STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALPINE REHABILITATION AND NURSING CENTER	**755 E MONROE STREET LITTLE FALLS, NY 13365**

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during an abbreviated survey (NY 714), the facility did not ensure all alleged violations involving abuse/neglect were reported to the New York State Department of Health (NYSDOH) as required for 1 of 3 residents (Resident #1). Specifically, facility staff served Resident #1 the incorrect consistency liquid, and failed to supervise the Resident at the meal. As a result, the resident had a choking incident that required staff intervention and led to the Resident's expiration. The Facility did not report the incident to the NYSDOH as required. Findings include: The ,[DATE] New York State Department of Health (NYSDOH) Nursing Home Incident Reporting Manual expressly identifies as an example of a reportable incident, an accident related to choking with a care plan violation with regard to incorrect consistency consumed, including incidents in which a resident requires thickened liquids and is served liquids of an incorrect consistency resulting in choking. The facility's ,[DATE] Abuse, Neglect, and Mistreatment Reporting policy documents the 2016 NYSDOH Nursing Home Incident Reporting Manual is used to determine if an event is reportable to the NYSDOH. It further documents the Administrator or designee is responsible for reporting to the NYSDOH when there is reasonable cause to believe that abuse, neglect, or mistreatment has occurred. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The [DATE] physician's orders [REDACTED]. The [DATE] registered nurse Supervisor (RNS) #4's progress note at 11:34 AM documented she was paged to the resident's room at 10:36 AM. The resident was unable to answer questions, was coughing and exhibited respiratory distress. Respirations were labored and rapid at 36 per minute. Oxygen was applied at 3 Liters (L) and the resident's saturation (level of oxygen in blood) was 84%. The RNS called the nurse practitioner who ordered a chest x-ray and oxygen. The resident's respirations then slowed and ceased, and the resident expired. The [DATE] Incident Report documented: - The resident was admitted to the facility on [DATE] at 5:00 PM and their diet order was Regular diet, pureed texture, extremely thick/pudding thick liquids consistency. - The diet order was communicated with the kitchen and the kitchen could not print meal tickets on the weekends, so the resident's meal ticket was handwritten and documented puree/pudding on half a sheet of paper. - Temporary Nursing Assistant #1 prepared Resident #1's meal tray and thought the diet order meant pureed food with chocolate or vanilla pudding. Temporary Nursing Assistant #1 did not know the resident required thickened liquids. Temporary Nursing Assistant #1 served the resident the meal tray in the resident's room and left the resident to eat unsupervised. - At 10:36 AM, licensed practical nurse (LPN) #2 entered the resident's room and noticed the resident was having difficulty breathing. The resident had a breakfast tray and 3 empty cups in front of them at that time. - LPN #3 and RNS #4 were notified. The resident became hypoxic (lack of oxygen in the blood), supplemental oxygen was provided, and the resident declined and expired 10 minutes later. - Temporary Nursing Assistant #1's statement documented the meal ticket did not document pudding-thick liquids, she left the resident alone in the room with the meal tray to eat, and she was told the resident aspirated on the liquids and passed away. - RNS #4 and LPN #3's witness statements documented the resident had three empty cups on the bedside table and one had a small amount of thin liquids remaining in the bottom of the cup. - The report documented the resident received the incorrect fluid-consistency and staff were disciplined. - It was determined there was no abuse, neglect, mistreatment, or misappropriation of property. The Administrator and Director of Nursing (DON) signed that they reviewed the incident. During an interview on [DATE] at 8:13 AM, NP #5 stated she was notified on [DATE] by nursing staff that the resident was having difficulty breathing. She could not recall being notified that the resident received an incorrect fluid consistency. She stated 600 ml was a lot of fluid to consume and had she known the resident was estimated to consume that much thin liquid, she may have documented the resident's cause of death as possible aspiration pneumonia. During an interview on [DATE] at 12:41 PM, the DON stated she and the Administrator jointly decided when incidents were reportable to the NYSDOH and they referenced the Nursing Home Incident Reporting Manual when deciding when to report. They determined this incident was not reportable as the resident was able to state that they could not breath which meant that their airway was never obstructed, which meant the resident did not choke. The DON stated the resident's rapid decline did not present like aspiration, there was not a thorough investigation completed by staff to determine how much fluid the resident drank besides the empty cups in front of them, and the NP documented the cause of death was cardiac related. During an interview on [DATE] at 1:43 PM, the Administrator stated that she and the DON decided whether an incident was reportable based on the Nursing Home Incident Reporting Manual. It was decided that this was not a reportable incident as it was believed to be a medical event rather than a choking incident. She was notified that the resident received the incorrect fluid consistency, but the Administrator stated she was not told that the resident was coughing or choking at any point; the resident had been short of breath and reported that they could not breath. She stated that the resident coughing out colored liquids was a different story than what was reported to her. 10NYCRR 415.4(b)(2)

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.