroon area of intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure) to the right heel that measured 0.5 centimeters (cm) x 0.5 cm. The left heel had a DTI measuring 4.2 cm x 4 cm. The plan included apply skin prep, sponge boots to both feet (a boot that floats the heels from resting on a surface, helping to reduce pressure) and to elevate their legs. A late entry progress note dated 9/7/22 at 3:59 PM (the note did not document when the actual late entry was) by LPN #26 (former wound nurse) documented the resident was seen by the wound care physician for new DTIs to both heels. The left heel was intact (not impaired), and the right heel had a small scab. The resident would dig their heels into the bed to push themselves up. A physical therapy (PT) consult would be ordered, and skin prep would be applied. There was no documented evidence a PT consult or sponge boots were ordered or added to the CCP. On 2/2/23 at 9:37 AM, the Director of Nursing (DON) documented in a correspondence email that physical therapy did not have any consults or notes for the resident around the date of 9/7/22. A 9/9/22 physician order (2 days after wound physician recommendations) documented skin prep to both heels daily and off load heels (elevating the heels to relieve pressure). A wound evaluation summary by wound physician #22 entered on 9/14/22 at 10:54 AM documented the left heel unstageable DTI had a fluid filled blister, had deteriorated, and measured 6 cm x 6 cm. Recommendations included to continue skin prep and switch to a sponge boot. The impaired skin integrity CCP updated 9/15/22 documented the resident had an alteration in skin integrity. Interventions included to evaluate the wound weekly, monitor dressing, report changes to the physician, and refer to the wound specialist as needed. There was no documented evidence the resident had sponge boots added to the plan of care. A nutrition progress note by registered dietitian (RD) #24 dated 9/19/22 at 11:46 AM (16 days after the development of skin impairment), documented they were notified of the resident's impaired skin after reviewing the resident's chart. The resident's estimated needs for skin were 2250 Kcals (calories), 94 grams of protein, and 2250 cubic centimeters (cc) of fluid. Supplements were in place for weight and included super cereal (fortified cereal) for breakfast, and fortified pudding/potato for lunch and dinner. The plan was to continue supplements for wound healing. Nursing progress notes documented: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-on 9/24/22 at 3:35 PM by LPN #27 they reported to the RNS the resident's heel wound opened and the original order was to apply skin prep. The RNS stated they would assess the heel. -on 9/25/22 at 6:10 AM by LPN #18 the RNS assessed the open areas on the resident's heel. -on 9/25/22 at 10:40 PM by LPN #29 the resident's left heel was open with a moderate amount of bloody drainage. The area was cleansed with normal saline and a dry sterile dressing (DSD) was applied and covered with Kling (elastic) wrap. -on 9/26/22 at 9:08 AM by LPN #26 the resident's left heel DTI had deroofed (the top of the blister rubbed off) and the right DTI remained closed. The resident was scheduled for the wound physician visit on 9/27/22. There was no documented evidence of an RNS assessment of the resident's heel wounds or a physician order for the applied treatment of normal saline, DSD, and Kling wrap. A physician order dated 9/26/22 documented to cleanse the left heel with normal saline, apply a petroleum wound dressing and cover with a dry dressing every day. A wound evaluation summary entered on 9/27/22 at 7:12 PM by wound physician #22 documented the DTI to the right heel was resolved. The left heel was a Stage 3 (full thickness tissue loss) and measured 4.5 cm x 6 cm x 0.1 cm with 100% necrotic (dead) tissue and moderate exudate (drainage). The plan was to begin collagen powder (sprinkled on a wound to form a protective gel), petroleum wound dressing, covered with an abdominal pad (absorbent dressing) and Kerlix daily. There was no documented evidence wound physician #22's recommended treatment of collagen powder, petroleum wound dressing, covered with an abdominal pad (absorbent dressing) and Kerlix daily were ordered for the left heel wound. On 10/12/22, 10/18/22, and 10/25/22 wound evaluation summaries by wound physician #22 documented the resident's had a Stage 3 pressure wound to the left heel, the wound was improved and continue collagen powder, petroleum wound dressing, abdominal pad, and Kerlix daily. There was no documentation the wound physician's recommendation to add collagen powder was ordered. The 10/2022 Treatment Administration Record (TAR) documented the resident's left heel treatment included cleanse with normal saline, apply petroleum wound dressing and cover with a dry dressing and was administered every day from 10/1/22 through 10/31/22. The 10/19/22 risk for pressure ulcer CCP documented the resident had a history of pressure ulcers. Interventions included sponge boots to both feet to offload heels, inform family of any new area of skin breakdown, and monitor/document/report to physician changes in skin status. The 10/27/22 at 1:19 PM diet technician (DT) #30 progress note documented the resident's weight was down to 203.4 pounds (8 pound loss) though intakes remained excellent at 86%. The resident received double entree portions at meals, double scrambled eggs, and fortified cereal at breakfast, fortified mashed potatoes and fortified pudding at lunch and dinner. The resident consumed 51-75% of supplements/nourishments. The plan was to trial a liquid protein supplement 30 cubic centimeters (cc) twice daily for wound healing support. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A 11/4/22 wound evaluation summary by wound physician #22 documented the resident's visit was rescheduled. There was no documentation the resident's wound was assessed by a qualified professional from 10/25/22 to 11/9/22. A wound evaluation summary dated 11/9/22 entered by wound physician #22 (13 days after the last assessment) documented the resident had a Stage 3 pressure wound of the left heel which measured 9 cm x 7 cm x 0.1 cm, was 70% necrotic with moderate serous exudate and had deteriorated. The plan was to continue collagen powder, petroleum wound dressing, abdominal pad and rolled bandage daily. There was no documentation the resident's recommended treatment was ordered. The 11/10/22 physician order documented liquid protein supplement 30 cc twice daily (14 days after recommendations by the diet technician). A wound evaluation summary dated 11/15/22 and entered by wound physician #22 documented the resident had a Stage 4 pressure wound of the left heel measuring 5.4 cm x 6 cm x 0.7 cm. The wound had moderate serous drainage with an odor, was 100% necrotic and had deteriorated. The plan was to change the treatment to a debriding ointment (removes dead tissue), calcium alginate dressing (absorbs wound fluid), covered with an abdominal pad and rolled bandage daily. The 11/22 TAR documented the resident's left heel treatment was to cleanse with normal saline, apply petroleum wound dressing, and cover with a dry dressing and was administered every day from 11/1 through 11/16/22. There was no documentation the 11/15/22 recommended treatment by the wound physician of debriding ointment and calcium alginate was ordered. The 11/15/22 progress note by LPN #23 documented the resident was seen by the wound physician and the left heel had deteriorated. Debridement (removal of dead tissue) was limited by pain. The plan was to debriding ointment/calcium alginate dressing and elevate and offload heels. The 11/17/23 physician order (2 days after recommendation) documented debriding ointment, calcium alginate, abdominal pad and Kerlix daily to heel, and offload heels at all times. From 11/17/23 to 1/17/23, the resident was seen by the wound physician weekly and the Stage 4 pressure wound on the left heel had no documented changes. The 1/18/23 wound evaluation summary by wound physician #31 documented the left heel was a Stage 4 pressure wound and measured 5 cm x 6 cm x 0.3 cm, was 40% necrotic and had no change. The plan was to use gauze-soaked dilute bleach solution, debriding ointment, and cover with abdominal pad and Kerlix. The 1/19/23 physician order documented to cleanse the left heel with normal saline, apply debriding ointment and calcium alginate, cover with abdominal pad and Kerlix. The order did not include gauze-soaked dilute bleach solution as recommended by the wound physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 2/1/23 wound evaluation summary by wound physician #31 documented the left heel Stage 4 pressure wound measured 4.6 cm x 3.6 cm x 0.3 cm and had 20% slough (moist, dead tissue) and was improved. The plan was to begin gauze-soaked dilute bleach solution, leptospermum honey (wound treatment containing honey), abdominal pad and Kerlix. The 2/1/23 physician order documented to cleanse the left heel with normal saline, apply honey containing wound treatment followed by calcium alginate, abdominal pad and Kerlix. The order did not include gauze-soaked dilute bleach solution as recommended by the wound physician. The resident was observed: - on 2/14/23 at 8:50 AM, sleeping in a low bed with their covered breakfast tray on the bedside table. The resident had a padded boot on their right foot and the left foot was not visible under a blanket. - on 2/15/23 at 11:09 AM, during a wound evaluation with wound physician #31. The resident's padded booties and the dressing on the left heel were removed. There was a 4.6 cm x 4 cm x 0.2 cm pink/red wound on the left heel with a scant (minimal) amount of slough. Wound physician #31 debrided the wound and the nurse applied the honey containing dressing, calcium alginate and covered the wound with an abdominal pad and Kerlix. During a telephone interview on 2/23/23 at 8:50 AM former wound physician #22 stated when they made recommendations for a wound treatment, the medical providers at the facility would review and approve the treatment, and they expected treatments to be implemented within 24 hours. They stated they had rounded weekly with wound nurses LPNs #23 and #26 and would tell them the recommended treatments. The wound physician would document on the consult form which was uploaded into the electronic medical record. A nutritional assessment should be done within a week after the development of a pressure ulcer and recommended interventions should be implemented as soon as possible. Nutritional interventions were important for wound healing, and the goal was for the resident to have adequate protein stores. If a protein supplement was recommended at the time of the assessment, it should have been ordered then, and waiting 2 weeks was not timely. When the resident's DTI opened on 9/24/22 the skin protectant was no longer appropriate as it could irritate an open wound and they expected medical to be notified for a different treatment to be used. The wound physician stated on 9/27/22 they recommended collagen powder for additional wound healing and was not aware it was not ordered. Wounds should be assessed weekly and if they were not available, they expected an RN to assess the wound. On 11/15/22 the resident's wound had deteriorated, and they ordered the debriding ointment to remove dead tissue and the calcium alginate to absorb drainage and was not aware the treatment had not been ordered until 3 days after the recommendation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/23/23 at 10:50 AM LPN #23 stated as a wound nurse they assisted the wound physician during wound rounds, took recommendations from the wound physician and addressed them with the facility providers who typically had no issue ordering what the wound physician wanted. A sponge boot required a physician order, and a therapy evaluation was usually needed to obtain the boots. Once ordered the boots would be on the TAR and the resident's care plan. The RN or Unit Manager was responsible to update the care plan. The Unit Manager should notify the RD that a resident had a new skin impairment. An RN should assess wounds when the wound physician was not available. There were RNs available in the facility to assess wounds. The LPN stated when the resident developed DTIs on their heels, they did not recall what interventions were initially in place. LPN #23 did not know why wound physician #22's recommendation of collagen powder was not ordered on 9/27/22. The wound physician would verbally tell them what treatment they wanted during rounds however in the past the verbal order and the wound evaluation summary did not always match so they waited for the completed wound evaluation summary. The wound physician did not always get their summary uploaded into the electronic record timely and that was why the order for debriding ointment and calcium alginate was delayed for 2 days after the wound consult on 11/15/22. During a telephone interview on 2/23/23 at 12:41 PM, RNS #24 stated when a resident had a newly identified pressure ulcer, an RN assessment was done, the physician was contacted, the family was updated, the resident was referred for a wound consult, an accident/incident report was completed, and the care plan was updated. On 9/3/23, they would have notified the on-call provider of the resident's DTI because that was a weekend, and no facility provider was on duty. They did not get an order for the resident's heel because the areas were not open. A wound care referral required a physician's order, and they should have gotten one. During a telephone interview on 2/23/23 at 1:07 PM, former wound nurse LPN #26 stated therapy evaluations and sponge boots required a physician's order and needed to be on the care plan. They were not sure why the therapy evaluation was not completed after they wrote in their note on 9/7/22 that it was ordered. During a telephone interview on 2/27/23 at 8:08 AM, RD #24 stated they needed to know when a resident developed a skin impairment so they could assess the resident's nutritional needs for wound healing. The lead RD went to morning report and if a resident had a new skin impairment, they sent a report out to the nutrition team. RD #24 stated when they made nutritional recommendations, they discussed them with the Unit Manager who was responsible for communicating the recommendations to the physician for an order. RD #24 expected the order to be implemented the same day. RD #24 stated when they wrote their progress note on 9/19/22, they found out about the resident's pressure ulcer after reviewing the record and was not notified prior to that therefore, the assessment was not done timely. RD #24 stated the protein supplement was needed to assist with wound healing. The supplement being ordered 14 days after it was recommended was not timely and could impair wound healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/27/23 at 11:50 AM, LPN #12 (former Unit Manager) stated the wound nurses would put the orders in the electronic medical record for the wound physician. They were not aware that skin prep recommended by the wound physician on 9/7/22 did not start for 48 hours after the recommendation and that was not timely. When the resident's DTI opened, they expected staff to report it to the RNS who should assess the wound, call the provider, and document in a progress note. They were not aware there was no documented RN assessment on 9/24/22. Any nurse could send a therapy evaluation in the electronic record and a physician's order was not required and the request was automatically sent to therapy once it was entered in the electronic record. They were not aware the therapy evaluation was not ordered, and it should have been. The former wound nurse LPN #26 was responsible for sending the therapy evaluation. If the wound physician recommended a sponge boot, an order was needed, and it would be on the TAR for a nurse to sign for. The LPN said they were not aware the boot was not ordered. Nutrition staff should have been notified within 24 hours after a resident developed pressure and were typically notified during morning report. The LPN stated they were not aware nutrition was not notified for 16 days after the resident developed a pressure ulcer. The RD was responsible for calling the physician for an order when they recommended a nutritional supplement. The LPN stated, it was not timely when it took 16 days to start the protein supplement for the resident. During a telephone interview with NP #9 on 3/2/23 at 10:30 AM, they stated they expected to be called to review treatment orders from the wound physician and would approve the recommendations. The NP stated they should have been notified for a treatment order for the skin prep and booties when RNS #24 found the resident's heels discolored in September 2022. The NP stated recommendations from the wound physician should be implemented the same day and 2 days for the skin protectant to be implemented was not timely. Nutrition should assess a resident immediately after the development of or a change in a pressure ulcer because nutritional interventions were important for wound healing. If a nutritional intervention was recommended, they expected it to be ordered immediately. When nutrition recommended a protein supplement for the resident it was not timely for the supplement to be ordered 2 weeks later. It was the responsibility of nutrition staff to notify the Unit Manager or the provider to implement their recommendations. When the resident's ulcer opened, they expected an RN to assess the wound at that time. The NP stated that skin protectant was not an appropriate treatment for an open wound as it was very irritating to tissue. The collagen powder should have been added when the wound physician recommended it. The resident did not receive the treatment for 6 weeks after the recommendation and that was not appropriate. When debriding ointment and calcium alginate was recommended on 11/15/22, it was not ordered for 2 days and was not timely. The debriding ointment was needed to remove necrotic dead tissue and calcium alginate was needed for drainage. The NP stated when the wound physician was not available to assess a wound, they expected an RN to assess the resident's wound. 10NYCRR 415.12(c)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	03/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34996 Based on record review and interview during the abbreviated survey (NY00303239) the facility failed to ensure that pain management was provided to residents who required such services consistent with professional standards of practice for 1 of 3 residents (Resident #5) reviewed. Specifically, on [DATE], Resident #5 sustained a fall and had a pain level of ,d+[DATE] (moderate pain) and was given acetaminophen (pain reliever) at 3:52 AM. At 9:52 AM the resident had a pain level of ,d+[DATE] (severe pain) and was administered acetaminophen. There was no documented evidence the resident's report of severe pain was communicated to medical staff or assessed by a qualified professional, no pain medication was administered after 9:52 AM, and at 3:23 PM the resident and their family requested the resident be sent to the emergency department (ED) for uncontrolled pain. Findings include: Resident #5 was admitted to the facility with diagnoses including acute respiratory failure, muscle weakness, and unsteadiness on feet. The [DATE] Minimum Data Set (MDS) assessment documented the resident was cognitively intact, required extensive assistance of 1 with bed mobility and toilet use, limited assistance with transfers and walking in their room, used a walker and a wheelchair for mobility, and did not have pain in the last 5 days. The comprehensive care plan (CCP) for Pain Management initiated [DATE] documented the resident had no reports of pain. Interventions included observe for and report pain/discomfort, able to communicate pain scale, monitor for change in level and/or location of pain using ,d+[DATE] pain scale, provide emotional support as needed. Physician orders dated [DATE] documented acetaminophen 325 milligrams (mg), give 2 tablets by mouth every 6 hours as needed (prn) for discomfort. A nursing progress note dated [DATE] at 4:20 AM by registered nurse (RN) #16 documented the resident fell while ambulating back from the bathroom. The resident was using their walker but lost their balance landing on their back. The resident also banged their chin on their breastbone causing a small skin tear. Range of motion (ROM) was normal for the resident, there was no evidence of a head strike, and neurochecks (evaluation of the nervous system to check for impairment) were within normal limits (WNL). Vital signs were stable except for their O2 saturation (amount of oxygen in blood) which was 86% on room air. Acetaminophen was given for general discomfort and a breathing treatment was administered. Telemedicine was contacted and they were awaiting a return call. A nursing progress note by licensed practical nurse (LPN) #17 dated [DATE] at 4:51 AM documented they administered 2 tablets of 325 mg acetaminophen to the resident. The administration was ineffective, and the follow-up pain scale was a 4. The resident's initial pain level was not documented. There was no documented evidence of a return call received from Telemedicine service. The ,d+[DATE] medication administration record (MAR) documented acetaminophen 325 mg, give 2 tablets by mouth every 6 hours as needed for discomfort was administered as follows: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on [DATE] at 3:53 AM by LPN #17 with an initial pain level of ,d+[DATE] and was ineffective (did not include follow-up pain level). - on [DATE] at 4:52 AM by LPN #17 (did not include initial pain level or follow-up pain level) and was documented as effective. - on [DATE] at 9:41 AM by LPN #18 with a pain level of ,d+[DATE] and was effective (did not include a follow-up pain level). There was no documented evidence the resident's severe pain level of 9 was reported to the Unit Manager or the medical provider. A nursing progress note by LPN Unit Manager #12 dated [DATE] at 3:23 PM documented they were informed by the unit LPN (unidentified) that the resident and their family member were requesting to have the resident sent to the hospital for uncontrolled pain because of a fall during the night. LPN Unit Manager #12 notified the nurse practitioner (NP #9) and together the resident was assessed. The resident voiced complaints of pain pretty much all over but mostly in their back/spine and legs. The NP offered to do X-rays in the facility and the family member requested the resident be sent to the hospital. The hospital ED (emergency department) provider note dated [DATE] documented the resident had an unwitnessed fall at the facility at 2:00 AM while going to the bathroom. The resident hit the back of their head and staff placed them back in bed. The resident reported ,d+[DATE] back pain and upper arm and neck pain. The resident stated they had a bad neck and thought they broke it. A hospital discharge summary documented the resident presented to the hospital on [DATE] at 3:44 PM with back pain after a mechanical fall. A CT (computed tomography, a type of x-ray) showed a new T3 (3rd thoracic vertebrae) compression fracture as well as a fracture of the spinous process (a bony projection off the back of each vertebrae) of T2-T3. A CT of the lumbar spine (lower back) showed a fracture of the S3 (sacral vertebrae). The resident was placed on pain regimen with oxycodone and fentanyl (opioid pain relievers). Additionally, the resident was diagnosed with bilateral lower lobe pneumonia, showed little clinical improvement, was placed on comfort measures, and expired on [DATE]. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN Unit Manager #12 on [DATE] at 1:30 PM they stated they were covering for another Unit Manager on the resident's unit on [DATE]. The LPN Unit Manager stated when they arrived at their unit, usually between 6:00 and 7:00 AM, they would receive report from the night nurse that had covered the unit and would not receive report from the nursing supervisor. If a resident fell overnight, they would check the resident's vital signs, skin, and any changes in pain. If a resident had a pain level of 9 it should be reported to the Unit Manager. The LPN Unit Manager stated they would then check on the resident and notify the nursing supervisor if the pain level was that high. They would also discuss pain with the resident. No one had told them the resident had a pain level of 9. They stated they went to check on the resident in the morning after the fall and the resident was agitated and confused and did not complain of pain. They did not write a progress note and they should have. Staff told the Unit Manager the resident had been like that for days. Later in the day, the resident stated they were not in pain, but they wanted the NP to see them anyway. They called NP #9. There was a family member in the room, and they said they wanted the resident sent to the hospital because of pain. The resident was not verbally voicing pain. The NP offered to have X-rays done at the facility, but the family wanted them sent to the hospital. During an interview with NP #9 on [DATE] at 11:30 AM they stated if a resident fell between 5:00 PM and 7:00 AM when medical staff was not typically onsite, the RN Supervisor (RNS) would assess the resident and call Telemedicine if there were any concerns. The Unit Manager should see the resident immediately the next morning and notify medical if they thought the resident needed further evaluation. The resident should have been seen well before 3:00 PM the day after the fall. If the resident had a pain level of 9 in the morning, a nurse on the unit should have called the NP immediately to evaluate the resident. A 9 pain level was severe pain. If a resident had a lower pain level right after a fall that could be normal but the pain could get progressively worse over time. The resident had a history of spinal fractures. There should have been a progress note and the medication nurse should have told the Unit Manager about a high pain level of 9. If the resident had a high pain level from 9:00 AM until after 3:00 PM, that was unacceptable. The family member could see the resident was in a lot of pain and wanted them sent to the hospital. The NP stated if they were not informed of medical issues by the unit staff, they had no way of knowing what had occurred. During an interview with LPN #18 on [DATE] at 4:09 PM they stated they had just started working at the facility in ,d+[DATE] and had been working on the resident's unit. They did not remember the resident. They stated when they asked a resident about their pain level it was on a scale from ,d+[DATE] and 9 would be considered significant pain. They would give the resident the pain medication listed on the MAR and document the pain level before giving the medication. They would let the Unit Manager or Supervisor know if the pain level was a 9 so they could assess the resident. LPN #18 stated after they gave the medication, they would recheck the pain level in about 30 minutes to 1 hour and document if it was effective. They did not think they used a pain score when they rechecked, but an E in the MAR meant it was effective. They would usually not write a progress note since all the information was in the MAR. If they let the Unit Manager or Supervisor know about pain, they would write in a progress note and if the pain remained severe after giving the medication. They stated they could not remember the resident or if they notified anyone about the pain level of a 9. 10NYCRR 415.12