STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335589	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAND REHABILITATION AND NURSING AT ROME	801 NORTH JAMES STREET ROME, NY 13440

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the abbreviated survey (NY 035), the facility did not ensure residents had the right to request, refuse, and/or discontinue treatment, and to formulate advance directives for 1 of 6 residents (Resident #4) reviewed. Specifically, Resident #4 had a Do Not Resuscitate order (DNR, allow natural death, do not perform cardiopulmonary resuscitation, CPR, in the event the heart stopped) and facility staff performed CPR when the resident was found unresponsive. Findings include: The ,[DATE] facility policy Identification of Advance Directives documents a resident would be provided a blue identification bracelet and blue dot on the chart (medical record) to designate full code status and a red identification bracelet and red dot on the chart to designate DNR status. If a resident has a history of removing his/her ID band and or refuses to wear the ID band, he/she will be offered an alternative, including a different location to wear the band. The nurse and/or social worker will be responsible for providing residents with a bracelet and placing the dots in the designated areas. The ,[DATE] Emergency Procedure-Cardiopulmonary Resuscitation policy documents if an individual is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR shall initiate CPR unless: it is known that a DNR order is in place and/or external defibrillation exists for that individual. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden [MEDICAL CONDITION] is likely, begin CPR. Instruct a staff member to activate the emergency response system announcing CODE BLUE and location and call 911. Instruct a staff member to retrieve the automatic external defibrillator. Verify or instruct a staff member to verify the DNR or code status of the individual. Resident #4 had [DIAGNOSES REDACTED]. The resident expired prior to completion of the Minimum Data Set (MDS) assessment. A hospital discharge summary dated [DATE], documented the resident had a Do Not Resuscitate (DNR, allow natural death), Do Not Intubate (DNI) and no [MEDICAL CONDITION] (a mask that is applied to force air into the lungs) order. The [DATE] registered nurse (RN) admission assessment documented the resident was oriented to person only, was confused, and was dependent on staff for all activities of daily living (ADLs). The nurse practitioner's (NP) admission note, dated [DATE] documented the resident was a DNR/DNI. The physician's orders [REDACTED]. The nursing progress note dated [DATE] by RN #13 documented a code blue was paged overhead and she responded to the unit. She observed RN Unit Manager #11 performing chest compressions on the resident while licensed practical nurse (LPN) #14 provided breaths via the ambu bag (artificial manual breathing unit). The automated external defibrillator (AED) unit pads were applied and the unit switched on. Before the machine could determine the need for a shock, another nurse came to the door and stated the resident was a DNR and to stop CPR. The resident was pronounced deceased at 10:22 AM. During an interview on [DATE] at 1:45 PM, certified nurse aide (CNA) #16 stated she found the resident on [DATE] in his bed, unresponsive. She left the room, got RN Unit Manager #11 who started chest compressions. She stated another staff, she could not recall who, said they did not know if the resident was DNR. The CNA knew that staff were to check the advance directives section of the chart for the MOLST, but CNAs were not allowed to do so, so she did not. While RN Unit Manager #11 continued compressions, someone left to check the chart. She overheard an unknown employee say they did not know the resident's code status, because they could not locate his chart. Other staff brought in a crash cart and called 911. During an interview on [DATE] at 1:13 PM, RN Unit Manager #11 stated she was in morning report when she heard a page for code blue. She responded immediately, went into the room, saw the resident was blue, and started compressions. She stated, time was of the essence and anytime she found someone not breathing, she jumped in and started CPR. The facility did not have code status identifiers in a resident's room or on the resident, and staff would have to determine that information from the electronic record or from the MOLST in the paper record. She thought she sent out LPN #14 to find out the code status, after she started compressions. During an interview on [DATE] at 2:14 PM, RN #13 stated a resident's code status could be found in their electronic medical record (EMR) and on the colored sticker on the chart. She stated today she spoke with a social worker and was informed the residents also wore colored bracelets for DNR and CPR and she did not recall if the resident had a bracelet on. During an interview on [DATE] at 3:15 PM, RN #17 stated she accessed the resident's EMR on [DATE] while staff were performing CPR and saw the resident was a DNR. She went to the resident's room and told RN #11 that the resident was a DNR and to stop CPR. During an interview on [DATE] at 3:41 PM, LPN #14 stated the binder of the residents' charts have red dots if a resident was a DNR and blue dots if they were a full code. She stated, if a resident was unresponsive, she would first check a resident's physician orders [REDACTED]. When she went to the resident's room on [DATE], the resident was unresponsive, so a code blue was called. She did not know at that time what the resident's code status was. She and other staff could not find the resident's chart at the time of the code. The RN Unit Manager responded to the code and began chest compressions. She was in the room when the RN Unit Manager was doing CPR and another staff member came to the door and said to stop as the resident was a DNR. During an interview with Director of Education #20 on [DATE] at 9:30 AM, she stated she was responsible for educating staff on advance directives. She educated staff if a code blue was called to look for the MOLST form in the resident's record, and the LPN or RN on the scene would decide what to do. She stated the residents did not wear code status identifier bracelets at the facility. There were blue dots on the chart for full code and red dots for DNR. She stated when a resident was unresponsive, staff needed the chart in order to determine if compressions should be started. During an interview with Assistant Director of Nursing (ADON) #19 on [DATE] at 10:51 AM, she stated when she taught CPR classes, she told staff to look at the paper chart first to find the MOLST. If there was no MOLST, then they should look at the orders in the computer. She stated there would also be a blue or red sticker on the chart that would identify code status. 10NYCRR 415.3(e)(1)(ii)
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation during abbreviated surveys (NY 528 and NY 928), the facility did not ensure residents had the right to be free from abuse and did not immediately protect residents from abuse for 1 of 3 residents (Resident #1) reviewed. Specifically, certified nurse aide (CNA) #6 hit Resident #1 resulting in the resident

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) falling to the floor, then hit and kicked the resident while the resident was on the floor. Additionally, CNA #6 was permitted to work the remainder of the shift. Resident #1 was sent to the emergency room and evaluated for a minor closed head injury, contusion to the head, and cervical strain with [MEDICATION NAME] and lumbar pain associated with a sprain. This resulted in actual harm to Resident #1. Findings include: The facility's abuse policy dated 3/2020 documented each resident had the right to be free from verbal, physical, and mental abuse, and each resident would be treated with dignity and respect. Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident's cognition was intact. The comprehensive care plan (CCP) dated 6/19/2020 documented Resident #1 had limited physical mobility, needed assistance with activities of daily living (ADL) related to muscle weakness and spasms to bilateral legs. The resident had behaviors, was socially inappropriate, verbally aggressive/abusive, and non-compliant with the rules of the facility. Interventions included to determine the cause of the behaviors, remove the resident from situations when necessary, and provide psychological services as needed. The facility's incident report dated 6/27/2020 at 1:10 AM, documented an unobserved physical assault/altercation occurred between Certified Nurse Aide (CNA) #6 and Resident #1. Licensed Practical Nurse (LPN) #3 and Registered Nurse Supervisor (RNS) #2 entered the unit and observed Resident #1 and CNA #6 wrestling on the floor. LPN #3 and RNS #2 attempted to separate the resident and CNA #6. An ambulance and the police were called. Statements obtained by the facility as part of the investigation included: - Resident #1's statement documented they had a previous issue with CNA #6 and the last time the resident asked her for something, CNA #6 slammed the resident's door. On 6/27/2020, Resident #1 rang the call bell and when no one answered, the resident went to the nursing station. CNA #6 was sitting at the desk. CNA #6 called the resident a crack head, knocked the resident down, hit and kicked the resident, and placed her knee on their chest. - Resident #4's, statement documented they witnessed the incident reported on 6/27/2020. They heard CNA #6 state she was not going to answer Resident #1's call bell because she had an issue with Resident #1 the prior week. Resident #4 heard Resident #1 and CNA #6 arguing. CNA #6 called Resident #1 a crack head, used foul language, and made a threat. Resident #4 heard a boom and saw CNA #6 on top of Resident #1, with her knee on Resident #1's chest while punching the resident in the head. Resident #1 was swinging back at CNA #6. RNS #2 and LPN # 3 attempted to grab CNA #6 off of Resident #1. CNA #6 continued to kick and punch Resident #1 during that time. - CNA #6 reported she had a previous issue with Resident #1 and on 6/27/2020, she told the nurse she was not answering the call bell because of the prior issue. CNA #6 was at the nursing station and Resident #1 approached her and began berating her. CNA #6 called the resident a crack head and Resident #1 threatened her, she put up her hand to protect herself, and the resident fell . Resident #1 tried to hit her with a stool, so she leaned on top of the resident while the resident was on the ground. - RNS #2's statement documented on 6/27/2020, she arrived on the unit and heard CNA #6 screaming that she was being bit and was using foul language. Resident #1 reported CNA #6 pushed, punched and kicked them several times. When interviewed on 7/20/2020 at 8:05 AM, the Director of Nursing (DON) stated the actual time of the incident was at 1:00 AM on 6/27/2020. The video surveillance time was not accurate and there was a three-hour difference between the time on the video and the actual time. The surveyor observed the video surveillance of the incident which documented the date was 6/26/2020 (actual date 6/27/2020 as video surveillance was three hours different from the actual time): - From 9:57 PM to 9:59 PM (actual time 6/27/2020 at 12:57 AM to 12:59 AM), Resident #1 was sitting in a wheelchair in front of the nursing station. CNA #6 was behind the nursing station desk. Resident #1 got up from the wheelchair and slowly walked to the nursing station. Resident #1 and CNA #6 engaged in conversation. - At 9:59 PM (actual time 6/27/2020 at 12:59 AM), CNA #6 lifted her right arm, reached for something on the desk, pulled back her arm and made forceful contact with the resident's face. Resident #1 fell to the floor. CNA #6 remained at the nursing station, moving things on the desk, while the resident remained lying on the floor. - At 10:00 PM (actual time 6/27/2020 at 1:00 AM), CNA #6 was standing kicked her right leg forward, towards the resident's face, then turned her body facing the desk, leaned into the desk and kicked backward while the resident remained on the floor. Resident #4 was then noted to arrive in a wheelchair at the nursing station. CNA #6 thrust her right foot and leg forward towards Resident #1 who remained on the floor. CNA #6 then kicked a foot stool backward and kicked her foot forward towards the resident. CNA #6 grabbed the stool, bent over, and continued to kick her foot forward towards the resident while the resident remained lying on the floor (the surveyor was unable to see whether she made contact with the resident at this time). - At 10:00:35 (actual time 6/27/2020 at 1:00:35 AM and 1:00:38 AM), RNS #2 and LPN #3 arrived at the scene. CNA #6 continued to thrust her hand forward punching at the resident with a closed fist. RNS #2 and LPN #3 attempted to remove CNA #6 from the resident and had difficulty pulling her off the resident. Once in a standing position, CNA #6 began pointing her right hand towards Resident #4 and appeared to be yelling at the resident and slammed her hand down on the nurse's station desk. - At 10:02 PM (Actual time 6/27/2020 at 1:02 AM), Resident #1 remained on the floor and CNA #6 remained behind the nursing station within a few feet of the resident until Emergency Medical Services (EMS) arrived. The hospital record dated 6/27/2020 at 2:59 AM, documented Resident #1 reported they were assaulted by a CNA at the nursing facility. The resident had complaints of moderate pain to the head, neck and lower back. The resident received [MEDICATION NAME] (narcotic pain medication) at 4:02 AM. The hospital imaging (scans and x-rays) did not show any relevant findings and the impression was no acute traumatic injury was identified. The general instructions documented the resident had a minor closed head injury, contusion to the head and cervical strain with [MEDICATION NAME] and lumbar back pain associated with sprain. During an observation and interview on 7/8/20 at 9:49 AM, Resident #1 was in bed in their room. Resident #1 stated they had pain in the left shoulder, back and right knee. Resident #1 reported they were assaulted by a CNA. The resident stated they were receiving pain medication however it did not help a lot and they continued to have pain. The Director of Nursing (DON) was interviewed on 7/8/2020 at 11:34 AM and stated Resident #1 had mobility issues and multiple behaviors. She was not aware that CNA #6 and Resident #1 had an incident prior to the 6/27/2020 incident. She was notified of this incident at 6:00 AM on 6/27/2020, and at that time, she placed CNA #6 on administrative leave. The DON stated video surveillance showed the resident had slow mobility and it took a while for the resident to ambulate to the nursing station. CNA #6 pushed Resident #1 to the floor and kicked the resident. The DON stated it was not visible on the video but Resident #4 reported CNA #6's knee was on Resident #1's chest. The DON stated after the incident, CNA #6 went to the emergency room to be evaluated and when she returned, RNS #2 allowed CNA #6 to work the rest of the shift. She stated CNA #6 should not have been permitted to work in the facility after the incident with Resident #1. CNA #6 was interviewed via telephone on 7/9/2020 at 10:43 AM, and stated she was the victim of an assault by Resident #1. She stated they had a prior incident on 6/25/2020 that was a verbal altercation and on 6/27/2020, she asked the nurse to answer the resident's call bell due to their previous altercation. The resident came to the desk and made threats against her and she did not walk away as she was the only person on the unit. She stayed at the nursing station and told the resident to go back to their wheelchair. She stated the resident was very close to her and was yelling and threatening her. She stated the resident hit her, but she could not state where on her body she was hit. She put her right hand up and the resident fell . She did not hit or push the resident, she just put her hand up. When the resident fell behind the desk, the resident picked up a stool and tried to hit her with it, so she was forced to restrain the resident. She held down the resident's arm and her leg was stretched over the resident's chest, not resting on the chest just over it then the resident bit her leg. She stated she did not think she hit the resident but may have. She was trying to restrain the resident and protect herself. LPN #3 was interviewed via telephone on 7/9/2020 at 11:38 AM, and stated on 6/27/2020, she was in the nursing office when CNA #6 told her she was not going to answer Resident #1's call bell due to the resident being rude to her a few days earlier. LPN #3 answered the call bell and the resident asked for pain medications. LPN #3 needed to clarify the orders with RNS #2 so she left the unit to speak to RNS #2. When she and RNS #2 returned to the unit, they heard CNA #6 yelling to get the resident off her. She observed Resident #1 lying on the floor and CNA #6 was positioned with each leg on either side of the resident's head and the resident had a hold of both her legs. She tried to separate them but could not get them apart. She did not see CNA #6 hit or kick the resident but did see CNA #6's knee on the resident's chest before the resident bit her. Both the resident and CNA #6 used foul language. Resident #1 and CNA #6 separated themselves and RNS #2 notified Administration, the police, and an ambulance. The surveyor attempted to contact RNS #2 via the telephone and via a certified letter and no response was received. When interviewed on 7/22/2020 at 9:38 AM, the nurse practitioner (NP) stated she saw the resident the day after the incident occurred. The resident presented with bruising on the lower back and left arm that was not present a few days earlier. The resident was very anxious and had an increase in their post-traumatic stress disorder symptoms. She ordered anti-anxiety medication and made a referral for psychological services. The resident had complaints of pain and received pain medication that was effective. 10NYCRR 415.4(b)(2)(3)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation during the abbreviated surveys (NY 528, NY 928, and NY 035), the facility did not ensure all alleged violations involving abuse or neglect are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events did not involve abuse and did not result in serious bodily injury for 2 of 9 residents reviewed (Residents #1 and 4). Specifically, certified nurse aide (CNA) #6 hit Resident #1 resulting in the resident falling to the floor and CNA #6 hit and kicked the resident while the resident was on the floor. Resident #1 was sent to the emergency room and evaluated for a minor closed head injury, contusion to the head, and cervical strain with [MEDICATION NAME] and lumbar pain associated with a sprain. The facility did not report the incident between Resident #1 and CNA #6 to the New York State Department of Health (NYS DOH) within 2 hours as required. Resident #4 had a physician order [REDACTED]. Any alleged violation of abuse neglect, exploitation or mistreatment are reported immediately. The facility was to report allegations of abuse to the NYS DOH within 24 hours. The Nursing Home Incident Reporting Manual dated [DATE] documents CPR concerns are reportable to the NYSDOH when CPR is provided against the resident's wishes, or CPR was initiated then stopped when staff became aware of the resident's wishes. 1) Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident's cognition was intact. The facility's incident report dated [DATE] at 1:10 AM, documented an unobserved physical assault/altercation occurred between certified nurse aide (CNA) #6 and Resident #1. Licensed practical nurse (LPN) #3 and registered nurse Supervisor (RNS) #2 observed Resident #1 and CNA #6 wrestling on the floor. LPN #3 and RNS #2 attempted to separate the resident and CNA #6. An ambulance and the police were called. The resident was sent to the hospital for evaluation following the incident. The hospital record dated [DATE] at 2:59 AM, documented Resident #1 reported an assault by a CNA at the nursing facility. The resident had complaints of moderate pain to the head, neck and lower back. The resident received [MEDICATION NAME] (narcotic pain medication) at 4:02 AM. The hospital imaging (scans and x-rays) did not show any relevant findings and the impression was no acute traumatic injury was identified. The general instructions documented the resident had a minor closed head injury, contusion to the head and cervical strain with [MEDICATION NAME] and lumbar back pain associated with sprain. The Director of Nursing (DON) was interviewed on [DATE] at 11:34 AM, and stated she was notified about the incident at 6 AM on [DATE]. The DON stated video surveillance showed CNA #6 pushed Resident #1 to the floor and kicked the resident. The DON stated it was not visible on the video but Resident #4 witnessed the incident and reported CNA #6's knee was on Resident #1's chest. When interviewed on [DATE] at 10:23 AM, the Administrator stated he was notified by RNS #2 on [DATE] at approximately 1:10 AM that Resident #1 had bitten CNA #6. He told RNS #2 that if the situation was serious, she should call the Assistant Director of Nursing (ADON) and ask her to come to the facility. He stated he did not receive any more calls from RNS #2. At 7 AM, he woke up to a text message sent at 2:33 AM from RNS #2 that documented CNA #6 and Resident #1 returned from the emergency room , the police responded to the facility and both the CNA and the resident wanted to press charges, RNS #2 tried to call the ADON three times with no response, and this was a state reportable incident. When he saw the text message, he asked RNS #2 to call him and she did not call. He called the ADON and she reported she knew nothing about the incident. The ADON then called the DON and he reviewed the surveillance footage of the incident. He stated he was aware an incident of abuse was to be reported within 2 hours to the NYS DOH and he was not made aware of the full incident when he was contacted by RNS #2 at 1:10 AM and if he had been, he would have reported the incident then. 2) Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident expired prior to completion of the Minimum Data Set (MDS) assessment. The nurse practitioner's (NP) admission note, dated [DATE] documented the resident was a do not resuscitate (DNR, allow natural death in the event the heart stopped)/do not intubate (DNI, do not place a breathing tube). The physician orders [REDACTED]. The nursing progress note dated [DATE] by registered nurse (RN) #13 documented a code blue was paged overhead and she responded to the unit. She observed RN Manager #11 performing chest compressions on the resident while licensed practical nurse (LPN) #14 provided breaths via the ambu bag (artificial manual breathing unit). The automated external defibrillator (AED) unit pads were applied and the unit was switched on. Before the machine could determine the need for a shock, another nurse came to the door and stated the resident was a DNR and to stop CPR. The resident was pronounced deceased at 10:22 AM. When interviewed on [DATE] at 11:10 AM, the Administrator stated that if an incident needed to be reported to the NYSDOH the Director of Nursing (DON) would be responsible to report it. If he was aware it needed to be reported, he could report it. The Administrator stated he was not aware the incident needed to be reported to the NYSDOH. When interviewed on [DATE] at 11:30 AM, the DON stated she did not report the incident because she did not realize it required reporting. 10NYCRR415.4 (b) (1) (ii)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the abbreviated survey (NY 224), the facility did not ensure services provided met professional standards of quality for 1 of 10 residents (Resident #10) reviewed. Specifically, when Resident #10 was found following a suspected fall, the resident was assessed to have an injury requiring a hospital evaluation, the transfer to the hospital was not completed timely, and the resident was not monitored by staff while awaiting the hospital transfer. Findings Include: Resident #10 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severe cognition impairment. The resident required supervision with activities of daily living (ADLs) including transferring, walking in their room and in the corridor and locomotion both on and off the unit. The 4/2/19 comprehensive care plan (CCP) documented the resident was at risk for falls related to unsteady gait. Interventions included to place the bed in the low position. The facility's 12/8/19 investigation documented at 8:45 AM, Resident #10 was found sitting on the edge of the bed with blood on their elbow and on the floor, and a fall was suspected. When staff attempted to stand the resident, the resident yelled out in pain. Statements obtained by the facility included: - The Director of Nursing (DON) documented that certified nurse aide (CNA) #23 last saw the resident asleep at 7:30 AM, and at 8:45 AM, when she brought the resident breakfast, the resident was sitting on the edge of the bed, their elbow was bleeding, and when she attempted to stand the resident, the resident screamed in pain. CNA #23 notified licensed practical nurse (LPN) #24 the resident was sitting on the bed bleeding. - The DON documented LPN #24 observed the resident sitting on the edge of the bed with copious amounts of blood noted on the bed and floor. The resident was noted with confusion, was unable to ambulate, bear weight or lie in bed. LPN #24 informed registered nurse Supervisor (RNS) #25 the resident was sitting on the edge of the bed and there was a large amount of blood leading from the bathroom to the bed. - The DON documented RNS #2 reported the resident was awake but confused per their usual state. The resident did state they fell in front of the door. RNS #2 was unsure which door the resident was referring to. RNS #2 reported the resident had a quarter size open area on the right elbow that was bleeding and had a moderate amount of swelling. The abrasion area was cleansed and dressed by LPN #24. The resident complained of severe right lower extremity pain and was not able to lift their own feet to place them on the bed. When staff attempted to lift the resident's feet, the resident yelled out very loudly in pain. The resident denied hitting their head, was able to follow commands, but was in their usual state of confusion. Neurological checks were initiated, and vital signs were within normal limits. A loose ice pack was applied to right elbow and secured with a sling. RNS #2 was unable to assess the resident's range of motion (ROM) due to complaints of pain. - RNS #25 documented the resident was sitting on the edge of the bed and their right elbow was bleeding. RNS #2 was in the room. RNS #25 left the room and placed a call to the resident's family member and made her aware of the possible fall, notified medical the resident would be sent out to be evaluated and possibly treated and she would start preparing the transfer paperwork. She documented the fall occurred at approximately 8:45 AM and the ambulance did not arrive at the facility until 10:15 AM. She documented she was interrupted, and this delayed her calling the ambulance. - The DON documented that the resident's family member informed her that she was told the resident fell at 8:58 AM. When the family member arrived at the facility, the resident was sitting on the edge of the bed alone without their call bell within reach. There was a trail of blood from the bed to the chair to the door. She stated the ambulance did not arrive until 10:21 AM. - The DON documented a follow-up interview with RNS #2 who reported she asked CNA #23 to stay with the resident until the ambulance or the other RNS came back to the room. She asked RNS #25 to call the family, medical, and medical transport. - The DON's conclusion documented RNS #25 had a lapse in judgement when prioritizing the immediate needs of Resident #10 and she was delayed in calling the ambulance. During a telephone interview with LPN #24 on 7/17/20 at 1:04 PM, she stated CNA #23

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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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) reported to her at 8:45 AM, the resident was found sitting on the edge of the bed, bleeding and was in pain. She called RNS #25 after ensuring the resident was safe. RNS #25 began to treat the resident's elbow and told LPN #24 to go to the dining room to provide supervision for the breakfast meal service. She was unsure when the ambulance was called and said there seemed to be some confusion but was told it was under control. Telephone interviews with CNA #24, RNS #2, and RNS #25 were attempted on 7/17/20 at 12:17 PM, 12:22 PM, and 12:23 PM, and no return calls were received. During a telephone interview with Resident #10's family member on 7/23/20 at 4:43 PM, she stated the facility called her at 8:58 AM on 12/8/19 to inform her the resident had a suspected fall. She left work and entered the facility around 10 AM. At that time, the resident was in their room alone, there was blood on the floor, and the ambulance had not arrived. When she asked why the resident was still at the nursing home, the RNS stated the ambulance was on the way. She reported she waited another few minutes and was going to call for an ambulance herself, but the ambulance arrived at 10:21 AM. When she asked the medical transport personnel what took so long to get there, she was told the call just came in. The family member stated the resident was diagnosed with [REDACTED]. During a telephone interview with the DON on 7/28/20 at 2:38 PM, she stated RNS #25 should not have waited to call the ambulance and the resident should not have been left alone while they were awaiting medical transport as it was apparent the resident had an injury. 10NYCRR 415.11(c)(3)(i)