STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335719	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QUANTUM REHABILITATION AND NURSING L L C	63 OAKCREST AVENUE MIDDLE ISLAND, NY 11953

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews during an abbreviated survey on 8/5/20 through 8/6/20 (Complaint number NY 781) the facility did not immediately consult with the resident's physician when there was a significant change in the resident's physical condition for 1 (Resident #1) of 3 residents reviewed. Specifically, on 3/8/20 Resident #1 complained of severe pain (10/10 on the numerical scale) to the right ankle, an X-ray on 3/9/20 indicating [MEDICAL CONDITION] tibia and fibula. Qualified medical personnel, Physician/Nurse Practitioner/Physician Assistant was not notified of Resident #1's complaint of pain, or the x-ray results until 3/10/20. The findings were: The facility's policy titled Notification of Physician for Change in Resident Status dated April 2020 documented to notify a physician when a resident displays a change in status including fall/trauma, abnormal laboratory values, and pain not alleviated by existing and prescribed medication. Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment tool) dated 1/31/20 documented the resident had intact cognition. The resident required extensive assistance of 2 persons for transfer and did not walk. The Comprehensive Care Plan (CCP) dated 7/22/19 documented potential for alteration in comfort evidence by verbalization of pain and non-verbal sounds. Interventions included observing for signs and symptoms of verbal complaints of pain, facial grimacing, or moaning, monitor the effectiveness of the medication. The Nursing Progress Notes (NPN) dated 3/8/20 at 7:41 PM by Registered Nurse Supervisor (RNS) #1 documented resident complained of right ankle pain that she believed was sustained status [REDACTED]. The ankle was tender to touch, and the resident cringed when moved. The pain level was 10/10. Tylenol (pain medication) 650 mg was given with a positive effect. The physician (MD) was made aware through the communication book for possible right ankle x-ray. The MD communication book lacked documented evidence of note related to Resident #1's complaint of pain dated 3/8/20. A telephone order was written by RNS #1 dated 3/9/20 at 7:41 PM for an x-ray of the right ankle. The x-ray result dated 3/9/20 documented non-displaced [MEDICATION NAME] tibia and fibula with Osteopenia (decrease in bone mass). The result was conveyed to the RNS at 9:19 PM. The NPN and the physician (MD) communication book dated 3/9/20 documented x-ray for Resident #1 showed right lower ankle fracture, MD to be notified. Resident requesting stronger medications for pain. The medical record lacked documented evidence that the MD was notified of the x-ray results on 3/9/20. The Medical Progress Notes (MPN) dated 3/10/20 at 10:17 AM documented the x-ray showed right ankle fracture, moderate pain with minimal response to Tylenol (per patient). Fracture likely pathological. The NPN dated 3/10/20 at 1:20 PM documented the resident continued with complaints of pain 10/10. PMD was notified. Orders obtained to send to ER for evaluation of the right ankle. The resident was admitted at 11:30 PM. On 3/16/20 the resident was readmitted to the facility with a cast to the right foot. The 3:00 PM- 11:00 PM RNS #1 was interviewed via phone on 8/6/20 at 12:11 PM and 8/11/20 at 1:01 PM. RNS #1 stated on 3/8/20 the resident reported that somebody (staff) moved her wrongly on prior shift and she had pain on her leg. The resident did not allow the RNS to touch or move the leg. RNS #1 thought the leg was broken. RNS #1 left a note in the physician's communication book but did not call the physician. On 3/9/20 the x-ray results came back with the fracture. RNS #1 did not notify the physician of the x-ray results. RNS #1 stated he was supposed to call the physician but did not because he knew the physician did not like to be called and wanted all concerns written in the communication book. The PMD/Medical Director was interviewed via phone on 8/6/20 at 3:20 PM and stated he was not aware of Resident #1's complaint of pain or the right ankle fracture until 3/10/20. The PMD stated that RNS #1 decided to give the pain medication to the resident. The PMD stated that he expected to be notified of the x-ray results and the unrelieved pain however, the PMD was not called. The DNS was interviewed on 8/6/20 at 3:58 PM and she stated RNS #1 assessed the resident, but he did not call the MD for the pain. RNS #1 should have called the MD for x-ray orders and pain medications because the resident had a change in condition. 10 NYCRR 415.3(e)(2)(ii)(b)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey on 8/5/20 through 8/6/20 (NY 781), the facility did not ensure that a resident received the necessary care and services to maintain the highest practicable well-being promptly for 1 (Resident #1) of 3 residents reviewed. Specifically, Resident #1 complained of right ankle pain on 3/8/20 with a pain level of 10/10 (severe) on a numeric scale. X-ray results on 3/9/20 indicated Tibia and Fibula fracture, and the resident continued to complain of intermittent pain. The Physician was not notified of the resident's complaint of pain or the results of the x-rays until 3/10/20. The findings were: The facility's policy titled pain management dated 2/2011 documented the licensed staff should assess the nature, onset, frequency, location intensity of pain. The 0-10 numeric pain scale must be utilized when defining the intensity of pain. 0 - no pain, 1-3 mild pain, 4-6 moderate pain, 7-9 severe pain, and 10 worst pain. The facility's policy titled Notification of Physician for Change in Resident Status dated April 2020 documented to notify a physician when a resident displays a change in status including fall/trauma, abnormal laboratory values, and pain not alleviated by existing and prescribed medication. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment tool) dated 1/31/20 documented the resident's cognitive status as intact. The resident required extensive assistance of 2 persons for transfer and was non ambulatory. The resident reported moderate pain occasionally. The Comprehensive Care Plan (CCP) titled Potential for alteration in comfort as evidence by verbal and non-verbal signs of pain such as crying, moaning, or groaning. The interventions included observing for signs and symptoms of pain and to monitor for effectiveness of the medication. The physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Upon reassessment, the resident continued to have moderate pain 5/10 on the numeric scale. The Nursing Progress Notes (NPN) dated 3/8/20 at 7:41 PM by Registered Nurse Supervisor (RNS) #1 documented the resident complained of right ankle pain that she believed was sustained status [REDACTED]. The ankle was tender to touch and the resident cringed when moved. The pain level was 10/10 on the number scale. Tylenol 650 mg was given with a positive effect. The physician (MD) was made aware in the communication book for possible right ankle x-ray. The physician communication book lacked documented evidence of note related to Resident #1's complaint of pain on 3/8/2020. The MAR indicated [REDACTED]. The NPN dated 3/9/20 at 2:21 PM by Licensed Practical Nurse (LPN) #2 documented the resident transported to [MEDICAL TREATMENT] at 10 AM and is expected to return by 5 PM. The right ankle was sensitive to touch, no redness or [MEDICAL CONDITION] was noted. The Physician's telephone orders (PO) dated 3/9/20 entered by RNS #1 at 7:41 PM documented x-ray of the right ankle. The x-ray result dated 3/9/20, documented a [MEDICAL CONDITION] Tibia and Fibula with Osteopenia (bone loss). The result was conveyed to RNS #1 at 9:19 PM. The NPN dated 3/9/20 at 10:15 PM by RNS #1 documented

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335719	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QUANTUM REHABILITATION AND NURSING L L C	**63 OAKCREST AVENUE MIDDLE ISLAND, NY 11953**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) x-ray results of the right lower ankle positive for fracture, MD (physician) to be notified. Resident #1 requesting stronger medications for pain. The NPN dated 3/9/20 at 10:21 PM by LPN #1 documented the resident returned from [MEDICAL TREATMENT] at 4:45 PM, complained of pain 10/10 to the right ankle. Tylenol 650 mg given with no effect. The NPN lacked documented evidence of a note from the 11-7 shift. The MD communication book dated 3/9/20 documented the resident with a positive fracture to the right ankle. X-ray results. Requesting for stronger medication for the patient. The MAR indicated [REDACTED]. The Medical Progress Notes (MPN) dated 3/10/20 at 10:17 AM documented the x-ray showed right ankle fracture, moderate pain with minimal response to Tylenol (as per patient). The resident was alert. Pain scale of 1-2/5 pain scale noted minimal soft tissue swelling, right ankle without discoloration. Fracture likely pathological. Added [MEDICATION NAME] as needed. Repeat x-ray in 4 weeks, non-weight-bearing, immobilization. Elective ortho appointment when available. The facility investigation summary dated 3/10/20 documented on 3/8/20 the resident reported injuring the right ankle during transfer to the 3-11 shift RNS (#1) and was experiencing pain. RNS #1 assessed the resident. The MD was notified, an x-ray was done and was positive for [MEDICAL CONDITION] tibia and fibula. There was no evidence of abuse, neglect, or deliberate mistreatment. The 7:00 AM-3:00 PM CNA #2 was interviewed on 8/5/20 at 3:01 PM and she stated the Resident was on her assignment on 3/9/20. The resident refused to lift the leg when CNA #2 was dressing the resident because the leg was hurting too much. CNA #1 informed LPN #2 who went and looked at it and informed the RNS. The 7:00 AM - 3:00 PM LPN #2 was interviewed on 8/5/20 at 4:35 PM and stated on 3/9/20 she checked Resident #1 before [MEDICAL TREATMENT], the resident had no pain. LPN #2 stated she did not recall communication with CNA #2 related to Resident #1's complaint of pain. The 11:00 PM- 7:00 AM CNA #1 was interviewed via phone on 8/6/20 at 10:02 AM and stated she worked 7-3 shift on 3/8/20 and was assigned to Resident #1. CNA #1 transferred Resident #1 from bed to chair by herself. CNA #1 stated there was no incident and the resident did not hurt herself. The resident did not complain of pain. On 3/9/20 she was again assigned to Resident #1. CNA #1 stated that Resident #1 was sleeping and did not complain of pain. The 3:00 PM- 11:00 PM RNS #1 was interviewed via phone on 8/6/20 at 12:11 PM and 8/11/20 at 1:01 PM. On 3/8/20 Resident #1 reported pain to the right leg after a staff (don't recall who) moved her the wrong way. The resident did not allow RNS #1 to touch or move the leg. RNS #1 thought the leg was broken, however, there was no swelling. RNS #1 did not call the MD and wrote a note in the communication book regarding the resident's complaint of pain and the need for an x-ray of the ankle. RNS #1 stated he did not call the PMD because the MD had previously instructed RNS #1 not to call him. RNS #1 stated that LPN #1 did not tell him that the pain was not relieved with Tylenol. RNS #1 stated he knew that Resident #1's X-ray results showed fractures. RNS #1 stated he did not call the PMD to notify him of the results, he wrote the results in the PMD communication book. The PMD/Medical Director was interviewed via phone on 8/6/20 at 3:20 PM and stated he was not aware of Resident #1's complaint of pain or the right ankle fracture until 3/10/20. The PMD stated that RNS #1 decided to give the pain medication to the resident. The PMD stated that he expected to be notified of the x-ray results and the unrelieved pain however, the PMD was not called. The DNS was interviewed on 8/6/20 at 3:58 PM and she stated RNS #1 assessed the resident, but he did not call the MD for the pain. RNS #1 should have called the MD for x-ray orders and pain medications because the resident had a change in condition. 415.12