STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335548	A. Building B. Wing	04/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37385 Based on record review and interview during the abbreviated surveys (NY00283558, NY00285382, and NY00276722), the facility failed to ensure all alleged violations of abuse, neglect, or mistreatment were thoroughly investigated and failed to ensure prevention of further potential abuse, neglect, or mistreatment while an investigation was in process for 3 of 5 residents (Residents #10, 21, and 22) reviewed. Specifically, - Resident #10's relative reported concerns of abuse by a staff member and the facility did not investigate the allegation or remove the staff from resident care while the investigation was pending. - Resident #22 reported a staff member assaulted them and the facility did not initiate a timely investigation to rule out abuse and the investigation was not thorough and complete. - Certified nurse aide (CNA) #45 continued to provide hygiene care to Resident #21 after the resident complained of pain and asked CNA #45 to stop. The investigation into the incident was not thorough and complete as the witness (roommate) was not identified in the report. In addition, CNA #45 was not immediately removed from resident care when the allegation was made. Findings include: The Abuse policy revised 2/2019 documents: - Physical abuse includes hitting, slapping, pinching scratching, spitting, holding roughly, kicking, etc. - Provide for the immediate safety of the resident upon identification of suspected abuse; - An investigation included interviewing any witnesses to the incident, interview the resident, and interview the resident's roommate. - Immediate suspension of suspected employee(s) pending outcome of the investigation; - Allegations/reports of suspected abuse, neglect, mistreatment, distortion, injury of unknown etiology shall be promptly and thoroughly investigated by facility management; (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 - Some	- The shift supervisor/charge nurse is identified as responsible for immediate initiation of the reporting process upon receipt of the allegation; - The Administrator and Director of Nursing (DON) are responsible for investigation and reporting; and - The investigation should be thorough with witness statements from staff, residents, visitors, and family members who may have information regarding the allegation. The facility policy ADL-Perineal Care created 7/2019 documents when performing care, wet washcloth and apply soap or skin cleansing agent. Wash the perineal area, wiping from front to back. Rinse perineum thoroughly in same direction. Gently dry the perineum. Document any complaints of pain or discomfort. The undated facility policy Daily Work Assignments documents certified nurse aides (CNA) and trainees are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures. 1) Resident #10 had diagnoses including metabolic encephalopathy (disturbed brain function) and dementia without behavioral disturbance. The 9/8/21 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment and exhibited no behavioral concerns. The resident required extensive assistance of 1 for all activities of daily living (ADL), utilized a walker and wheelchair, and was frequently incontinent of bladder and bowel. The resident had no falls since admission. The comprehensive care plan (CCP) initiated 8/31/21 documented the resident required assistance with ADLs related to weakness. Interventions included extensive assistance of 1 for bed mobility, dressing, hygiene, and toileting. The CCP did not include any areas related to behavioral concerns, yelling out during care, or care resistance. The 9/2021 Documentation Survey Report (care record) documented certified nurse aide (CNA) #18 provided care to the resident on multiple days from 9/1/21 to 9/11/21. There was no documented staff sign-off for care provided on 9/12/21. There were no nursing or social work progress notes on 9/12/21. The resident's record did not contain any documentation related to an abuse allegation on 9/12/21. The 9/13/21 at 8:37 AM registered nurse (RN) Supervisor #2's progress note documented the resident was to be discharged on [DATE] and the RNS reviewed discharge instructions with the resident and/or their representative. Nursing, medical, and social worker progress notes from 8/30/21 to 9/15/21 had no documentation related to behavioral concerns, the resident yelling out during care, or resistance to care. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/15/21 at 3:00 PM, RNS #2's progress note documented upon reviewing the discharge summary and medication with the resident's relative, they brought to the RNS's attention the resident's left lower hand appeared to be and was slightly edematous (swollen). The RNS palpated the hand and asked if the relative wanted the medical provided to be notified. The relative stated they would follow-up outside of the facility since the resident was being discharged . The resident was able to move their upper extremities and movement was within normal limits. There was no documentation the resident's relative made any inquiries to RNS #2 related to an allegation of abuse. Records requested from the facility on 3/21/22 and 3/24/22 included all investigations, grievances, and accident/incident reports for the resident and none were provided with the resident's record. During an interview with RNS #2 on 3/22/22 at 3:30 PM, they stated the weekend prior to the resident's discharge (9/11-9/12/21), the resident's relative approached them to report staff were rough with the resident's care. The relative had a picture of the staff member and asked the RNS their name. The RNS asked the relative to delete the picture due to staff privacy. The RNS could not recall if they assessed the resident when this allegation was made. The RNS stated the staff member in the photo was CNA #18. The RNS stated an investigation was not initiated and the CNA was not removed from resident care due to the relative reporting the resident only hollered out during care. When asked about the RNS's initial comment that the relative reported the CNA was rough with the resident's care, the RNS stated the relative did not report abuse, only that the resident yelled out. The RNS said a description of rough during care would constitute an allegation of abuse. RNS #2 stated when abuse allegations were reported an investigation needed to be initiated including resident assessment, staff statements, and immediate removal of the accused staff pending the investigation. During a telephone interview with CNA #18 on 3/24/22 at 3:25 PM, they stated on 9/12/21, they were asked to provide incontinence care to the resident. CNA #18 was not familiar with the resident and proceeded to provide care. During care, the resident's relative kept entering the room because the resident was yelling out. The relative stated the CNA was hurting the resident and the CNA asked the relative to leave to allow privacy. The CNA stated they heard from other staff the resident yelled out during care, and they were unaware if the resident had combative behaviors, as they could not recall if the resident was combative on this day. No one assisted the CNA during the care. The relative continued to question the CNA and when they left the room, the relative directly accused the CNA of abuse and inflicting harm to the resident. The CNA reported the allegation to RNS #2 and did not return to the resident's room. RNS #2 told CNA #18 the resident's relative had their picture and they were asked to delete it. The CNA was not aware of any other actions by RNS #2. The CNA was not removed from resident care and continued their shift. There was no suspension following the report and the CNA denied any type of abuse occurred. The CNA reported the allegation to the Administrator (former) and the Director of Nursing (DON, former) and was asked to complete a statement. They were not aware of any further action that occurred in regard to this allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with the resident's relative on 3/24/22 at 4:00 PM, they stated on 9/12/21, around lunchtime, or shortly after, CNA #18 arrived to provide incontinence care to Resident #10 and the relative was asked to wait outside the room. The relative heard the resident screaming out as if in pain, and when they entered to see what was going on, the CNA told the relative to leave. The relative said the CNA was hurting the resident and being abusive, the CNA told the relative to prove it. The relative continued to hear the resident screaming out and when the CNA exited the room, the relative told the CNA they abused the resident and the relative was going to report it. The relative then went to RNS #2, showed a picture of the CNA on their phone, telling the RNS the staff member was rough with the resident's care, and they suspected abuse by this staff member. RNS #2 said they did not know the CNA's name and asked the relative to delete the picture. The relative stated RNS #2 agreed to do an investigation if the relative deleted the picture. There was no follow-up from anyone at the facility related to the allegation. The relative was not asked for a statement and RNS #2 did not go to check on the resident. Another relative visited later in the evening and reported the resident had pain in their left arm and shoulder. Three days later when the resident was being discharged , RNS #2 continued to state they did not know the CNA's name, which led the relative to believe there was no investigation. At the time of discharge, the resident had a swollen, painful left hand, RNS #2 looked at it and offered to have a medical provider see it, but the relative declined and proceeded with the discharge. During a telephone interview with the DON on 3/29/22 at 12:45 PM, they stated at the time of this allegation, they were not yet employed at the facility or had just started. The DON stated there was no documentation or investigation related to the 9/12/21 abuse allegation. The procedure for responding to an abuse allegation was to call the DON and remove the accused staff from duty immediately. The DON was not aware of an abuse allegation for Resident #10 and recalled there was a noted skin alteration or swelling to the resident's hand the day they were discharged . The DON was not made aware of an allegation of abuse from the prior weekend. If the Supervisor was notified by staff or a visitor of an allegation of abuse, the DON would expect the supervisor on duty to initiate an investigation, assess the resident, obtain statements, and have the staff removed until it was determined what happened. 2) Resident #22 had diagnoses including major depressive disorder and anxiety disorder. The 8/8/21 Minimum Data Set (MDS) assessment documented the resident had intact cognition, exhibited behaviors, and required limited to extensive assistance for most activities of daily living (ADL). The comprehensive care plan (CCP), initiated 6/29/21 and active on 10/23/21 (after the incident), documented: - the resident had an alteration in comfort related to degeneration, decreased mobility, neuropathy, and spinal surgery. Interventions included administer medications as ordered, evaluate the effectiveness of pain interventions as needed, review for dosing schedules and resident satisfaction with results. - The resident had a history of substance abuse and demonstrated ineffective coping skills. Interventions included assist to improve problem solving skills, setting of priorities, persistence, and frustration tolerance, facilitate and explore expressions of feelings. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 8/18/21, the CCP was updated and documented the resident exhibited behavior symptoms such as medication seeking. Interventions active on 10/23/21 (after the incident) included administer psychotropic medications as ordered, initiate psychology evaluation as needed, notify physician of inappropriate behavior or activity, behavior symptoms (no explanation). Physician orders dated 8/26/21 documented to monitor the resident's behaviors (medication seeking and other depressive episodes) every shift and record the number of episodes. Staff were to document whether interventions were effective. A nursing progress note dated 10/13/21 at 5:53 PM by licensed practical nurse (LPN) #16 documented a weekly skin monitoring had been completed and no issues were found. A nursing progress note dated 10/23/21 at 9:10 PM by LPN #50 documented the resident displayed behaviors. The behaviors displayed were the resident's target behaviors with no explanation of those behaviors. There was no change in neurological status or pain. Interventions included the staff redirected the resident to their room. A police report documented on 10/25/21 at 3:38 PM, they responded to the facility for a harassment complaint. The resident reported on (Saturday) 10/23/21 at 10 PM, the accused LPN (LPN #50) entered the room, and they had a verbal dispute regarding a personality conflict. LPN #50 grabbed resident's left arm with their hand and left a bruise. The resident stated they made a fist with their right hand but did not hit LPN #50. The resident reported LPN #50 left the room without giving the medications and stated they would document the resident refused medications. The resident showed a bruise on the left arm to the police officer, and it was photographed. The officer noted multiple other bruises on the resident's arms and the resident stated due to their medications they bruised easily. The resident did not wish to press charges. The photographs taken by the police officer included multiple red bruises on the resident's arm and one dark purple bruise on the top of the left forearm that the resident identified as the bruise that resulted from this incident. The facility Investigation dated 10/27/21 documented: - and allegation of physical abuse involving Resident #22 on 10/23/21 (4 days prior to the investigation being initiated). - The resident alleged LPN #50 entered their room with their 8 PM medications and stood next to the bed. As LPN #50 was handing the resident their medications, LPN #50 stated I don't like you and the resident responded they did not like LPN #50 either. The two spent several minutes exchanging rude, vulgar comments. The resident continued to report LPN #50 grabbed the resident's left arm over the wrist and was squeezing tightly. The resident made a fist with their right hand and was going to hit LPN #50 and LPN #50 stated to them they would go to jail. LPN #50 left with inhalers. The resident then went into the hallway yelling for the Supervisor, motioned to a nurse at the other end of the hallway, and that nurse went to the resident, then to LPN #50. - The investigation findings documented LPN #50 reported they reached out and touched the resident's right hand and lowered it to the bed. - The resident reported an ecchymotic (bruise) area on their left lower arm was the result of LPN #50 grabbing and squeezing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN #50's statement, included with the investigation, documented they brought the resident their medications and the resident asked about the contents. The resident told the nurse they were in a grumpy mood and made additional inappropriate statements to LPN #50. During the exchange, the resident raised their right arm to hit LPN #50 and LPN #50 touched the resident's hand and lowered it to the bed. - LPN #51's statement, included with the investigation, documented they encountered Resident #22 in the hallway yelling and cursing. The resident reported to LPN #51 that they attempted to hit LPN #50 and LPN #50 used their arm to block the resident. The resident claimed that was assault. - The resident had multiple skin discolorations/ecchymotic areas on their bilateral arms, which the resident contributed to bruising easily and for no apparent reason. The resident had been on long term steroids causing fragile skin and bruising. - The Investigation conclusion documented the accused staff member was suspended pending investigation and there was no element of verbal abuse on the LPN's part. The LPN blocking the resident's arm did not meet the definition of a physical attack. Neither the staff nor the resident's report included inappropriate physical contact. The element of physical abuse was not met. It was reasonable to conclude the resident embellished some of the event. The investigation revealed there was no evidence to support resident abuse. The investigation was not signed or dated by the investigator, the DON, the Medical Director, or the Administrator. LPN #50's timecard documented: -on 10/23/21 punched in at 6:00 PM and punched out on 10/24/21 at 6:37 AM. -on 10/24/21 punched in at 5:44 PM and punched out on 10/25/21 at 6:28 PM. The next documented punch was 10/30/21. There was no documented evidence the resident was assessed by a qualified professional timely after reporting the allegation of abuse; an investigation was not initiated immediately upon the resident reporting a physical/verbal interaction, and LPN #50 continued to work in the facility after the allegation was made. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/29/21 at 12:58 PM, DON #3 stated the resident alleged LPN #50 grabbed their arm and caused a bruise. The resident alleged it as a physical attack. It was initially reported by LPN #50 they had been blocking a swing from the resident. The DON stated later when following up with LPN #50 the LPN said they reached out with their hand and lowered the resident's hand. The DON stated that action was not intent of abuse, and the resident's skin alteration was consistent with senile purpura (recurrent formation of purple bruises). The resident had pointed to a spot on their left arm but had reported their right arm was touched. The DON stated they offered the resident the police and was unsure of the outcome. The DON stated they had assessed the resident and the results would be in the accident and incident report and they could not locate any documentation of an assessment in the medical record. The resident would only allow them to see their arms and would not allow a head to toe assessment. The resident's CCP was updated after the incident to include allegations and the staff member was suspended during the investigation. LPN #50 was interviewed on 4/1/22 at 9:30 AM and stated the resident had behaviors prior to the incident such as being manipulative and accusatory, but they never personally had a problem with the resident until that day. On the date of the incident, LPN #50 entered the resident's room, and the resident was in a mood. If the resident was having behaviors, they would walk out of the room and go back in later and that usually worked. On 10/23/21, LPN #50 stated they went to give the resident medications and the resident asked if everything was there and they told the resident everything was in there. At that time, the resident threw the inhaler and started to raise their fist as if they were going to punch LPN #50. LPN #50 stated they took their hand and laid it on the resident's arm to put the arm down. LPN #50 stated they probably should not have stepped toward the resident to move their hand because it probably seemed threatening. LPN #50 stated they wanted the resident to realize they did not have to hit them. LPN #50 stated they walked out because the resident was calling them names. LPN #50 stated they were the Supervisor for the entire building that evening and responsible for a medication cart. They did not have any further interactions with the resident that night. Later LPN #51 took the resident their inhaler. LPN #50 stated they took in the resident's midnight medication (oxycodone) and at that time, the resident was over whatever they were mad about, and they slept the rest of the night. LPN #50 stated they reported the incident at change of shift the next morning, but it was not any type of altercation. During an interview with LPN #51 on 4/1/22 at 12:15 PM, they stated: - the resident tended to make allegations if staff did not give into their demands. - On the evening of 10/23/21, LPN #51 was present when the resident came out of their room cursing very loudly at LPN #50. They did not see what happened in the room, but the resident was loud and disrupting others in the hall. LPN #51 redirected the resident because they were screaming in front of other residents that LPN #50 hit them. The resident was still getting in LPN #50's face and eventually went back in their room. - LPN #51 switched medication carts with LPN #50 so LPN #50 would not have to interact with the resident again that shift and LPN #50 did not deal with the resident for the rest of the night. LPN #50 stayed the rest of the shift and worked until 6 AM. - Interventions for the resident would to be calm and reassuring, some of the nurses gave in to the resident's demands for medications but LPN #50 and they stood their ground. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN #51 was not sure what other nurses were in the building that night. - They did not hear anything about the incident until the next day when the police arrived. The resident claimed the bruise on their arm was from LPN #50. - Several days after the police responded, DON #3 asked them questions about the incident. DON #3 was re-interviewed on 4/4/22 at 3:02 PM and stated they were notified about the incident on Monday morning (the incident occurred on a Saturday) and was told LPN #50 blocked an assault by the resident. The resident made the accusation on 10/25/21 that they were hit. The investigation was started on 10/25/21. LPN #50 was called and suspended at that time. It was not a question of abuse until 10/25/21 so LPN #50 worked on 10/23/21 and 10/24/21. The DON stated an accident and incident report should be started when a resident attempts to hit a staff member. There was no abuse at that time, so LPN #51 did not report the allegation. The DON stated they wanted to be notified if the resident started to hit staff. Verbal education was given to LPNs #50 and 51 on abuse after the incident. DON #3 stated they tried to complete investigations within 5 days and the process for finalizing included having a corporate meeting, talking about the information collected, and review of the conclusion. After that, the CCP was updated, and education provided. DON #3 stated when a resident became aggravated, staff should give them space, deal with them at a distance, speak calmly, and give them what they want within reason. 3) Resident #21 had diagnoses including diabetes, unspecified personality disorder, and chronic pain. The 5/8/21 Minimum Data Set (MDS) assessment documented the resident was cognitively intact, did not reject care, required extensive assistance of 2 for toileting, extensive assistance of 1 for bed mobility, dressing and personal hygiene, and was dependent on 2 staff for transfers. The resident was frequently incontinent of urine and bowel. The comprehensive care plan (CCP, only dates included was cancellation date of 11/27/21) documented the resident required assistance with activities of daily living (ADL) related to confusion and limited mobility. Interventions on 10/27/20, included skin inspection, monitor for redness and report changes to charge nurse; extensive assistance of 1 for personal hygiene. The resident had potential for pain with interventions including observe for verbal/non-verbal signs and symptoms of pain. The resident Kardex (care instructions) report as of 5/1/21 documented skin inspection: monitor for redness and report changes to nurse; the resident required extensive assistance of 1 staff for personal hygiene. Licensed practical nurse (LPN) #44's progress note dated 5/25/21 at 4:45 PM, documented LPN #44 was alerted by the nurse on duty the resident was tearful and upset about ADL care they received. The nurse reported the resident stated a CNA was on their phone while providing care to the resident and pulled a wet, soapy towel roughly back and forth between their buttocks. The Clinical Regional Director and social services were notified immediately. The resident asked that the CNA not to be sent into their room again. The resident stated the CNA really hurt them and they were scared of the CNA. The resident stated the CNA did not stop when they told the CNA it hurt. LPN #44 viewed the area and there was redness present. The resident requested their family not be notified and requested to see the medical provider the next day because it really hurts. The resident was reassured they would receive care from a different CNA that evening. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #44's progress note dated 5/25/21 at 9:33 PM, documented a skin alteration was identified. The resident's coccyx (tailbone) had a reddened area approximately palm sized at the base of the buttocks. The resident complained of pain that was relieved with Tylenol. The facility Incident/Accident Report dated 5/25/21 at 3:45 AM completed by Director of Nursing (DON) #46 documented: - the resident reported the CNA was rough with the wash towel while cleaning them and the CNA was on the phone while providing care. The resident stated the CNA said they had a situation they have to attend to, and the resident stated they did not want the CNA back in their room. There were no witnesses. - The Investigation form documented findings included: slight redness to the peri area no open areas or injury noted; resident crying and upset; roommate statement the resident was screaming (the roommate was not identified); accused CNA confirmed they were on the phone and upset. - The social worker interviewed other residents to ensure no past experiences with CNA #45 (accused CNA) and none were identified with similar experiences. - The conclusion documented after a thorough investigation they determined the allegation of abuse was unsubstantiated. - CNA #45 was educated regarding abuse and verbalized understanding. The CNA was educated on the use of cell phones in resident rooms. There was no documented evidence CNA #45 was immediately removed from resident care once the allegation was made and while the investigation was in progress. In addition, the roommate who was interviewed, was not identified, or named in the report. Statements taken by the facility and included with the investigation documented: - CNA #45's undated statement documented they cleaned the resident as they were wet. CNA #45 wet the towel and used soap and water and cleaned up the resident. CNA #45 was on the phone when providing care. The resident told the CNA they were rubbing too hard, and the CNA asked the resident what they meant by rubbing too hard. The CNA walked out of the room after that. The CNA stated every resident said the towels were too rough. The resident was not crying while they were in the room. - An undated statement by LPN #48 documented the resident was crying and upset and told them CNA #45 was on their phone while providing care and used the towel to clean between the legs and was very rough. The LPN went to registered nurse (RN) Unit Manager #47 to report the event and was told if it happened again let the Supervisor know. The LPN immediately reported to the Supervisor. During telephone interviews on 3/29/22 at 11:40 AM and 3/31/22 at 10:00 AM CNA #45 stated: - they remembered the date in question, and they were assigned to the resident's floor, and it was the first time they had been assigned to that floor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- They went to help the resident because the resident said they were wet. The resident was soaked through with urine. The resident's peri-area was reddened because they had been sitting in urine for a long time. - They did not recall specifics and did not recall writing a statement documenting the resident told them it hurt. - They were called (could not remember when) to the office and was told they were suspended while the facility investigated. They were suspended for 3-4 days, then went back to work and was told they could not work on that side where the resident was anymore. - They worked the evening and night shifts at the facility. On the day of the incident, they stated it occurred around 5:00 PM. - The CNA was not aware of the resident's complaints until 2-3 hours later when a nurse approached them (unknown name) and reassigned CNA #45 to another unit and CNA #45 stated they remained at the facility to complete their shift until 6:00 AM. During a telephone interview with former DON #46 on 3/30/22 at 3:30 PM they stated they were the acting DON at the time of the event but was not in the building when the incident occurred. They stated the resident's roommate was not named or interviewed during the investigation and they could not identify the name of the resident. DON #46 stated CNA #45 was from an agency and had worked the overnight shift on 5/25/21 and the event occurred at 3:45 AM. The DON stated since it was on the overnight shift, it was reported at 6 AM and the investigation was started that day. The CNA was sent home immediately after the event was discovered but was not sure what time they left. The DON stated they had reviewed CNA #45's timecard and it was wrong because it showed CNA #45 worked after the event, but they had not. During an interview with LPN #44 on 3/31/22 10:30 AM, they stated they heard the resident was upset during shift change which was about 2:15 PM to 2:30 PM on 5/25/21. LPN #44 stated they were the evening Supervisor, and they immediately went to see resident. The resident was very upset, and the LPN looked at the resident's skin. The resident had a reddened area the size of a palm. The resident told the LPN who the accused staff was. The LPN stated they had CNA #45 go to the other side of the building to sit in the little break room area to get them away from the resident. The LPN stated they did not reassign the CNA to another unit. The Regional Manager, who was an RN, was in the building so they notified them. The LPN stated they and the Regional Manager met with CNA #45 and they sent them home right away. The CNA had a history of behaviors and started screaming and yelling when they sent them home. CNA #45 sat on the benches outside while waiting for the cab to take them back to their hotel. The LPN stated the resident was okay when they checked back with them. They did not know if the RN assessed the resident. The LPN stated they did not talk to the roommate. They stated they obtained the CNA's statement they had signed before the CNA went home during the shift. The LPN was not aware of any other residents who complained about the care from CNA #45. CNA #45 needed a lot of verbal prompting to complete their job correctly without cutting corners. 10NYCRR 415.4(b)(2,3)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 40491 Based on interview and record review during an abbreviated survey (NY00291521), the facility failed to ensure the transfer or discharge was documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider for 1 of 1 resident (Resident #26) reviewed. Specifically, Resident #26 was transferred to the hospital on 2/14/22. The reason for the transfer was not documented and there was no evidence the transfer was necessary for the resident's welfare and the facility was unable to meet the needs of the resident. This is evidenced by: The facility policy Change in Resident's Condition dated 5/2019 documents the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Resident #26 was admitted to the facility with diagnoses including myopathy (disorder of skeletal muscles), diabetes, and Guillain-Barre syndrome (rare autoimmune disorder causing muscle weakness and sometimes paralysis). The 1/30/22 Minimum Data Set (MDS) assessment documented the resident was cognitively intact, required extensive assistance or total dependence for activities of daily living (ADLs), had an indwelling catheter, had an unstageable (full thickness tissue loss in which the base of the ulcer is obscured) pressure ulcer on admission, had pressure relieving devices for bed and chair, nutrition or hydration intervention, and pressure ulcer care. The 2/14/22 discharge MDS assessment documented the resident was cognitively intact, required extensive assistance or was totally dependent for ADLs, had an indwelling catheter, and had a Stage III (full thickness tissue loss) pressure ulcer which was present on admission. The 2/11/22 licensed practical nurse (LPN) #16 progress note documented the resident's weekly skin monitoring had been completed. There was no other nursing progress notes from 2/11/22 through 2/14/22. On 2/14/22 at 2:09 PM LPN #15 documented the resident was sent to the emergency room for further evaluation. The progress note did not include what the resident was being evaluated for. The 2/14/22 INTERACT form (Hospital Transfer Form with resident status and information) completed by registered nurse (RN) Unit Manager #1 documented the resident's most recent vitals from 8:00 AM on 2/14/22, code status, and primary care clinician. The section Reason for Transfer, name of the hospital, and pressure ulcers/injuries was left blank. The form documented the resident had a urinary catheter in place for retention, the date of insertion was left blank. The 2/14/22 Hospital History and Physical documented the resident was sent to the hospital due to a suprapubic catheter (a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder) malfunction. The 2/17/22 physician order documented to discharge the resident to the hospital, which was 3 days after the resident's actual discharge. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/22 at 9:40 AM, physician assistant (PA #68) stated nursing staff were to call either the on-call provider service or the PA directly if the resident had a major change in condition. When the nurse called, they expected a quick triage with vitals, a quick review of systems (for example, if a resident reported abdominal pain, were they having diarrhea, did they have any other issues with the gastrointestinal system), and pertinent past medical history. The PA stated ideally, when a resident was sent to the hospital, they expected nursing staff to document the reason why, what prompted the transfer, any positive pertinent symptoms, and a quick assessment. The information was important to the emergency room to help them triage patients. There should be an order for discharge to the hospital entered by a nurse and signed off by the provider. The documentation should include why the resident's needs could not be met in the facility. The PA stated they were not sure why the resident was sent to the hospital. They reviewed the record and there were no nursing progress notes indicating why the resident was sent out. The PA stated there should have been more documentation available in the medical record; at minimum, there should have been more up to date vitals when the resident was sent out. The nurse should have also documented they spoke with the provider regarding the transfer. The discharge order was entered 2-3 days later; the order should have gone in on the day of the discharge or the following day. The resident did not have a suprapubic catheter while at the facility. If the facility documentation had been clearer, the hospital may not have thought the resident had a suprapubic catheter malfunction. The PA was unsure why the resident went to the hospital. During an interview on 4/15/22 at 10:34 AM, RN Unit Manager #1 stated the resident had a Foley (a tube that passes through the urethra and into the bladder to drain urine); they were sent to the hospital to have their Foley replaced. On 2/14/22, the resident's Foley would not flush, and the RN could not replace the catheter, thus the resident was sent to the hospital. There should have been more documentation regarding the resident's discharge. They had called PA #68 and documented it on the transfer form. The reason for the transfer was left blank on the form. The RN had been working on the unit on that date and did not have time to document the reason for the transfer. Documentation was important to know what happened to the resident and was important as a part of communication with the hospital. The discharge to the hospital order should have been entered on 2/14/22. The RN stated they had failed to document on the resident. During an interview on 4/15/22 at 11:32 AM, the Director of Nursing (DON) stated they were not sure why the resident went to the hospital. They reviewed the progress notes and there was no documentation of the reason why the resident was sent out. The DON expected some documentation that supported the decision to send the resident to the hospital and why a higher level of care was needed. The facility utilized an INTERACT form that accompanied the resident to the hospital. The reason for discharge was blank and it should have been filled out; it was a part of the communication and supporting reason why the resident was sent out. The discharge order should have been entered on 2/14/22. 10NYCRR 415.3(ii)(iii)(b)

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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. 40491 Based on interview and record review during the abbreviated survey (NY00288354), the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals' condition demonstrates that they were unavaoidable and failed to ensure a resident with pressure ulcers receives 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 2 residents (Resident #8) reviewed. Specifically, Resident #8: - was admitted with an unstageable pressure ulcer on the dorsum (top) of left foot and a deep tissue injury (DTI) on the left heel and treatments were not ordered until 3 days after admission. - The resident developed a pressure ulcer on the ball of the left foot that was not assessed or treated timely. - Treatment orders recommended by the wound consultant were not implemented timely on 3 occasions. - The orthopedic surgery consult recommended for evaluation of a CAM (controlled ankle motion) boot (used to limit foot and ankle movement after a fracture) was not arranged timely by the facility and the resident developed additional pressure ulcers as a result of the CAM boot. This resulted in actual harm to Resident #8 of 3 unstageable pressure ulcers that was not Immediate Jeopardy. Findings include: The 4/2019 Wound Ulcer policy documented: - Licensed staff would perform a head-to-toe assessment admission and document findings. - Wounds were to be measured weekly by licensed staff. - At the time a skin issue is discovered, it must be measured. - Wound care was to be consulted when appropriate. - Treatments were determined based on tissue type and drainage; all orders must be approved by a physician within 24 hours of discovering the open area or change in treatment. Resident #8 had diagnoses including a left tibia and fibula (lower leg) fractures. The 11/4/21 Minimum Data Set (MDS) assessment documented the resident was cognitively intact, required extensive assistance for most activities of daily living (ADL), and had an unstageable pressure ulcer on admission. Interventions included pressure reducing devices for the chair and bed and pressure ulcer care. The 10/28/21 Hospital Discharge Summary documented: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- the resident had a left leg boot to treat lower leg fractures. - On 10/22/21, it was noted in the hospital the resident had multiple pressure ulcers as a result of the boot. - Discharge medications included Santyl (to remove dead tissue) and to follow directions on the change dressing nursing order. - An orthopedic surgery follow-up was recommended in 2 weeks and the facility was to schedule. The 10/28/21 Director of Nursing's (DON) admission progress note documented: - Left heel deep tissue injury (DTI), measuring 4 by 4 and not open. - Dorsum (top) of the left foot, wound measured 4 by 1. There was no staging or depth documented. - Multiple pressure injuries/ulcers were documented on the resident's discharge paperwork. - The resident's Braden score (measures risk for developing pressure ulcers) was 13, meaning they were at moderate risk for developing pressure ulcers. There were no physician's orders for treatments for the skin impairments documented in the admission assessment. The 10/31/21 (3 days after admission) physician's order documented: - cleanse the wound (no location identified) with normal saline, may apply Sureprep (skin protectant) rapid dry to peri wound and allow to dry; apply Santyl and calcium alginate AG (highly absorbent and antimicrobial dressing), cover with border dressing; change daily and as needed. - Apply skin prep to the left heel (DTI) twice a day. - T-scope brace (knee immobilizer) to the left leg at all times and check each shift for skin integrity. - Short CAM (controlled ankle movement) boot to left foot at all times and check each shift for skin integrity. There was no documentation for the orthopedic surgery consult in 2 weeks as recommended in the hospital Discharge Summary. The 10/31/21 comprehensive care plan (CCP) documented the resident had impaired skin integrity related to an ulceration on the left leg. Interventions included treatments per order; document the location, drainage, peri-wound area, pain, edema, and measurements of wounds. Document progress in wound healing on an ongoing basis; monitor/document/report any signs and symptoms of infection to the physician as needed and refer to the appropriate medical. The resident also had a fracture and a brace or immobilizer was to be applied as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 11/3/21 Wound Consult by Wound Advanced Practice Nurse (APN) #56 documented: - dorsum (top) of the left foot, full thickness ulcer, which was unstageable, measuring 3.8 centimeters (cm) by 2.1 cm x 0 cm. The wound base was 100% slough (moist, dead tissue) with non-odorous serous (thin, clear) drainage. The wound edges were adherent to the wound base. - The treatment recommended was to cleanse the site with normal saline, apply Medihoney gel (used to treat open wounds and prevent infection) to wound base daily and as needed. If present, gently pack any cavity or undermining with normal saline moistened gauze. Apply skin protectant to the periwound prior to applying secondary dressing. Cover with gauze or bordered dressing. - Off-load pressure to affected areas and continue repositioning in accordance to assessed needs. - There was no documentation APN #56 assessed the DTI on the resident's left heel. The 11/3/21 Wound Documentation progress note by the DON documented the wounds assessed by APN #56 and the recommended treatment. The 11/5/21 physician's order documented cleanse the left dorsal foot with normal saline, apply Medihoney gel-nickel thickness to the wound base, apply skin prep to periwound and cover with bordered dressing; complete daily and as needed. The physician order was dated 2 days after the recommendation by APN #56. The skin prep to the resident's left heel DTI continued. The 11/11/21 licensed practical nurse (LPN) #29's progress note documented the resident had a deep dark purple area on the ball on their left foot and the left toe had a reddened area. There was no documentation this area was assessed by a registered nurse (RN) or that medical was notified. During an interview on 3/29/22 at 7:26 AM, LPN #29 stated they worked with the resident one time and when they went to do the resident's treatment, they opened the resident's boot and what they saw was different than the ordered treatment. LPN #29 stated it was bad and they notified an agency Supervisor and another staff member but could not identify them. LPN #29 could not recall what treatment was ordered at that time and they thought the ball of the resident's foot was black and blue. LPN #29 stated the Supervisors were not concerned, so the LPN documented what they saw in a progress note. LPN #29 stated they did not receive instructions on how to remove the CAM boot, but they had worked with them in the past. They did not think they removed the CAM boot all the way; they opened it to do the treatment and closed it afterwards. The 11/17/21 Wound Consult by APN #56 documented: - left dorsal (top) foot, full thickness ulceration that was unstageable, measuring 3.0 cm by 2.1 cm by 0 cm. The wound base was 100% slough with scant non-odorous serous drainage. Wound edges were adherent to the wound base. - The treatment recommended was Santyl to wound base daily and as needed. If present, gently pack any cavity or undermining with normal saline moistened gauze. Apply skin protectant to the periwound prior to applying secondary dressing, cover with gauze or bordered dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Offload pressure to affected area and continue repositioning in accordance to assessed needs. - There was no documentation related to the left heel DTI or the deep purple area on the ball of the left foot that was noted by LPN #29 on 11/11/21. The 11/17/21 Wound Documentation progress note by the DON documented the wounds assessed by APN #56 and the recommended treatment. The 11/19/21 Weekly Wound Assessment by Registered Nurse (RN) #64 documented additional padding was added to the resident's leg brace. There were no orders for additional padding or updates to the CCP related to padding the leg brace. The 11/19/21 physician's order (2 days after recommended by APN #56) documented to cleanse area (location of wound not specified) with normal saline, apply skin prep to surrounding area, apply nickel-thick layer of Santyl to wound bed, and cover with optifoam daily and as needed for pressure ulcer. The skin prep to the left heel DTI continued. The 11/24/21 Wound Consult by Wound APN #56 documented: - left dorsal (top) foot, full thickness ulceration that was unstageable, measuring 3.0 cm x 2.1 cm by 0 cm. The wound base had 100% slough with scant non-odorous serious drainage. APN #56 recommended the Santyl treatment to continue. - Left plantar (ball of the foot), deep red tissue/purplish discoloration measuring 3.5 cm by 5 cm with the epithelium intact and slight surface induration noted. - Left heel, deep red tissue/purplish discoloration measuring 5.5 cm by 5 cm. The epithelium was intact. - Left plantar foot and heel, unstageable pressure ulcer of the left foot and heel due to deep tissue injury. The treatment was to cleanse the affected areas with normal saline or wound cleanser, apply skin prep to affected area each shift and as needed. The staff were to monitor site for signs and symptoms of infection, bogginess, drainage or erythema. - APN #56 documented to evaluate current orthopedic boot as it appeared to be the source of the pressure. The 11/24/21 Wound Documentation progress note by the DON documented the wounds assessed by APN #56 and the recommended treatments. There was no documentation of an orthopedic appointment being made for the resident. The 11/26/21 physician's order documented to cleanse the left outer ankle with wound cleanser or normal saline, apply alginate to wound bed (cut to size), cover with optifoam daily and as needed. The 11/19/21 physician order to cleanse area and apply Santyl remained active. Skin prep to the left heel continued. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There was no prior documentation regarding the area on the left outer ankle noted in the 11/26/21 physician's orders. The 11/30/21 (former) Assistant Director of Nursing (ADON) #55's progress note documented a team meeting was held and the resident was at high risk for developing skin issues. Interventions included requesting in house medical provider to assess, placing pillow boots on bilateral feet, placing the resident on a pressure reducing mattress, full head to toe skin assessment, therapy evaluation for a new/alternate brace, moisturize dry skin areas, and Doppler studies of the bilateral lower extremities to rule out PVD (peripheral vascular disease, poor circulation). There was no documentation physical therapy (PT) was contacted to evaluate the leg brace after the 11/30/21 meeting. During an interview on 3/30/22 at 10:37 AM, former ADON #55 stated: - the bedside nurse was responsible for removing CAM boots and braces as per the physician's orders and if they saw a new skin alteration, they should report up the chain of command and a RN should evaluate. If no RN was available, the resident should be assessed the next time a RN was working. - The resident had a knee immobilizer and a CAM boot and was seen by Wound APN #56 and should have been seen weekly. - The resident had a pressure ulcer on their heel, maybe on their toe, and on the top of the foot where the boot crossed over. The pressure ulcers occurred on the foot with the boot, and they were strange. The resident's pressure ulcers seemed worse than a boot issue, which prompted the Doppler study to rule out a vascular aspect. - The facility utilized paper orders, which occasionally caused a delay in order entry after the APN recommended a treatment. The 12/3/21 and 12/8/21 Wound Consult by APN #56 documented: - the resident had three unstageable ulcerations of the left foot on the dorsal (top), plantar, and heel. - It was recommended to evaluate the current orthopedic boot as it appeared to be the source of pressure. The 12/3/21 Ultrasonography report documented a bilateral lower extremity venous duplex color Doppler was performed. The left leg was somewhat difficult technically due to fracture with a cast, but the major veins were visualized. No thrombus (clot) was seen and there was good flow and augmentation. The 12/5/21 attending physician's progress note documented the resident had ongoing wound care to the ulcer of the left lateral foot. The venous Doppler showed good blood flow and good venous augmentation. The wound of left lower extremity was stable without signs of infection and with appropriate orders in place as well as appropriate wound care follow-up scheduled. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 12/8/21 RN Unit Manager #1's progress note documented a left dorsal (top of foot) pressure ulcer with treatment of Santyl; left plantar foot unstageable with Santyl treatment; left heel unstageable with Santyl treatment. During an interview on 4/15/22 at 10:34 AM, RN Unit Manager #1 stated they had been assisting with pressure ulcer treatments when they wrote the progress note on 12/8/21. They were not working at the facility when the resident was admitted . They stated outpatient consults were scheduled by the Unit Managers. They could not recall the resident or who was responsible for taking off the resident's brace or CAM boot. The 12/8/21 physician's order documented the resident had an orthopedic appointment on 12/14/21 (over 6 weeks after admission). The 12/14/21 Orthopedic Consult documented the resident's left foot revealed multiple dressings on the resident's heel, lateral malleolus (ankle), and dorsum (top) of the foot from their previous partial-thickness sores that were pre-existing to the hospitalization . With regards to the foot, wound care team needs to continue aggressive treatment to the foot; it was outside the physician's expertise, and it was a chronic problem. During an interview on 3/31/22 at 10:07 AM, a receptionist at the orthopedic office stated the resident was seen on 12/14/21. The facility called for an appointment on 12/8/21 at 1:14 PM; there was no other record the facility called regarding the CAM boot or for an earlier appointment. The resident left the facility Against Medical Advice (AMA) on 12/14/21. During an interview on 4/15/22 at 11:06 AM, physical therapist (PT) #63 stated the resident had a boot and immobilizer and they deferred to the orthopedic physicians for those orders. The CAM boot was to be worn with transfers and was not to be worn in bed; the PT stated they would don (apply) the CAM boot when providing therapy and would remove the boot at the end of the session when the resident was in bed. The resident was admitted with pressure ulcers on their lower legs. PT #63 reported that they asked the Unit Manager about follow up with Orthopedics at least once; they could not recall who the Unit Manager was at the time. They stated they thought the resident saw Orthopedics once during their stay and then left the facility shortly thereafter. The PT stated they had not been asked about recommendations for the boot due to the resident's pressure ulcers on the lower leg. During an interview on 3/29/22 at 1:00 PM, LPN #34 stated LPNs were responsible to check skin under braces or boots as a part of the skin check. Certified nurse aides (CNA) would also report any skin alterations they saw. They could vaguely remember the brace and CAM boot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/29/22 at 3:04 PM, LPN #24 stated if the resident had a treatment ordered, the LPNs were responsible to remove braces and CAM boots. For the resident's CAM brace, the LPNs were responsible to remove it and check the skin underneath for any open areas and pad as needed. If the resident needed padding, it would be documented on the Treatment Administration Record (TAR). The orders on the TAR should be specific as to treatment location; if the area needed clarification, the LPNs should ask the Supervisor where the treatment needed to go before going any further and for the order to be reentered. It was important for the location to be specific on the orders so the LPN could easily locate the pressure ulcer to provide the correct treatment. When completing skin checks, the LPNs only documented a progress note if a new area was identified; if there was no progress note at the time of the skin check, then no new areas were identified. During an interview on 3/31/22 at 9:23 AM, Wound APN #56 stated: - residents were seen weekly once they were on their list. - They communicated order recommendations verbally and sent them to the facility at the end of the day. - They expected recommended orders to be entered the same day or the next morning. - If orders were not implemented timely, it affected care because when they saw the resident the following week, they would not know the resident missed 2 days of the recommended treatment making it difficult to assess whether the recommendations were effective. - The resident's wounds were caused by the CAM boot and they recommended the facility consult Orthopedics to evaluate the boot as it seemed to be the cause of the pressure. The Orthopedic Surgeon would be the best discipline to evaluate the boot. - On admission, the facility physician was responsible for ordering wound treatments as recommended by the hospital and 3 days was too long for a resident to go without a treatment ordered. - Treatment orders should document the specific location; residents could have different wounds with different etiologies requiring different treatments; documenting a specific location would ensure the nurse was not putting the wrong treatment on an area. - The resident's pressure ulcers deteriorated while at the facility which they attributed to the boot. During an interview on 4/15/22 at 11:32 AM, the DON stated: - skin was assessed on admission by a RN and then followed weekly during wound rounds. - If a resident had a wound on admission, they would follow the hospital orders and facility protocol for wound care. Orders for treatments should be entered on admission. - The DON assessed the resident on admission and the resident had an immobilizer and a CAM boot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335548	A. Building B. Wing	04/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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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 0686 Level of Harm - Actual harm Residents Affected - Few	- On admission, the resident had a DTI to the left heel and an ulcer on the dorsum (top) of their foot from the brace. The hospital documentation stated the resident had multiple areas and the DON believed those were the only pressure ulcers found when they removed the braces and performed a full body check. - The DON was unsure why the resident's admission treatment orders were not implemented until 10/31/21 as they should have been implemented on admission. - The CAM boot was to be worn at all times, which was documented in the hospital paperwork. - The DON stated the resident's DTI on the left heel should have been tracked and they expected weekly tracking. - The DON stated if APN #56 recommended an Orthopedic consult on 11/24/21, the Unit Manager should have called for an appointment. - If the hospital discharge paperwork documented to call for an Orthopedic appointment in 2 weeks, it should have happened. The DON did not know why Orthopedics had not been called until 12/8/21 for an appointment on 12/4/21. - If the resident had any additional padding to the brace or the boot, it should have been documented on the CCP and they did not know why RN #64 documented additional padding was added. - LPN #29's progress note from 11/11/21 should have been followed up by a RN; if a LPN saw an area on the ball of the foot, the DON expected RN documentation that the area was visualized. - Treatment orders should document a location; the LPNs should have been communicating that the treatment orders were not clear and the order should have been clarified. It was important to document the location as best as could be described for accurate treatments. During an interview on 4/18/22 at 9:48 AM with nurse practitioner (NP) #34 (the NP who had been following the resident), they stated: - treatment orders for residents should be entered within a few hours of admission if the wound was known on admission. - Discharge summaries or after visit summaries would document the expected follow up for orthopedics; if the summary documented to call within 2 weeks for a follow up appointment, the order should have been entered on admission to follow up and it should have been done. - If APN #56 recommended to follow up with Orthopedics on 11/24, the facility staff should not have waited until 12/8/21 to call for a follow up appointment. - If the facility was having a hard time obtaining a consult and the resident had things in question such as the CAM brace, the NP would call the office themselves to see what the delay was or what could be done in the meantime. The NP had not called, which likely meant they were not notified of the resident's issues. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- The NP expected the resident to have an order to remove the CAM boot in bed if the discharge summary documented to do so. - The NP stated Wound APN #56's orders should have gone in the day of their visit; they were unsure the APN's order process and the facility liked handwritten orders. If the Wound APN provided verbal orders, the person taking the verbal should have entered the order. During an interview on 4/18/22 at 2:44 PM, the attending physician stated: - residents admitted with pressure ulcers should be added to the wound care list. - If a resident had a wound identified on admission and had orders from the hospital, treatment orders should go in at the time of admission. If the resident went from 10/28/21 to 10/31/21 without treatment orders, that was terrible; it was a delay and the orders needed to be entered timely. Residents who had pressure ulcers had deteriorating skin, were very sick, and the facility needed to be aggressive and on top of wound care to promote healing. - If Wound APN #56 saw a resident on 11/3/21 and made order recommendations, the orders should go in immediately by the nurse rounding with APN #56; waiting until 11/5/21 to enter orders would be too long and it was not optimal. - Follow up Orthopedic consults should be ordered as per the discharge summary; if the discharge summary documented to follow up within 2 weeks, the resident should have had an appointment within 2 weeks. To go from 10/28/21 to 12/14/21, that was potentially the time frame of an entire admission and discharge, which would not be timely. If APN #56 requested an Orthopedic consult, it should have been completed. Wound monitoring should be done weekly at minimum; if the resident had a deep tissue injury identified on admission, it should have been documented on and followed up on before 11/24/21. - The system was broken and everybody dropped the ball with the resident. With the delay in admission orders, delay in Wound APN #56 order entry, delay in orthopedic follow up, and lack of wound monitoring, it could have had a negative impact on the resident, and it could have caused harm to the resident. - The physician stated they had requested better communication on residents with wounds, and the nutrition team should also be included with the communication as it was an integral part of wound care. 10NYCRR 415.12(c)(2)