STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335184	A. Building B. Wing	01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Duyn Center for Rehabilitation and Nursing	5075 West Seneca Turnpike Syracuse, NY 13215

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the abbreviated survey (NY 557), the facility did not develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical and nursing needs that are identified in the comprehensive assessment for 1 of 3 residents reviewed (Resident #1). Specifically, Resident #1's care plan and therapy recommendations for non-ambulatory status were not implemented by the certified nurse aides (CNA) who did not review the care plan, were not aware of the resident's non-ambulatory status, and did not intervene when the resident attempted to ambulate independently. The resident fell while ambulating independently to the bathroom and subsequently expired from asphyxiation when their hospital gown became entangled on the door handle. Findings include: The Fall Prevention Program, revised ,[DATE], documented interventions to prevent falls included educating family/residents on prevention strategies; reviewing activity and mobility privileges with residents and discussing safety risks with the interdisciplinary team and identifying strategies for fall prevention in the comprehensive care plan (CCP). Resident #1 had [DIAGNOSES REDACTED]. The resident required limited assistance from 1 person for bed mobility, transfers, and walking in the room. The resident was toileted with supervision and assistance from 1 person. The resident had no falls. The [DATE] comprehensive care plan (CCP) documented the resident was at risk for falling. Interventions included proper footwear/non-skid socks, proper lighting, educate on mobility and transfers, and supervision for all ADLs. The CCP did not document the resident's ADL ability for ambulation or the resident's ambulation status. The CCP did not document the resident exhibited behaviors or was non-complaint with care. The [DATE] at 5:46 PM, nursing progress note documented the resident was found on the floor in their room and the resident stated they walked to the bathroom and after using the toilet, became dizzy, and hit their head during the fall. Neurological checks were in place and the nurse practitioner (NP) was aware. The resident did not sustain any injuries. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] NP #13's progress note documented the resident fell on [DATE] with no injury. The resident would be placed on fall precautions and neurological checks per protocol. The plan was to monitor and try to keep the resident safe. The [DATE] Physical Therapy (PT) Plan of Care documented the resident was referred for generalized weakness from COVID-19 isolation and a recent fall when ambulating to the bathroom. The resident used to be independent for transfers and ambulation with assistive devices, needed minimum assistance from 1 person for transfers, and now was unable to ambulate. The resident was educated on fall prevention, slow transfers, and pacing activity. Therapy was necessary for bed mobility, transfers, ambulation, strengthening, balance, and functional activities. Without therapy, the resident was at high risk for falls. For static standing, the resident required handheld support and moderate assistance to maintain position. The undated Kardex documented the resident needed extensive assistance from 1 person with bed mobility and transfers, was dependent for walking in the room with a note that specified pt (patient) is non-ambulatory. The resident was continent of bladder, used pull-ups and needed set up for toileting. On [DATE], the CCP was updated by registered nurse (RN) #19 and documented the resident sustained [REDACTED]. The CCP contained no documentation the resident was non-complaint with care. The [DATE] at 11:12 AM, PT #15's progress note documented the resident was discontinued from therapy secondary to reaching maximum potential. The resident required minimum assistance from 1 person for bed mobility and transfers and was unable to ambulate secondary to poor participation in therapy to improve gait, despite encouragement from the therapist. The caregivers were instructed in bed mobility, transfers, range of motion, and bed mobility. On [DATE] at 2:41 PM, PT #15, who was the Assistant Director of PT, stated in a telephone interview, when the resident completed PT on [DATE], they were independent with ambulation and required no assistive devices. On [DATE], the resident was referred to therapy due to a fall while ambulating to the bathroom. At that time, the resident was changed to extensive assistance from 1 person with bed mobility and transfers, and non-ambulatory. From [DATE] through [DATE], the resident received PT, there was no significant change, and the resident refused to participate. The resident was discharged from therapy on [DATE] and therapy recommended the resident to be non-ambulatory. He stated the resident was not able to demonstrate she could safely ambulate on their own and he would not expect staff to allow independent ambulation because of the risk of falling. He stated when therapy made recommendations in the EMR, the changes were automatically transferred to the Kardex and CCP. He stated they did not need to update the CCP separately. He stated staff would review the CCP or Kardex to know how to care for residents. The Care Log (certified nurse aide, CNA, documentation of care provided) documented: - On [DATE] at 1 PM and 9 PM, CNA #1 documented the resident was independent for toileting and walking in the room. - On [DATE] at 1 PM, CNA #1 documented the resident was independent for toileting, bed mobility, transfers, and walking in the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE] at 5 AM, CNA #3 documented the resident was independent for toileting and locomotion on unit. The [DATE] at 7:22 AM, RN #14's progress note documented at 1:55 AM, the resident was on their knees and buttocks and was caught on the bathroom door by the left arm. The resident was hung up on the door by the hospital gown, face was bluish grey and eyes were bulging. 911 and the police were called. At 2 AM, the police, emergency medical services (EMS), and the coroner responded. The staff told the police they last saw the resident alive at 12:35 AM. The resident's family was called, and they were able to speak with the coroner. The [DATE] Preliminary Forensic Autopsy Summary documented the resident was found by staff with the tie of their hospital gown caught on a door handle. The scene suggested the resident got up to use the bathroom and on exiting the bathroom, the tie that fastened the neck of the gown became entangled with the door handle of the bathroom door. The resident then stumbled to their knees, tightening the tie which then partially encircled their neck. This acted as a noose compressing the vessels at the sides of the neck causing cerebral [MEDICAL CONDITION] (lack of oxygen to the brain). The [DATE] Incident Summary documented the CCP and Kardex were reviewed as part of the investigation. The resident's death appeared to be accidental from a fall. The report documented the resident was care planned for assistance with ambulation but frequently ambulated independently. The report was signed by the Director of Investigations, the facility's prior Administrator and the DON. On [DATE] at 12:20 PM, CNA #1 stated in an interview, she was the resident's primary CNA on day shift and knew the resident well. She stated the resident was confused at times, seemed more depressed towards the end, was not getting up as much, and seemed weak. The resident recently started wearing pull-ups and she encouraged the resident to get up out of bed and assisted them to the bathroom. The resident still got up and went to the bathroom on their own, unassisted. She knew how to take care of the resident by looking at the care plan and her understanding was the resident could ambulate independently with no assistive devices while the staff provided distant supervision. On [DATE] at 9:08 AM, CNA #2 stated in a telephone interview, she knew the resident and worked on the evening and night shifts. She stated she knew how to care for residents by looking at the Kardex and the resident could walk independently and toilet themselves. She stated the resident recently declined in health, was more depressed, and incontinent. The only time the resident needed assistance was when she wet the bed. The resident never used the call bell and ambulated to the nursing station to tell the staff when she needed something. To her knowledge, the resident was not deemed to be non-ambulatory. She worked on the 3 PM to 11 PM shift on [DATE] and saw the resident at mealtime. The resident was lying in bed and nothing seemed out of the ordinary. She continued to work on the 11 PM to 7 AM shift and was not assigned to the resident. She stated CNA #3 was assigned to the resident and she came on duty at 12 AM. When CNA #3 went to do vitals on the resident, she found the resident in the bathroom. CNA#2 went to the resident's room and saw the resident hanging by the hospital gown and the neck and sleeve of the gown were caught on the door handle. She said the resident was hanging by the hospital gown and the neck and sleeve were caught on the handle. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:08 AM, CNA #5 stated in a telephone interview, she worked the 3 PM to 11 PM shift on [DATE] and saw the resident in bed. The resident usually stayed in their room and was able to ambulate to the bathroom on their own. The resident kept their bedroom door cracked open to keep wandering residents out of the room. The resident never used the call bell. The resident would independently ambulate to the nursing station if they needed something. CNA #5 knew how to care for residents by checking the care plan and she was supposed to check it daily for updates. She stated she was on the unit when the resident expired. When she saw the resident, the gown sleeve was caught, through the neck and left sleeve, on the bathroom door handle. The resident's left arm was positioned behind their body and was hung up by the sleeve. The resident was sitting on the floor, strangulated. On [DATE] at 3:07 PM, NP #13 stated in a telephone interview, she believed she was told the resident was still able to ambulate to the bathroom on her own when she saw the resident on [DATE]. She never saw the resident walk independently. She was not sure how staff found out what a resident's ambulation status was but expected staff to follow the recommendations of the physical therapist if they recommended the resident be non-ambulatory. On [DATE] at 9 AM, registered nurse (RN) #14 stated in a telephone interview, she was a Supervisor at the facility and responsible for initiating accident and incident reports and determine if the care plan was followed. She was on duty the night of the resident's incident and responded when she was called to the unit. She collected statements and interviewed staff that night. She asked multiple staff about the resident's ambulation status and staff reported the resident was capable of ambulating to the bathroom independently. She did not review the resident's care plan to determine if it was followed because she was busy dealing with EMS and police that responded to the incident. She was not aware the resident's care plan documented the resident was totally dependent for ambulation. On [DATE] at 9:34 AM, during a joint telephone interview with the DON and Director of Investigations the DON stated: - when an incident occurred, the RN was responsible for reviewing the CCP to determine if there was a CCP violation. - She expected RN #14, who initiated the resident's incident report, to review the CCP and was not aware she had not. - She did not interview any staff involved in the incident and RN #14 did not report to her any of the interviews she completed. - When an investigation was completed, she and the Director of Investigations, or RN #19 reviewed it. - The CNAs were responsible to know the residents' CCPs and to review the Kardex daily for updates. - When PT recommended changes, they documented in the EMR and the Kardex was automatically updated. The CCP was not automatically updated with those changes, that was done manually. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- When the CNAs documented the resident was independent for ambulation in the CNA Log, it meant the CNA observed what the resident was doing and documented it. The resident may have been non-compliant, and the CNAs could have observed the resident ambulating independently. The Director of Investigations stated she reviewed the resident's CCP herself after the incident, the resident was care planned for assistance with ambulation, verified this in the medical record by looking at PT notes and there was no CCP. She stated she was not aware the resident was care planned as non-ambulatory. 10NYCRR 483.21

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during the abbreviated survey (NY 557), the facility did not ensure each resident maintained acceptable parameters of nutritional status for 1 of 3 residents reviewed (Resident #1). Specifically, Resident #1 had a significant weight loss and decreased meal intakes and was not reassessed timely to determine whether changes to the nutrition plan of care were warranted. Findings include: The ,[DATE] Resident Weights policy documented each resident be weighed on admission and at least monthly unless otherwise indicated by the physician, nurse practitioner (NP) or dietitian. Nursing staff is responsible for documenting weights in the Weight Book. An assessment of a resident's nutrition requirements and need for regular/scheduled weights is to be determined by the dietitian, Nurse Manager, and physician. In the same manner, reassessment and evaluation of the need for ongoing intervention is to be done by the same professionals as needed by the indications of a change up or down of five (5) pounds. The physician/NP will document assessment, analysis, and plan for treatment of [REDACTED]. A five-pound gain or loss requires that a re-weight be obtained, unless specifically contraindicated by the physician. Upon receipt of the second weight, the physician/NP/dietitian shall determine the need for follow-up weights and the intervals between each follow-up weight. Resident #1 had [DIAGNOSES REDACTED]. The [DATE] admission Minimum Data Set (MDS) assessment documented the resident's cognition was intact. The resident required limited assistance from one person with activities of daily living (ADL) and supervision/set-up with eating. The resident had no swallowing issues and weighed 146 pounds. The [DATE] at 3:24 PM, nursing progress note documented the resident had an order for [REDACTED].>The [DATE] Weight Record documented the resident weighed 146.6 pounds. The [DATE] comprehensive care plan (CCP) documented the resident had nutrition/hydration concerns. Goals included stable weight without significant changes and interventions included regular diet, sandwich as entree at lunch, and water in place of milk at all meals. The [DATE] at 1:58 PM, dietetic technician (DT) #18's progress note documented the resident's admission weight was 146 pounds and Body Mass Index (BMI, an indirect estimate of body fat based on height and weight) was 29.6 (overweight). The [DATE] at 6:33 AM, DT #6's progress note documented sandwiches were added to lunch to replace entrees per resident request. The [DATE] registered dietitian (RD) #7's nutrition assessment documented the resident's weight on [DATE] was 146 lbs. The resident's daily needs included 1652 calories, 66 grams (g) of protein, and 1650 milliliters (ml) of fluid. From ,[DATE] through [DATE], the resident's meal intakes were 92%, fluids were 1314 ml fluid with meals, 165 ml with snacks, and 240 ml with medications. RD #7 documented the resident was meeting their needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] Weight Sheet documented the resident weighed 143 pounds. The undated [DATE] Weight Sheet documented the resident weighed 127.5 pounds (15.5 pound/10.84% loss in 1 month, significant weight loss). Documented on the Weight Sheet was a note copied on [DATE] and reweigh. There was no re-wight documented for the resident on the Weight Sheet. The [DATE] at 1:09 PM, DT #6's nutrition progress note documented the resident was observed and ate well at breakfast and had poor intake at lunch per nursing. The resident was tired of hamburgers and wanted peanut butter and jelly sandwiches alternated with egg salad for lunch. The resident's breakfast entre would be doubled, peanut butter crackers added, and the resident would be monitored for acceptance. The note did not document the resident had a significant weight loss and did not document the RD or physician were notified of the weight loss. There was no documentation the resident's nutritional needs were reassessed by clinical nutrition staff or that the CCP was updated. The [DATE] to [DATE] Intake and Output (I & O) sheets documented the following meal intakes for the resident: - 0 to 25%, 4 times; - 26 to 50%, 9 times; - ,[DATE]%, 17 times; and - Refused, 30 times. Meals were not documented 29 times. The [DATE] at 10:03 PM, nursing progress note documented the resident was status [REDACTED]. The [DATE] nurse practitioner (NP) #13's progress note documented the resident fell on [DATE] with no injury and had decreased oral intake and depression. The plan was to start [MEDICATION NAME] (antidepressant, appetite stimulant) 7.5 milligrams (mg) daily, and continue to monitor, and encourage eating. The note did not document the resident had a significant weight loss and did not document the resident's family was made aware of the addition of [MEDICATION NAME]. The [DATE] at 8:33 PM, nursing progress note documented the resident had poor appetite, declined oral intake, and lips, tongue, and oral mucosa were dry. An attempt to obtain catheterized urine for a urinalysis was not successful due to no urine in the bladder. The resident was assisted to drink 240 ml of water. There was no documented evidence the CCP was updated to reflect the resident's change in appetite, the addition of [MEDICATION NAME], or the resident's hydration status. The undated December Weight sheet documented the resident weighed 116.5 pounds (11 pound/8.63% loss in 1 month and 29.5 pound/20% loss in 3 months, significant weight loss). Documented on the Weight Sheet was [DATE], updated-copied. and reweigh. There was no reweight documented for the resident on the Weight Sheet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the resident was reassessed by clinical nutrition staff following the significant weight loss. The ,[DATE] to [DATE] I & O sheets documented meal intakes for the resident including: - 0 to 25%, 8 times; - 26 to 50%, 3 times; - ,[DATE]%, 1 times; and - Refused, 15 times. Meals were not documented 9 times. The [DATE] at 7:22 AM nursing note documented the resident fell while ambulating from the bathroom and expired. On [DATE] at 8:58 AM, the resident's family member stated in an interview, she was the resident's emergency contact and Health Care Proxy (HCP). Early on during the resident's admission, she received frequent notifications from the Nurse Manager and then communication stopped. She did not think anything of it and assumed if something was wrong, the facility would contact her. The resident reported to her a dislike of the facility food and was also losing weight. Nobody from the facility notified her the resident was refusing meals and losing weight and she was not notified when [MEDICATION NAME] was added. On [DATE] at 11:05 AM, DT #6 stated in an interview, she reviewed the I & O sheets quarterly unless staff alerted her to an issue with a resident's consumption, then she would review them sooner. She tracked residents daily during meal rounds and if concerns were identified, she addressed them. She recalled the resident and stated the resident was not a great eater and she adjusted the resident's food preferences. The resident seemed depressed and after a while, no longer asked for changes to preferences. She did not recall staff bringing concerns to her about the resident's consumption and if they had, she would have seen the resident to determine if anything needed to be changed. She stated she was not aware the resident was refusing meals, it was not reported to her, and she did not notice the resident lost weight. On [DATE] at 11:20 AM, RD #7 stated in an interview, she expected the DT to do daily meal rounds and look at the percentage residents were eating. She stated certified nurse aides (CNA) documented residents' consumption in the Electronic Medical Record (EMR), and she and the DT looked at I & O sheets the week before the residents' quarterly assessments were due. She relied on staff to report to nutrition staff when a resident was not eating or not taking in adequate amounts of foods and fluids. If the resident was refusing meals, she would reassess the resident, and she was not notified of the resident's meal refusals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:20 PM, CNA #1 stated in an interview, she was the resident's primary CNA, the resident was not a good eater, might eat breakfast, and never ate lunch. She stated she thought the resident was depressed and she frequently encouraged the resident to eat. She recalled reporting the resident refused meals to the Nurse Manager and the Nurse Manager stopped working at the facility about a month ago. She did not recall if she notified anyone else of meal refusals. On [DATE] at 12:25 PM, registered nurse (RN) #8 stated in an interview, she recently started covering the resident's unit after the previous Nurse Manager left a couple of months ago. Weights were obtained by the 10th of the month and documented in a book on the unit. CNAs were responsible to notify nursing when a resident refused meals and together they would come up with a plan. If it was reported to her a resident was refusing meals, she would have referred the resident to dietary. She stated she did not recall discussing weight loss during morning huddles and did not recall CNAs reporting to the her the resident refused meals. After RN #8 reviewed the [DATE] I & O sheets for the resident, she stated she would have wanted someone to make her aware of the meal refusals so the resident could have been assessed. On [DATE] at 1:30 PM, RD #12, who was the Director of Nutrition Services, stated in an interview, the facility did not have a policy for nutrition assessments and did not have nutrition standards of care followed by all clinical nutrition staff. RD #12 stated nutrition staff were trained to assess residents following the MDS schedule, initially, annually, quarterly, or with a significant change. The DT completed quarterly reviews of residents unless the resident was at high nutritional risk, such as those on [MEDICAL TREATMENT], with skin issues, on a tube feeding, and those with unplanned weight changes. The DT did meal rounds, received information on residents during morning huddle, and through the 24-hour report captured from the progress notes. She stated dietary staff were not doing quality assurance (QA) reviews of consumption reports, they only intervened when issues were brought to their attention, and if something was noticed during meal rounds they would also intervene. She stated it looked as though NP #13 ordered an appetite stimulant for the resident in ,[DATE] and there were no notes written by clinical nutrition staff after [DATE]. The DT was responsible to track resident weights, enter the weights into the EMR, and to notify the RD of weight loss. Reweights were requested by the DT if there was a significant change and she expect reweighs to be completed in 2 days. On [DATE] at 3:28 PM, DT #6 stated in a telephone interview, resident weights were typically done by the 10th of each month. If she noted a loss of 5 pounds or more, she requested a reweight during morning huddle and expected the reweight to be done within 48 hours. If the reweight confirmed a significant loss, she would write a note that went on the 24-hour report alerting nursing, and nursing or herself notified the RD to complete an assessment. In [DATE], the resident weighed 127.5 pounds, she requested a reweight during morning huddle. The reweight was not done in 48 hours and she reported it was not done during morning huddle. The resident potentially had a significant loss from 144 to 127.5 pounds, she was not sure if she notified the RD about the lack of a reweight, and the RD should have assessed the resident. She stated she was not usually involved with family notification for significant losses and that was done by either nursing, the social worker, or the RD. In [DATE], the resident went from 127.5 pounds to 116.5 pounds, she requested a reweight in morning huddle and she did not think she followed up to see if the reweight was done and she should have. She stated the weight loss was significant, she should have notified the RD and the resident was not reassessed timely. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:44 PM, RD #7 stated in a telephone interview, the DT was responsible for getting reweights when there was a significant loss to confirm the loss. After the reweight was obtained, the DT would enter the weights into the EMR. When the resident went from 144 pounds to 127.5 pounds, it was a significant loss and she was not notified. If she had known, she would have done an assessment, reassessed nutrition needs, and evaluated the meal plan versus what the resident was taking in. She would have possibly added fortified food, weekly weights, and notified the physician and the interdisciplinary team. In [DATE] when the resident went from 127.5 pounds to 116.5, pounds it was a significant loss and she was not notified. If she was notified, she would have done another assessment including notifying the physician and the physician would notify family of the significant weight loss. On [DATE] at 3:07 PM, NP #13 stated in a telephone interview, she ordered [MEDICATION NAME] for the resident after it was reported to her the resident was not eating and hoped a low dose could stimulate the resident's appetite. Nursing was responsible to notify the family of the medication. When the resident lost 15. 5 pounds from [DATE] to [DATE], nobody notified her of the loss, just that the resident was not eating. If the resident continued to refuse meals after she prescribed [MEDICATION NAME], she expected to be notified so she could intervene. From [DATE] to [DATE] when the resident lost another 10 pounds, she could not say for sure if she was aware and wanted to be notified so she could reassess. She stated she assumed it was the Nurse Manager that would be responsible to notify the family regarding the resident's weight loss. 10NYCRR 415.12(i)(1)