STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335833	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson's Ferry	500 Mather Drive South Setauket, NY 11720

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observation, record review, and interviews conducted during an abbreviated survey (NY00344039) the facility did not ensure that all residents were free from physical restraints imposed for the purpose of discipline or convenience and are not required to treat the resident's medical symptoms. This was identified for 17 (Resident #1 through, Resident #17) of 17 residents observed with alarms and reviewed for restraints. Specifically, 1) Resident #1 was observed to have a chair and bed alarm. 2) Resident #2 was observed sitting on an alarm pad that was connected to their shirt by a cord. 3) Resident #3 was observed with a clip attached to the back of the collar and connected by a wire to an alarm box hooked to the back of Resident #3's wheelchair. There was no documented evidence that an assessment for medical necessity was completed for the use of the alarm restraints for 17 of 17 residents. The findings are: The facility's policy titled, Physical Restraint Use last revised 6/2023 documented in accordance with federal and state regulations, the use of physical restraints will be imposed only to assure the physical safety of the resident or other residents. The policy further documented, a physical restraint is any physical means used to control or restrict freedom of movement. It includes any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove, and which restricts freedom of movement or normal access to the body. The facility's policy titled, Alarms for Fall Prevention with an effective date of 9/28/2017 documented, staff will be aware of the different types of alarms utilized to prevent falls if warranted using The Morse Scale (a tool used to assess a resident's risk of falling). The policy further documented; a new resident will be evaluated using The Morse Scale to determine if an alarming device is warranted. A mean score of 55 or above will determine 5-day usage and the Charge Nurse will assess the continued need for an alarm for any new admission and will assess need for any other resident who displays a lack of safety awareness and the need for the alarm. 1) Resident #1's diagnoses included Chronic Obstructive Pulmonary Disease (a common lung disease causing restricted airflow and breathing problems), Acute Respiratory Failure with Hypoxia (when the lungs are unable to provide enough oxygen to the body's tissues), and Gout (a form of arthritis caused by too much uric acid that crystallizes and is deposited in joints). (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1#'s Minimum Data Set, dated dated dated [DATE] documented Resident #1 had a Brief Interview for Mental Status of 10 indicating a moderately impaired cognition. The Minimum Data Set Documented Resident #1 used a chair and bed alarm daily. The Minimum Data Set Documented Resident #1 used a walker and a wheelchair for mobility, had upper and lower extremity impairment on both sides and required substantial/maximum assistance for transfer. Resident #1's Morse Fall Scale dated 6/8/2024, 6/17/2024, and 8/21/2024 documented Resident #1 was a high fall risk and to implement fall prevention interventions. Resident #1's Comprehensive Care Plan for falls effective 10/26/2021 documented Resident #1 was at risk for falls for reasons that included but were not limited to, not using their call bell, not asking for assistance, right foot drop, use of bilateral ankle (both ankles) foot orthotics, and gout. Interventions included but were not limited to a low bed, bed alarm, chair alarm (physical or electronic device that monitors resident movement and alerts the staff when movement is detected) in place, and education related to call bell usage. A note in the Comprehensive Care Plan Documented Resident #1 was found on the floor on 6/2/2024 and was sent to the hospital. Resident #1's Certified Nursing Assistant Accountability for June 2024, July 2024, August 2024, September 2024, and October 2024 documented Resident #1's chair and bed alarms were check for functionality each shift. There was no documented evidence that Resident #1 was assessed for the use of alarms or had a physician's order in place for the chair and bed alarms. Resident #1 was discharged from the facility and was not available for observation or interview. During an interview on 11/7/2024 at 11:20 AM with Licensed Practical Nurse #1they stated the alarms were used for resident safety. During an interview on 11/7/2024 at 11:29 AM Certified Nursing Assistant #1 stated they were responsible for checking that the alarms were functioning, and they documented that they check the alarms in the Certified Nursing Assistant Accountability for each resident. Certified Nursing Assistant #1 stated they needed to check the alarms for resident safety when they are a high fall risk. During an interview on 11/7/2024 at 11:37 AM with Certified Nursing Assistant # 2 they stated they were assigned to Resident #1 on 6/2/2024 when Resident #1 fell in their room. Certified Nursing Assistant #2 stated the chair alarm was not sounding when they found Resident #1 on the floor. Certified Nursing Assistant # 2 stated alarms are used for resident safety. During an interview on 11/7/2024 at 1:15 PM the Assistant Director of Nursing stated residents do not need a physician's order for chair and bed alarms because they are not considered restraints. During an interview on 11/8/2024 at 2:48 PM with Licensed Practical Nurse #3 they stated an alarm would be put in place if a resident was observed ambulating unsafely or a fall concern. Licensed Practical Nurse #3 stated alarms would be used for resident safety, as an alert to staff if a resident was getting up. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/8/2024 at 3:00 PM with Registered Nurse #2 they stated if a resident is a high fall risk an alarm is used as a nursing intervention for resident safety and is not a restraint. The alarms do not require physician's order. During an interview on 11/8/2024 at 3:16 PM with the Assistant Director of Nursing they stated alarms are put in place if a resident is deemed a fall risk and if there are other factors such as a resident that does not ask for assistance. The Assistant Director of Nursing stated alarms are a nursing intervention and do not need a physician's order. The Assistant Director of Nursing stated they do not consider an alarm a restraint. During an interview on 11/8/2024 at 3:58 PM the Administrator they stated alarms are used if a resident is considered a high fall risk and are based on their fall assessment, which is a nursing intervention, and does not require a physician's order. The Administrator stated they did not consider an alarm a restraint. During an interview on 11/18/2024 at 2:14 PM the Medical Director stated they were aware that alarms were in use for some residents. The Medical Director stated alarms were used for resident safety if a resident was a high fall risk. The Medical Director stated alarms did not require a physician's order, but the attending physician should be aware that an alarm was in use. The Medical Director did not consider an alarm a restraint. 2) Resident #2's diagnoses included a fracture of the pubis (both pair of bones that form the two sides of the pelvis), Osteoarthritis (degenerative joint disease that causes the cartilage in the joints to break down over time), and Hypertensive Heart Disease (a disease of the heart caused by chronic high blood pressure). Resident #2's Minimum Data Set, dated dated dated [DATE] documented Resident #2 had a Brief Interview for Mental Status of 12 indicating a moderately impaired cognition. The Minimum Data Set Documented Resident #2 used walker and wheelchair for ambulation, did not have upper or lower extremity impairment, and required partial/moderate assistance with transfer. The Minimum Data set documented Resident #2 did not use any alarms. Resident #2's Morse Fall Scale dated 8/30/2024 documented Resident #2 was not at risk for falls. Resident #2's Morse Fall Scale dated 9/15/2024 documented Resident #2 was a high fall risk and to implement fall prevention interventions. Resident #2's Comprehensive Care Plan for Falls effective 8/30/2024 documented Resident #2 was at risk for falls related to not using the call bell and not asking for assistance. Interventions included but were not limited to a low bed, a bed alarm, and a clip alarm. A Nursing Progress Note dated 10/24/2024 written by Registered Nurse #3 documented they were walking past Resident #2's room and Resident #2 was ambulating in their room without their assistive device, their gait was unsteady, and they were holding on to their bed while attempting to go to the bathroom. Resident #1 was very confused, unsure of where they were and asked to go to the bathroom. Registered Nurse #3 assisted Resident #2 to the bathroom, Resident #2 remained confused, and Resident #2 was assisted back to their recliner chair. A clip alarm and bed alarm were issued, and the Comprehensive Care Plan was updated. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that Resident #2 had physician's orders in place for the chair and bed alarms. There was no documented evidence that Resident #2 was assessed for use of the chair and bed alarms. On 11/7/2024 at 11:42 AM Resident #2 was observed in their room. Resident #2 was seated in their recliner chair. Resident #2 had their eyes closed and they did not response to a greeting. Resident #2 was sitting on an alarm pad and there was a clip attached to back of their shirt at the collar. There was a wire attached to the clip and the wire ran down the back of Resident #2's shirt to the alarm pad. A second observation of Resident #2 was made on 11/7/2024 at 2:24 PM. Resident #2 was seated in their recliner in their room. Resident #2 was sitting on an alarm pad and there was a clip attached to back of their shirt at the collar. There was a wire attached to the clip and the wire was attached to the alarm pad. Resident #2 stated they were not aware of the alarm pad or the clip on the back of their shirt at the collar. Licensed Practical Nurse #1 entered the room and assisted Resident #2 to rise from their recliner chair. When Resident #2 stood the wire detached from the alarm pad and an alarm sounded. During an interview with Licensed Practical Nurse #1 on 11/7/2024 at 2:27 PM they stated when a chair alarm in a resident's room sounds it can be heard from the hallway and alerts staff to a safety concern. Licensed Practical Nurse #1 stated the alarm is one measure used to ensure resident safety. During an interview on 11/8/2024 at 3:16 PM with the Assistant Director of Nursing they stated alarms are put in place if a resident is deemed a fall risk and if there are other factors such as a resident that does not ask for assistance. The Assistant Director of Nursing stated alarms are a nursing intervention and do not need a physician's order. The Assistant Director of Nursing stated they do not consider an alarm a restraint. During an interview with Registered Nurse #3 on 11/8/2024 at 3:42 PM they stated they put Resident #2's chair and bed alarms in place when they observed Resident #2 ambulating unsafely in their room. Registered Nurse #3 stated Resident #2 was very confused, not aware of their surroundings and they were not using their walker. Registered Nurse #3 stated they were concerned for Resident #2's safety and spoke to the care team at the morning meaning about putting the alarms in place as a nursing intervention, they do not require a physician's order and are used for safety. During an interview on 11/8/2024 at 3:58 PM the Administrator stated alarms are used if a resident is considered a high fall risk and are based on their fall assessment, they are a nursing intervention, and does not require a physician's order. The Administrator stated they did not consider an alarm a restraint. During an interview on 11/18/2024 at 2:14 PM the Medical Director stated they were aware that alarms were in use for some residents. The Medical Director stated alarms were used for resident safety if a resident was a high fall risk. The Medical Director stated alarms did not require a physician's order, but the attending physician should be aware that an alarm was in use. The Medical Director did not consider an alarm a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #3 had diagnoses that included Alzheimer's Disease, Cerebral Ischemic Attack (a temporary interruption of blood flow to the brain), and Cerebral Infarction (ischemic stroke, when blood flow to the brain is blocked, causing an area of dead brain tissue). Resident #3's Minimum Data Set, dated dated dated [DATE] documented Resident #3 had a Brief Interview for Mental Status of 12 indicating a moderately impaired cognition. The Minimum Data Set Documented Resident #3 used a chair and bed alarm. The Minimum Data Set Documented Resident #3 used walker and wheelchair for ambulation, did not have upper or lower extremity impairment, and required partial/moderate assistance with transfer. Resident #3's Morse Fall Scale dated 10/28/2024 and 11/5/2024 documented Resident #3 was a high fall risk and to implement fall prevention interventions. Resident #3's Comprehensive Care Plan for Falls effective 12/20/2023 documented Resident #3 was at risk for falls related to restlessness, anxiety, poor safety awareness, medication use, frequent falls, not using the call bell and not asking for assistance. Interventions included but were not limited to a low bed, a bed alarm, a clip alarm, and visual checks. Notes in the Comprehensive Care Plan dated 9/1/2024, 9/27/2024, and 10/25/2024 documented Resident #3 fell after standing up from wheelchair and attempting to ambulate. On 9/1/2024 Resident #3 was in a high visibility area, stood up from their wheelchair, hit a staff person and fell backwards. On 9/27/2024 Resident #3, while in the company of a Certified Nursing Assistant assigned as their one-to-one supervision, rose from their wheelchair, and turned around and placed themselves kneeling on the floor. On 10/25/2024 Resident #3 was in a high visibility area when a loud noise was heard, and Resident #3 was observed on the floor. There was no documented evidence that Resident #3 had physician's orders in place for the chair and bed alarms. There was no documented evidence that Resident #3 was assessed for use of the chair and bed alarms. During an observation of Resident #3 on 11/7/2024 at 11:40 AM they were observed in their wheelchair in the common area in front of the nurse's station. Resident #3's eyes were closed, and they did not respond to a greeting. Resident #3 was observed with a clip on the back of their shirt at the collar. A wire extended from the clip to an alarm box hooked to the back of Resident #3's wheelchair. During an observation of Resident #3 on 11/8/2024 at 2:26 PM they were observed in their wheelchair in the common area in front of the nurse's station. Resident #3's eyes were closed, and they did not respond to a greeting. The clip and alarm box were not in place. During an interview on 11/8/2024 at 2:48 PM with Licensed Practical Nurse #3 they stated an alarm would be put in place if a resident was observed ambulating unsafely or note another fall concern. Licensed Practical Nurse #3 stated alarms would be used for resident safety, as an alert to staff if a resident is getting up. During an interview on 11/8/2024 at 3:00 PM with Registered Nurse #2 they stated if a resident is a high fall risk alarms are nursing intervention used for resident safety, not a restraint and do not require physician's order. Registered Nurse #2 stated when they put an alarm in place, they documented the intervention in a progress note and updated the Comprehensive Care Plan. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/8/2024 at 3:16 PM with the Assistant Director of Nursing they stated alarms are put in place if a resident is deemed a fall risk and if there are other factors such as a resident that does not ask for assistance. The Assistant Director of Nursing stated alarms are a nursing intervention and do not need a physician's order. The Assistant Director of Nursing stated they do not consider an alarm a restraint. During an interview on 11/8/2024 at 3:58 PM the Administrator stated alarms are used if a resident is considered a high fall risk and are based on their fall assessment, is a nursing intervention, and does not require a physician's order. The Administrator stated they did not consider an alarm a restraint. During an interview on 11/15/2024 at 2:14 PM the Medical Director stated they were aware that alarms were in use for some residents. The Medical Director stated alarms were used for resident safety if a resident was a high fall risk. The Medical Director stated alarms did not require a physician's order, but the attending physician should be aware that an alarm was in use. The Medical Director did not consider an alarm a restraint. 10NYCRR 483.10(e)(1)