STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335600	A. Building B. Wing	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Utica	1657 Sunset Ave Utica, NY 13502

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 0686 Level of Harm - Minimal harm or potential for 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** 37385 Based on record review and interview during the abbreviated survey (NY00269105) conducted on [DATE], the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 1 of 5 residents (Resident #437) reviewed. Specifically, Resident #437 had a Stage 4 pressure ulcer (full thickness loss of skin layers) that became infected. When the wound did not improve, the medical provider was not notified so that treatments could be evaluated. The infection worsened and the resident was hospitalized with sepsis (widespread infection in the body). Findings include: The facility policy Pressure Ulcer/Skin Breakdown Clinical Protocol effective ,d+[DATE] documents: - The physician will help clarify relevant medical issues, for example, whether there is a soft tissue infection or wound colonization, whether the wound has necrotic (dead) tissue, the impact of comorbid conditions on the wound healing, etc.; - The physician will help identify medical interventions related to wound management, treating a soft tissue infection removing necrotic tissue, addressing comorbid medical conditions, managing pain; - During resident visits, the physician will evaluate and document the progress of wound healing, especially for those with complicated, extensive or non-healing wounds; - The physician will help staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wound develop. The facility policy Wound Care effective ,d+[DATE] documents: - Documentation of wound care in the resident's record should include: the type of wound care given, date and time, any change in resident's condition, all assessment data, if the resident refused and the reason; - Notify the supervisor if the resident refused the wound care; - Report other information in accordance with facility policy and professional standards of practice. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #437 had diagnoses including acute and chronic respiratory failure, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and chronic kidney disease. The [DATE] Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment and was dependent on 2 people for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident had 1 Stage 2 pressure ulcer (partial thickness loss of skin layers) and 1 Stage 4 pressure ulcer present on admission. The [DATE] registered nurse (RN) #23's Admission Assessment documented the resident had a Stage 4 sacral (bottom of the spine) pressure ulcer measuring 11.5 centimeters (cm, length) by 15.4 cm (width), and 4.5 cm (depth). The pressure ulcer had a mild odor, with heavy slough (moist, yellow dead tissue), and a large amount of bloody drainage. The resident was bedfast, dependent on 2 people for bed mobility, and required extensive assistance of 2 people for personal hygiene. The [DATE] physician orders documented Santyl ointment (removes dead tissue), apply a thick layer to the sacral wound, fluff pack with normal saline (NS) moistened Kerlix (gauze), cover with ABD (absorbent pad) and secure with tape every day shift. The [DATE] Kardex Report (care instructions) documented the resident was dependent on 2 people for bed mobility and personal hygiene. The resident had an indwelling (urinary) catheter and an ostomy (opening from the intestine to the outside of the body). Skin and ulcer treatments included pressure reducing devices for the bed and chair, nutrition intervention, pressure ulcer care, non-surgical dressings, and ointments/medications. The comprehensive care plan (CCP), initiated [DATE] and updated [DATE], documented the resident had impaired skin integrity. Interventions included: apply treatment per physician's order, document location of the wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements. There were no other interventions noted for the resident's pressure ulcers. The [DATE] wound physician #38's progress note documented the sacral wound was 14 cm by 11.5 cm by 6. 5 cm, with odor present, light serous (thin, clear) drainage, 35% necrotic (dead) tissue, and 65% granulation (new tissue). The wound was debrided (removal of dead/infected tissue) and the treatment was changed to add Dakin's solution (antiseptic) twice daily for 30 days, gauze roll, and discontinue the barrier cream. The [DATE] physician order documented Dakin's with Kerlix (gauze) pack, cover with dry protective dressing, twice per day. Nursing progress notes documented: - on [DATE], RN #39 noted the resident was seen by the wound team for the sacral pressure ulcer measuring 14 cm by 11.5 by 6.5 cm with 35% necrosis and 65% granulation. Debridement was done to the coccyx (bone at base of spine). - On [DATE], RN #23 noted the resident's wound had odor and bloody/green drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 11:25 AM, RN #39 documented the resident was seen by the wound team for the left sacrum wound measuring 12.5 cm by 8.2 cm by 3.1 cm with undermining (the wound spread out underneath the skin that surrounds the visible part of the wound) of 5.5 cm, 50% necrosis, and 50% granulation tissue. The [DATE] wound physician #38's progress note documented the sacral wound was debrided of devitalized tissue and necrotic periosteum (tissue on the bone) and friable bone (easily crumbled) were removed at a depth of 3.6 cm. the wound progress was noted as improved and the current treatment was to be continued. The [DATE] at 2:43 PM, licensed practical nurse (LPN) #40's progress note documented the dressing was changed per the physician's order, a strong foul odor was noted with a large amount of bluish green bloody drainage. The resident complained of pain and Tylenol was given with little effect. NP #19's [DATE] progress note documented nursing reported a low-grade fever (99 degrees Fahrenheit, F) and foul smelling odor to the wound. The NP ordered doxycycline (antibiotic) 100 milligrams (mg), CBC (complete blood count) and CMP (comprehensive metabolic panel) on [DATE]. The resident had an appointment with the surgeon the following week, if the fever continued, they may consider intravenous (IV) antibiotics. The physician' orders dated [DATE] documented doxycycline, 100 milligrams (mg), 1 tablet twice a day for wound infection for 7 days (end date [DATE]). The [DATE] at 11:57 AM LPN Supervisor #18's progress note documented the wound was cleansed and packed with Dakin's solution gauze, the old dressing had a large amount of green/brown drainage and there was a strong foul odor noted to the wound. The resident continued on the antibiotic for the wound and had a follow-up appointment with a surgeon. The [DATE] NP #19's progress note documented the resident was started on antibiotics, had a follow-up with the surgeon today, and the NP asked nursing to have the resident evaluated as well to let the office know that if further antibiotic coverage was needed, they may be able to do that in the facility. The resident continued on doxycycline 100 mg, was afebrile (no fever) and followed by the wound team. The [DATE] surgical consultation form documented the resident was seen that date for a colostomy check. The form documented (by the facility) to please check the wound on the sacrum. The consultant noted the resident was to be referred to another surgeon for the sacral wound and the colostomy bag should be changed as needed as it leaked that day. There was no documented evidence this surgeon visualized or assessed the residnet's sacral pressure ulcer. The [DATE] at 2:40 PM nursing progress note by LPN Unit Manager #21, documented a call back from the surgeon's office, a new order for referral to the plastic surgeon was received. There was no documentation regarding follow-up on the antibiotic coverage. The [DATE] at 9:37 AM, LPN #41's progress note documented the resident's sacral wound had a strong odor noted, with beefy red parts to the wound bed, bloody green/blue drainage. The resident was compliant with dressing changes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] wound physician #39's progress note documented the visit had been rescheduled, staff were unavailable due to a snow storm. The next appointment was not documented. The [DATE] wound team note completed by the Director of Nursing (DON), documented the sacral wound measured 12.8 cm x 8.3 cm by 3 cm, with undermining at 9 o'clock at 5.5 cm, and there was a foul odor. The wound bed had 50% eschar (dry, dead tissue) and 50% granulation. There was no change to the wound treatment. An appointment for the surgeon was scheduled for [DATE]. The physician' orders documented the end date for the doxycycline, 100 mg, 1 tablet twice a day was [DATE]. Nursing progress notes documented: - on [DATE] at 1:52 PM, LPN #41's progress note documented the resident's wound on the sacrum had a strong odor, was beefy red in the wound bed, bloody, green/blue drainage, the resident was compliant with dressing changes. - On [DATE] at 9:32 AM, LPN Manager #2's progress note documented the surgical consult was rescheduled for [DATE]. - On [DATE] at 1:52, LPN #41's progress note documented the resident's wound on the sacrum had a strong odor, was beefy red in the wound bed with bloody, green/blue drainage, and the resident was compliant with dressing changes. - On [DATE] at 1:52 PM, LPN #41's progress note documented, the resident's wound on the sacrum had a strong odor, was beefy red in the wound bed, bloody, green/blue drainage, and the resident was compliant with dressing changes. - On [DATE] at 1:51 PM, LPN #40's progress note documented the resident was washed and dressed by staff, their intake was poor, fluids were encouraged, the dressing was changed as ordered, and a strong foul odor was noted with large amount of bluish green bloody drainage. The ,d+[DATE] TAR did not include documented evidence the treatment to the sacral ulcer was completed on ,d+[DATE] and [DATE] during the day shift. There was no reason documented for the missed treatments. Nursing progress notes and the ,d+[DATE] TAR documented: - on [DATE] at 2:52 PM, RN #37 (DON at the time) noted the resident's dressing to the sacral area was changed, there was a large amount of bloody drainage noted, slight blood-tinged urine with sediment in the catheter drainage bag. - On [DATE] at 3:08 PM, RN #37 noted the resident refused the dressing change after multiple attempts. The ,d+[DATE] TAR did not document the treatment was completed on the day or evening shift that date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 2:38 PM, RN #37 noted the resident refused treatment, attempted twice, explained the importance of ensuring the wound care was done. The ,d+[DATE] TAR documented the resident received the treatment once that date on the evening shift. - From [DATE] to [DATE], there were no documented nursing progress notes. - On [DATE], the TAR documented the treatment was completed twice. - On [DATE], the TAR documented the treatment was completed on the evening shift and not the day shift. From [DATE] to [DATE], there was no documented evidence the medical provider or wound specialist was contacted regarding the ongoing drainage and odor in the wound. From [DATE] to [DATE], there was no documented evidence the wound team saw or assessed the resident's wound when signs of ongoing infection continued. The ,d+[DATE] TAR documented the residnet's temperature was 97.3 Fahrenheit (F) on [DATE] and 99 F on [DATE]. The [DATE] NP #19's progress note documented nursing reported the sacral wound was worsening, the resident's intake and mobility were poor. The resident had issues with elevated blood pressure and low oxygenation and COVID-19 tests were pending. The wound was evaluated and had necrosis to the wound bed, some beefy red tissue to the surrounding area and a moderate to large amount of serous drainage. It appeared unchanged since the NPs last evaluation. An IV of NS was ordered for 80 milliliters (ml) per hour times 2 liters. Prior to this visit, the NP last saw the resident on [DATE]. The [DATE] at 2:14 AM nursing progress note written by LPN #42, documented the resident had a change in condition with altered mental status. The resident became lethargic and would not respond to staff. The medical provider was notified and provided an order to send the resident to the emergency room (ER). [DATE] hospital ER report documented: - The resident presented with altered mental status and a deep sacral pressure ulcer. Per emergency medical service (EMS), on their arrival the resident was unresponsive, respirations were being assisted with bag-valve mask. - The resident was profoundly tachypneic (rapid breathing) and tachycardic (rapid heart rate) with fluctuating blood pressure. The resident appeared clinically dehydrated and had mottled extremities (reddish/purple marbled appearance of the skin indicative of poor blood circulation). - There was a severe sacral ulcer that was approximately the size of a fist and the coccyx was directly palpable (able to be felt). On exposing the wound, copious amounts of black-grey pus poured out of the wound. Per the ER physician, 40 cubic centimeters (cc) of black pus were present in the wound. - The white blood count (WBC) was elevated at 13.4 (normal range is 4 to 10, higher levels can be related to infection). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The COVID-19 swab was negative. Antibiotics were started for likely sepsis secondary to a UTI as well as the resident's severe sacral ulcer. The chest x-ray was negative for acute infectious pathology that would be causing the septic shock. - The resident was transferred to a neighboring hospital due to a needed ICU (intensive care unit) bed. The [DATE] hospital discharge summary documented: - The resident was transferred from the sister hospital due to no ICU beds, was confused, had a sacral wound that was to the bone, black surrounding the area, draining a moderate amount of brown purulent drainage. - The resident was admitted [DATE] for management of sepsis/septic shock and noted to have a large decubitus ulcer. - Admission and discharge diagnoses included sepsis/septic shock secondary to gram-negative bacteremia, sacral Stage 4 decubitus ulcer, metabolic encephalopathy, acute kidney injury, hypernatremia, morbid obesity, and history of pulmonary embolism. - The [DATE] blood culture was positive for proteus mirabilis and enterococcus faecalis (bacteria) and the [DATE] wound culture was positive for proteus mirabilis. The resident was placed on IV antibiotics and had a guarded prognosis. - The family declined to pursue surgical debridement of the wound, the resident had a poor prognosis and high surgical risk. - The resident was placed on comfort care, started on IV morphine, and passed away on [DATE]. During an interview with the DON on [DATE] at 10:00 AM, they stated if the wound consultant physician was not available, the resident would be seen on wound rounds by the wound team. The NP would generally not see the wound specialist's patients unless there was a concern and a consult was needed. If the wound was worsening, it should have been assessed by a medical provider. Signs of infection or worsening wound status included colored drainage and foul odor. In ,d+[DATE], the facility was faced with a COVID-19 outbreak, which resulted in multiple nursing staff absences. There were only 2 RNS available for some time during the month. The DON, who was the Assistant DON (ADON) at the time, was unaware of what occurred with the resident and stated if the wound was worsening, medical staff should have been notified. A worsening wound could lead to sepsis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN Unit Manager #21 on [DATE] at 10:50 AM, they stated odor or worsening condition of a wound should be brought to the attention of the medical provider. It would be the responsibility of the Unit Manager or nurse who did the treatment to notify the provider. If the resident was on or completed antibiotics and there was no improvement, the medical provider should be notified. If the wound was not seen from [DATE] to [DATE], that was not timely to address signs of an ongoing infection. An untreated infection could lead to sepsis. If the resident refused treatment, the supervisor and/or medical provider should be notified, especially if there were signs of infection. The LPN Manager could not recall anything specifically about the resident and stated they expected staff to bring any issues to their attention, document in the record if treatments were missed or refused, and to notify the RN or medical provider for foul odor and ongoing drainage immediately. During an interview with RN #37 on [DATE] at 1:10 PM, they stated they were the DON in ,d+[DATE] and was primarily working on the units to cover nurse absences due to a COVID-19 outbreak. The RN was not certain if wound rounds were occurring at that time. If a wound was worsening, such as having ongoing drainage and odor, the medical provider should have been notified by either an LPN or RN. The RN was not certain if the medical provider should have been notified upon missed or refused treatments and could not state what other steps should have been taken due to the crisis occurring at the facility at the time. During a telephone interview with NP #19 on [DATE] at 1:15 PM, they stated they were out on medical leave from [DATE] to [DATE] and physician #20 was covering the facility. The NP could not state if anything different could have been done when the colored drainage and foul odor persisted following completion of the antibiotic course. The NP would look for an elevated temperature, decreased blood pressure, and increased heart rate as a sign of infection. The drainage and odor may not have been due to infection, as the dressing may have an odor noted during changes. The resident's white blood count (WBC) was 14 on [DATE], and the NP did not consider this high as the resident was still on an antibiotic at the time. The NP stated the resident's non-compliance was a factor in their wound worsening. An RN should have been seeing and assessing the wound at least weekly and if any concerns were noted from [DATE] to [DATE], then it would be up to nursing to notify a medical provider. The NP stated the resident's hospitalization did not appear to be related to the wound, as their oxygen was low and there may have been other medical issues going on. During a telephone interview with attending physician #20 on [DATE] at 2:10 PM, they stated they would leave the decision to notify the medical provider to the nurse's discretion. The physician stated they could not state what circumstances would require medical provider contact and could not state what factors would be indicative of a worsening or infected wound but expected staff to contact them if they were concerned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with the wound consultant physician #38 on [DATE] at 2:20 PM, they stated they accompanied the wound team at the facility to see their patients. The physician was not aware of the reason for the canceled visit on [DATE]. Based on the description in the nursing notes, a wound with characteristics of ongoing bluish, green drainage with a foul odor was not an acceptable state for the wound and indicated infection. A medical provider should have been notified to assess the wound and review treatment, as what was being done at the time was not improving the wound. If there was any necrotic tissue, it would need to be removed to prevent infectious spread and worsening condition. An infected wound could lead to sepsis, a serious life-threatening illness if left untreated. Although the physician was not at the facility, the facility had the capability to contact them and conduct a tele-health visit for their consultation for the condition of the wound. There were no further visits or consultations following the canceled [DATE] visit, as the resident expired. 10NYCRR 415.12(c)(2)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40491 Based on observation, interview, and record review during the abbreviated survey (NY00287704) conducted on 2/1/22, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #2) reviewed. Specifically, Resident #2 had approximately 15 unwitnessed and observed falls from 6/17/21-9/24/21 and the resident was not provided with adequate supervision to prevent reoccurrence. The resident had 4 falls on 10/11/21 resulting in hospitalization with diagnoses including a thoracic (upper spine) compression fracture, multiple facial bone fractures, and kidney trauma. This resulted in actual harm to Resident #2 that was not immediate jeopardy. Findings include: The facility policy Falls Prevention Program revised 1/2021 documents residents must be assessed in a timely manner for potential causes of falls. The nursing staff in conjunction with the attending physician, pharmacist, therapy staff, and others will seek to identify and document resident risk factors for falls. After more than one fall, the physician/clinical team will review the resident's gait, balance, and current medications that may be associated with increased risk of falling. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If an individual continues to fall, the staff and physician will re-evaluate and consider other possible reasons for the resident's falling besides those already identified and will re-evaluate the continued relevance of current interventions. The facility policy Managing Falls and Fall Risk revised 1/2021 documents staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If a resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to contribute or change interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The facility policy Routine Resident Checks revised 2/2021 documents the facility will make every effort to physically observe all residents while in the facility. During the off-shifts or timeframe identified by the facility, the assigned staff will make physical rounds on residents at least routinely throughout the shift. Staff were to initial and sign that they saw the resident and ensured their safety; and it would be documented in the electronic medical record. Resident #2 was admitted to the facility with diagnoses including hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke). The 8/7/21 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment, required extensive assistance of 2 for transfers, did not walk, required supervision with assistance of one for locomotion on the unit. extensive assistance of 2 for locomotion off the unit, was not steady when moving from seated to standing position, had 2 or more falls with no injury since the prior assessment, 0 falls with injury, and did not use an electronic device that monitored movement or alerted staff when movement was detected. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The comprehensive care plan, (CCP) initiated on 5/19/20, documented the resident was at risk of falls related to a history of falls, impulsive behaviors, and left-sided weakness from a cerebral vascular accident (CVA, stroke). The resident was to have the bed in the lowest position and staff were to anticipate and meet the resident's needs. Updates to the CCP included: - On 5/27/20, the resident was placed on a toileting schedule. - On 5/27/20 and revised on 6/4/20, a floor mat was placed to the right and left side of the bed, and the resident would place themselves on the fall mats and sleep there. - On 5/29/20, the resident exhibited poor safety awareness and interventions included distraction with activities including classic rock music, television, looking at picture boards, and talking with their family. - On 9/5/20, anticipate the resident's needs. The resident was noncompliant with transfers - On 9/15/20, the resident was to use non-skid socks, the bed was in the lowest and locked position, and they were to have the call bell within reach. The resident was to be referred to therapy services as needed. - The resident's medications were reviewed on 12/10/20 and 2/22/21. - On 5/21/21, the resident was to be in common areas when out of bed as the resident allowed. The resident had the following documented falls: - On 6/4/21 registered nurse Supervisor (RNS) #3 documented in an Accident and Incident Report (A&I) the resident was found on the floor in their bathroom. The resident had a scratch on their left nostril and a small cut on their upper gum. - On 6/13/21 at 6:02 PM Unit Manager #37's progress note documented the resident was transferred to the hospital at 6:00 PM after falling by the elevator at 4:40 PM. The resident had redness to their neck and head. At 10:45 PM, Unit Manager #37 documented the resident returned from the hospital with a facial laceration and six sutures. - On 6/17/21 licensed practical nurse (LPN) Unit Manager #13 documented in an A&I the resident was found lying on their right side in the dining room doorway and their knee was reddened. - On 6/18/21 at 8:27 AM, LPN #15's progress note documented the resident had swelling and bruising on their left hip. Per report, the resident had fallen twice the previous day and hit their left hip. - On 6/19/21, RNS #3 documented in an A&I the resident was found on the floor by the nurse's station, lying on their back with a rolling chair next to their head. Recommendations included a physical therapy (PT)evaluation and psychiatric nurse practitioner (NP) #28 was following the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Utica	1657 Sunset Ave Utica, NY 13502

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 0689 Level of Harm - Actual harm Residents Affected - Few	- On 6/19/21 at 8:05 AM, RNS # 6 documented in a progress note the resident was sitting in a lounge chair and got up unassisted and tripped over a chair and landed on their back. The resident had a tennis ball size area with induration (hardening) and redness on the left side of the head. The resident was transferred to the hospital for evaluation. The resident returned to the facility at 11:56 AM with no issues noted. - On 6/22/21, LPN Unit Manager #13 documented in an A&I the resident was found on the floor in their room on their left side. Therapy staff found the resident on the floor and the resident's wheelchair was found pushed into the doorway. The resident reported pain in their left shoulder and X-rays were to be completed. The 6/22/21 Radiology report documented the resident had an age indeterminate fracture of the distal left clavicle (shoulder blade) and clinical correlation was needed. - On 6/24/21, LPN Unit Manager #13 documented in an A&I the resident was observed standing at the nursing station, went to sit in their wheelchair, fell on their side, and hit their head on the medication cart. The resident was sent to the ED (emergency department) for evaluation. - The 6/24/21 ED summary documented the resident presented following a fall. Their sutures were removed from their left eyebrow (from 6/13/21 ED visit) - On 6/29/21, LPN Unit Manager #13 documented in an A&I the resident was found in the hallway outside of a room, with one sock on and one sock off lying flat on their back. There was no apparent injury. - On 7/6/21 at 4:35 PM RNS #6 documented the resident was found by nursing staff on the third floor after their empty wheelchair was found at the fourth floor's locked stairway exit. The resident was assessed and found to have reddened area to the right forehead/temple area, right ear, back of left head at the base of the skull area, and a skin tear located to outer aspect of left forearm. Maintenance checked the functionality of the door, which was functioning properly, and unlocked the door after pressed for a certain period of time (delayed egress). The resident was to have safety rounding. - The 7/6/21 at 5:30 PM A&I completed by RNS #6 documented the resident was found on the third floor in the stairwell. Certified nurse aide (CNA) #9's statement, included with the report, documented CNA #9 was assisting another resident with dinner when the incident occurred. The resident had been agitated and restless all day, and they were last seen in their wheelchair going into other resident's rooms. - On 7/7/21, LPN #30's progress note documented the resident was seen out of their wheelchair standing and pushing against the emergency exit door. The resident was found banging on other resident's doors, trying to enter, and attempting to stand without assistance. PRN (as needed) Haldol (antipsychotic) injection was administered There was no documented evidence the resident had a supervision plan in place, after multiple falls and falls with injury and after the resident was able to access a locked stairwell undetected, to ensure the resident was safe. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 7/12/21 at 7:30 AM A&I initiated by LPN #15 documented the resident was found on the floor next to the nurse's station on their back; the resident had a small bump on the back of their head. RN #7 added to the A&I under recommended steps to prevent recurrence, monitor the resident every hour and continue current plan of care. The Assistant Director of Nursing (ADON) documented in the summary of investigation the fall was unavoidable as the resident continuously stood up from their chair unassisted. The 7/12/21 at 12:00 PM a Change in Condition Evaluation and progress note completed by RN #43 documented the resident had a laceration above the left eyebrow. The resident had a fall earlier in the day and the laceration was not noticed at the time of the previous fall. The resident had a 1.4-centimeter laceration with slight swelling above their left eyebrow. The CCP, updated on 7/12/21, documented the resident had an actual fall with no new injuries; they were bleeding at their brow from a previous injury that day. The CCP also documented on 7/12/21, the resident was found on the floor next to their bed with a superficial injury. On 7/13/21, the updated CCP documented the resident was to be checked when passing their room and to continue safety rounds to ensure safety. The 7/14/21 A&I completed by LPN Manager #13 documented the resident fell outside of another room on the unit while attempting to walk into that room. The resident was bleeding from their left toe with a large amount of blood; they had a laceration under their second toe on their left foot. Recommended next steps were to provide shoes and socks, have their call bell within reach, and keep their bed in a low position. The conclusion documented the resident got out of their chair unassisted and fell . The resident had a large laceration, the bleeding could not be controlled, and the resident was sent to the hospital. There was no documented evidence how frequently the resident had been checked for safety rounds. The 7/14/21 ED note documented the resident had a laceration to a lesser toe on the left foot and had sutures. The 7/16/21 updated CCP documented to provide the resident with a wheelchair if noted to be self-ambulating. From 7/16/21 through 9/2/21, there were no updated interventions on the CCP for falls. The 9/2/21 at 5:40 PM, A&I documented the resident had an unwitnessed fall in the hallway with an abrasion to the inner left forearm. Recommended steps to prevent reoccurrence documented a medication review, refer to therapy for seating evaluation for their wheelchair, and monitor for latent signs of injury. The 9/2/21 updated CCP documented to initiate medication review to reduce fall risk and the resident was referred to therapy services. The 9/4/21 at 7:00 PM A&I completed by RN #38 documented the resident had a fall in another resident's room. The fall was unwitnessed and the resident that resided in the room was unable to state what occurred at the time of the fall. The resident had bleeding to the upper corner of their left lip and upper lip. Recommended steps to prevent reoccurrence documented the resident was to have a psychiatric evaluation for medication review. From 9/5/21 through 9/22/21, there were no documented updated interventions on the CCP for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 9/7/21 unsigned Physical Therapy Screen documented the resident was being evaluated for a fall. The resident did not demonstrate a change in functional mobility and the resident's most recent fall was due to impaired safety awareness and behaviors. There were no additional recommendations. A&I reports documented the resident had the following falls: - On 9/12/21 at 8:46 AM, by LPN #39 the resident had an unwitnessed fall in their room. The bed was in the lowest position with fall mats on the floor; the resident had been sleeping in bed when last seen. The resident had swelling and redness to the left side of their face, redness on their left upper arm, and a cut/open area on their left lower arm. - On 9/22/21 at 6:40 PM, by the ADON the resident had an observed fall in the hallway; the resident was observed to hit their head and they had scabs on their left knee from a previous fall. The ADON documented medications were discussed with NP #19 and Haldol (anti-psychotic) was decreased. - On 9/23/21 at 8:30 AM, by LPN Unit Manager #13 the resident had an unwitnessed fall in their room with no apparent injuries. The resident was encouraged to use their call bell for assistance. - On 9/24/21 at 4:00 PM, by RN #38 the resident had an unwitnessed fall in their room. - On 9/26/21 RNS #3 documented at 7:00 PM, the resident had a fall which occurred in the fourth-floor stairwell. The resident was found on the staircase facing up. The resident had no apparent injuries except a reddened left knee and left forearm. CNA #9's statement, included with the report, documented the resident was moving in their wheelchair and was eager to stand up. Steps to prevent reoccurrence documented physical and occupational therapy, anticipate the resident's needs, floor mats, provide appropriate footwear, toileting schedule, pain evaluation, medication review, and rounding on the resident. There was no documented evidence the resident had a supervision plan in place, after multiple falls and falls with injury and after the resident was found at the bottom of a stairwell, to ensure the resident was safe. On 10/11/21, nursing progress noted documented: - at 11:37 AM, LPN # 29 documented they were notified by a CNA the resident was lying on the floor of their room. Upon entering the room, the resident was observed lying on their left side on the floor next to the bed. The left forearm had purplish blue blotches. The resident denied pain. LPN Manager #13 was notified as well as the ADON for assessment (no RN assessment was documented). - At 11:44 AM, LPN Manager #13 documented the resident presented with a change in condition falls. All changes in their condition were documented and had been reviewed with NP #4 on 10/11/21 at 11:35 AM, they did not recommend any changes. The family was notified. - At 11:55 AM, LPN Manager #13 documented a pain evaluation for the resident. The resident had no complaints of pain, and no signs and symptoms of pain were noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- At 12:21 PM, LPN Manager #13 documented the NP #4 was in to see the resident regarding the fall and blotchy areas noted on the arms and legs. NP #4 ordered laboratory work including complete blood count (CBC) and comprehensive metabolic panel (CMP). - The 10/11/21 untimed NP #19's progress note documented the resident had a fall and did not suffer any injuries. The resident had some discoloration noted to their extremities. The NP ordered a CBC and CMP for that day to see if there were any other processes going on. For the fall, the resident was to continue with the fall protocol, nursing was to continue neuro checks, and to notify the providers if there were any changes. The resident may need to be transferred to a higher level of care. - at 4:55 PM, LPN # 14 documented they heard a loud noise from the resident's room. The resident was observed lying on the floor in their room under the bedside table. The resident was not able to state what happened. The Supervisor was called to the unit. The resident was helped off the floor and cleaned up. The resident has a small laceration to the left eye and was bleeding from their nose. Neurological checks were in place from the previous fall that day. - at 6:30 PM, LPN #14 documented they were administering medications to another resident when they heard a loud noise from the resident's room. They ran to see what happened, and the resident was observed on the floor next to their bed. The resident was not able to answer question about what happened. The resident was assisted back to bed after approval from the Supervisor. There was no documentation by the Supervisor. - at 9:41 PM, LPN #14 documented they heard the resident fall in their room, and the resident was observed face down at the foot of their bed. The resident was bleeding, but they could not locate where the bleeding was coming from. A phone call was placed to the on-call physician/NP. The on-call NP instructed staff to send the resident to the hospital for an evaluation. When paramedics arrived, the blood was cleaned from the resident's face, and their left eye was swollen, black and blue, and there was a small laceration in the corner (of the eye) from the previous fall. The resident had a bloody nose and was sent to the emergency room . - There were no documented RN assessments or neuro checks on 10/11/21. The 10/11/21 Unit Staffing Sheet documented CNA #10, CNA #17, and LPN #14 were working on the resident's unit during the evening shift. The 10/11/21 CNA Documentation included the resident's every 3-hour toileting and turning and positioning was provided between 7:49 PM to 8:02 PM on the evening shift; there was no documentation the resident had more frequent checks on the evening shift. On 10/12/21 at 2:05 AM, LPN #66's progress note documented the hospital called the facility and stated the resident was being transferred to another hospital for left side facial fracture, orbital (bone around eye) fracture and maxillary sinus fracture. The resident was admitted to the hospital on 10/12/21 and was discharged and returned to the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 11/19/21 hospital discharge summary documented the resident was admitted on [DATE] after an unwitnessed fall. The primary discharge diagnosis was thoracic (upper back) compression fracture, multiple facial bone fractures, acute blood loss anemia, and traumatic perinephric hematoma of the left kidney (blood outside the vessel near the kidney) secondary to the fall. The patient was transferred from another hospital after a fall at the long-term care facility. While hospitalized the patient was managed for behavioral issues which had been ongoing. The patient stay was prolonged due to their intermittent agitation, resident was seen by psychiatry and social work, behavior was stabilized. On 11/19/21 the patient was stable for discharge to the skilled nursing facility with condition upon discharge documented as non-verbal, alert, unable to assess denotation, need assistance while standing and walking, wheelchair bound, and risk for fall. On 1/4/22 at 9:50 AM, 10:53 AM, 1:25 PM, and 4:07 PM, the resident was observed lying in bed. The bed was in the lowest position with a fall mat on the floor; the other side of the bed was pushed up against the wall. The resident had a radio with music in their room. During an interview on 1/6/22 at 9:11 AM, LPN #1 stated they worked on the resident's floor before the last hospitalization when the resident was moved. LPN #1 stated in 7/21 when the resident fell down the stairs, the LPN was completing a medication pass and had seen the resident just before wander alert alarm sounded (a sensor that alarms when a resident wearing a wander alert device crosses the sensor) the LPN #1 stated they went to the door, found that it was ajar and saw a wheelchair at the landing between the floors. The RNS assessed the resident. The LPN stated following the 7/21 incident, the staff on the unit were checking on the resident more frequently for safety. The resident required a lot of redirection and more supervision and it was a team effort to provide the supervision the resident needed between the nurses, CNAs, and the unit helper. LPN #1 stated they were unsure if the resident's need for supervision was on the CCP. During an interview on 1/6/22 at 9:57 AM, physical therapist #8 stated the resident was very unsafe; they would transfer and walk when they wanted to. The resident was impulsive and had poor safety awareness. The physical therapist stated that supervision could be recommended but they were unsure if it would happen. If the resident was having falls and had fallen down the stairs, the resident should have been referred to therapy. During an interview on 1/6/22 at 11:28 AM, RN #7 stated if they were working as a supervisor, they updated CCPs when they responded to falls. RN #7 stated the resident had a lot of falls; was impulsive and would get up when they were not capable. RN #7 stated they were unsure what the facility staff put in place for the resident for fall prevention and thought they had 1:1 at times or was placed near the nurse's station. RN #7 stated when staff would walk away, the resident tried to stand. The resident needed supervision; they did not have 1:1 supervision every day and would likely be on hourly checks. Hourly checks were documented on paper by the CNAs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/6/22 at 12:34 PM, RNS #3 stated the resident had quite a few falls; they were nonverbal and would not stay still. The resident would attempt to walk, and they were not safe to do so. The resident very much needed a 1:1 and increased supervision. The RNS stated in 9/2021, the resident had broken through the fire door and went down the stairs. When the resident went down the stairs, the wander alert alarmed which signaled staff to the stairwell. The resident had made it down of the stairs before falling. The RN stated the resident's fall interventions included mats on the floor, padding parts of their wheelchair, non-skid socks, and they would try to put a 1:1 on the resident whenever possible or try to keep the resident by the nurse's station. The RNS stated the resident needed supervision and it was difficult to provide at the facility. There was not enough staff to provide 1:1 supervision 24/7 for the resident. During an interview on 1/7/22 at 8:25 AM, CNA #16 stated the resident fell down a whole flight of stairs in 9/2021 when they were working. The resident moved around a lot and would attempt to stand on their own, which lead them to fall a lot. To keep the resident safe from falls, the resident had a low bed, fall mat, and had increased supervision. The resident did not have increased supervision documented on their care plan and the CNA had not been told to supervise them more; the CNA knew to supervise the resident from working with them During an interview on 1/7/22 at 8:33 AM, LPN #14 stated they were not regularly assigned to the resident's floor but worked with the resident a few times. The resident would wander the unit and into other resident's rooms. The LPN would help the CNAs keep an eye on the resident. The LPN worked on 10/11/21 and was told in report the resident had a fall in the morning. The resident had been sleeping in bed before the first fall of the shift. The LPN called for the Supervisor LPN #18 and reported the fall. The resident fell again, and the LPN paged the supervisor; LPN #18 came to the unit again. At the third fall, the LPN called the on-call medical provider that the resident continued to fall and asked for the resident to be sent out. The LPN stated each fall was about an hour apart. The resident had a low bed with fall mats in place at the time of the falls. If the facility had the staff, they would increase supervision and keep a close eye on the resident. There were 2 CNAs and the LPN on that day, and the LPN stated they did not think there was any more that they could have done. After the first fall, the resident had a slash above their eye which LPN #18 told the LPN to clean up. The resident fell again and had bleeding from the same area, then at the last fall, the resident had facial injuries. When the emergency medical technicians (EMTs) got the resident up and cleaned up their face, one of the resident's eyes was completely swollen shut. The LPN had spoken with the DON, who stated they were going to come to the floor, and they were sending LPN #18 in the meantime. No RN came to the unit. All three falls that evening the resident had fallen on their face; they had gotten up from their bed and walked across their room before falling. The resident needed more supervision and there was not enough staff to provide the level of supervision the resident needed. During an interview on 1/7/22 at 10:16 AM, CNA #17 stated the resident had a low bed to keep them from falling and they could not recall any other interventions. The staff on the unit kept an eye on the resident, but this was difficult to do if they were helping other residents. If they had extra staff, they would provide a 1:1 for the resident. During an interview on 1/7/22 at 10:37 AM, CNA #10 stated the resident had quite a few falls; they fell weekly, sometimes daily, or multiple times per day. The resident was impulsive and was hard to redirect. The CNA stated the resident needed to be a 1:1, especially when they started to exhibit behaviors and falls, but the staff could not take care of other residents when the resident acted like that. They did not do a 1:1 for the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/7/22 at 12:06 PM, NP #19 stated they were notified when residents had falls; they would assess the resident at that time if they were in the building or the day after if the fall occurred on off hours. They evaluated their medications and medical condition to see if changes were needed; nursing took care of other interventions. The NP stated the nursing staff helped with supervision; they provided the resident with a little more attention to keep the resident safe. Nursing staff would attempt to put the resident at the nurse's station, but the resident could wheel away. It was hard to provide a 1:1; the NP thought the resident may still have fallen with a 1:1 given their stature and that a small CNA may only be able to assist the resident in falling. During an interview on 1/7/22 at 12:15 PM, LPN Supervisor #18 stated they assisted with supervising if there was no RN in the building and there would be a RN on call. Fall interventions were completed with the interdisciplinary team as part of the A&I process. The night the resident fell on [DATE], the LPN was working on a medication cart in addition to working as the supervisor. The LPN was not aware the resident had a fall earlier in the day. The nurse that was working on the unit had not had supervisory experience and was unsure what to do when the resident fell . The LPN went to the unit after the resident's first fall; they had a small cut on their eyebrow, they were very agitated, and the resident would not allow the staff to take vitals or complete neuro checks. The LPN Supervisor recommended giving the resident space since they were so agitated; they did not make any other recommendations. The DON was called When the LPN Supervisor spoke with LPN #18 a second time, the LPN Supervisor told LPN #18 they were passing medications and they would have to wait. LPN #18 reported the resident had another fall, was acting crazy, and the unit nurse was sending the resident out to the hospital. LPN #18 had paged for the supervisor on the overhead page. The LPN Supervisor stated when the resident exhibited behaviors, it did not matter how many staff were present since the resident was so agitated. During an interview on 1/19/22 at 10:49 AM, LPN Unit Manager #13 stated the resident was falling constantly, and it was hard to redirect them. They would place the resident near the nurse's station on the other side of the desk and the LPN would have to jump or reach through the window to keep the resident from falling since the resident was impulsive. The LPN stated the resident needed a 1:1 when they were exhibiting behaviors and was on the move; they needed someone with them constantly and there was not enough staff to do that. The LPN could not recall if they had discussed increased supervision as an intervention to reduce falls. The LPN stated a 1:1 or increased supervision was not on the resident's care plan; they had wanted a 1:1 for the resident but it was not feasible due to staffing. The LPN stated they would not put a 1:1 on the resident's care plan because they would not be able to do it. During an interview on 1/19/22 at 12:53 PM, the Director of Therapy stated they were familiar with the resident since they had several falls. The resident did not have safety awareness and had poor judgement control. If redirected or told to wait for assistance, the resident would not wait for help. The staff would keep the resident in common areas, but the resident would self-propel and was mobile so would not remain in common areas. The resident would have benefited from increased supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/19/22 at 12:36 PM, the ADON stated they reviewed Accident and Incident Reports and ensured the care plans were updated. The resident had several falls, had an extensive TBI (traumatic brain injury) with poor safety awareness and it was difficult to redirect the resident. The resident's interventions included floor mats and frequent rounding. Frequent rounding was used for all residents and the resident was kept in the common areas. The ADON stated they tried to give as much supervision as they possibly could. If the resident got in a mood, then nothing would work to keep the resident safe. The facility did not usually use 1:1 supervision for the residents since they did not have the staff to provide it. The resident would have benefited from 1:1 supervision. The ADON stated they tried to find a facility which could provide additional supervision for the resident but were unsuccessful. During an interview on 1/19/22 at 1:04 PM, the DON stated common fall interventions included low beds, mats, closer supervision including putting in common areas, and different activities for the resident. Frequent rounding included putting the resident in common areas to visualize the residents. They did not typically do 15-minute and 1:1 supervision because it was difficult with the staffing in the facility, and they had to prioritize with the need they had. 10NYCRR 415.12(h)(2)