

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2024
NAME OF PROVIDER OR SUPPLIER  The Cottages at Garden Grove, A Skilled Nrsng Comm		STREET ADDRESS, CITY, STATE, ZIP CODE  5460 Meltzer Court Cicero, NY 13039	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>33420</p> <p>Based on record review and interview conducted during the abbreviated survey (NY00329594 and NY00331170), the facility did not ensure all alleged violations involving mistreatment, neglect, or abuse were thoroughly investigated for 2 of 3 residents (Resident #1 and 2) reviewed. Specifically,</p> <ul style="list-style-type: none"> <li>- Resident #1 was found with a bruise of unknown origin and an assessment was not completed timely, and an investigation to rule out abuse/neglect was not initiated at the time of the report.</li> <li>- Resident #1 fell and sustained an injury and the investigation did not identify if the resident's care plan was followed for toileting (every 2 to 4 hours) or if the resident's fall mat was in place at the time of the fall.</li> <li>-Resident #2 had a fall and it was documented they were clearly incontinent. The investigation did not determine when the resident was last provided incontinence care and whether the care plan for toileting was followed.</li> <li>- Resident #2 had a fall while in another resident's room. The resident was incontinent at the time of the fall and the facility's investigation did not identify if the resident's care plan was followed for toileting every 2 to 4 hours.</li> </ul> <p>Findings include:</p> <p>The facility's Abuse policy dated 3/2014 documented all reports of resident abuse or neglect were to be promptly and thoroughly investigated by facility management.</p> <p>1) Resident #1 had diagnosis including dementia and heart failure. The 10/11/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not have impairment of the arms and legs, used a wheelchair or cane for mobility, and required supervision or partial assistance with most activities of daily living. They required supervision or touching assistance with walking 10 to 50 feet. The resident had a history of falls and had falls while at the facility.</p> <p>The comprehensive care plan, initiated on 9/23/2019, documented the resident was at risk for falls. Interventions included to keep in highly visible areas as able, a motion sensor alarm with floor mats when asleep in bed, and toileting every 2 to 4 hours. On 8/15/2023, the comprehensive care plan was revised and documented the resident had a sensor alarm, low bed, and fall mats.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Incident #1</p> <p>The 11/25/2023 Quality Assurance Report (Incident /Accident Report) completed by registered nurse #15 documented at 8:20 AM, certified nurse aide #6 reported Resident #1 had a bruise on their chin. The injury was of unknown origin and there were no witnesses. The directions on the report documented to obtain staff statements for the past 24 hours and notify the Director of Nursing. Resident #1 was alert to themselves only and reported something fell on their face. The report documented the bruise lined up with the dining room table and the care plan was followed.</p> <p>Statements included with the facility's 11/25/2023 Quality Assurance Report documented:</p> <ul style="list-style-type: none"> <li>- on 11/25/2023, certified nurse aide #6 noted they were assigned to Resident #1 that morning and last saw the resident at 7:05 AM sitting at the dining room table. They did not see an incident and found the bruise while washing the resident up for morning care. The Supervisor was notified at that time.</li> <li>- On 11/25/2023, a statement by an unidentified staff person documented licensed practical nurse #17 heard certified nurse aide #18 tell licensed practical nurse #19 about the bruise on 11/25/2023 at around 5:00 AM. They spoke to certified nurse aide #18 on the telephone at 9:36 AM and they reported they first saw the bruise after 5:00 AM and reported it to licensed practical nurse #19 when observed.</li> </ul> <p>The 11/25/2023 progress note by registered nurse #15 at 9:51 AM, documented a reddish/purple bruise was noted on Resident #1's chin. There was no swelling or complaints of discomfort. The note further documented because the resident was so petite when sitting at the dining room table, they noticed the resident's face at the edge of the table. The on-call medical provider, health care proxy, and the Director of Nursing were notified.</p> <p>There was no documentation the facility followed-up with licensed practical nurse #19 regarding the report that they were told about the bruise at 5:00AM; no documentation of notification of a Supervisor at the time the bruise was initially reported, and no documentation the resident was assessed by a qualified professional at the time the bruise was identified.</p> <p>During a telephone interview on 4/25/2024 at 8:20 AM, licensed practical nurse #19 stated when they were notified of a bruise they would go to the cottage and call the Supervisor as they were not able to assess residents. They did not recall if they were aware of the bruise on 11/25/2023 or if they notified the Supervisor.</p> <p>During a telephone interview on 4/25/2024 at 8:32 AM, registered nurse #15 stated Resident #1 was alert to himself. Their role as the Supervisor was to complete an Incident/Accident Report and obtain and review statements from staff at the time the incident occurred. They did not recall being notified of Resident #1's bruise on the chin. They did not recall information being on the 24-hour report or having been notified by the 11:00 PM to 7:00 AM shift of the incident. They completed the investigation and obtained staff statements when the bruise was reported that morning at 8:20 AM. They did not obtained statements from the staff on the previous shift as they did not have a lot of time to do that. If they suspected abuse, they would notify the Director of Nursing or the Assistant Director of Nursing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 4/25/2024 at 10:09 AM, certified nurse aide #18 stated they worked with Resident #1 on the 11:00 PM to 7:00 AM shift and licensed practical nurse #19 was the nurse. They did not recall the incident on 11/25/2023 with Resident #1 having a bruise on the chin. They stated, if they documented the bruise was reported to licensed practical nurse #19 then it was reported. They did not recall any further information about the incident.</p> <p>During a telephone interview on 5/2/2024 at 11:21 AM, registered nurse #1 stated on 1/25/2023, Resident #1 was found with a bruise on the chin. They gathered all the information for the incident and did not do the report. They were asked to collect statements after as the incident occurred. When a bruise occurred, statements would be obtained for the past 24 hours. The investigation documented an unsigned, undated document with interviews. The document did not have a name and they were unable to identify who wrote that document.</p> <p>They stated it did not appear licensed practical nurse #19 provided a statement and was not interviewed on what they did after being notified of the bruise during the 11:00 PM to 7:00 AM shift. They stated the investigation was not complete and it needed more information to determine if abuse, neglect, or mistreatment occurred.</p> <p>Incident #2</p> <p>The 12/8/2023 progress note by registered nurse #21 at 6:40 AM, documented:</p> <ul style="list-style-type: none"> <li>- Resident #1 was found in their room, on the floor, and the sensor alarm was not sounding.</li> <li>- The resident had a deep laceration (cut) measuring 1 inch by 0.5 centimeters to the mid-forehead. The surrounding area had a hematoma (an injury when blood collects under the skin) and blue bruising to the bridge of the nose. The area was cleaned and approximated, steri strips (treatment to keep a wound closed) and ice were applied.</li> <li>- The resident was brought to the common area for close observation.</li> <li>- Certified nurse aide #18 found the resident lying on the floor in the middle of their room with their walker. The bedside stand (treatment cupboard) was tipped over with personal items on the floor. A moderate amount of sanguineous (red) drainage was noted to be dried in their hair and a red area was on the right shoulder and the left hand was noted with ecchymosis (bruising). The resident was often up and around overnight and was difficult to redirect.</li> </ul> <p>The 12/8/2023 Quality Assurance Report (Incident/Accident Report) by registered nurse #21 documented at 6:40 AM, certified nurse aide #18 found Resident #1 in their room, lying on the floor in dried blood. The resident sustained a laceration and hematoma on the forehead. The right finger was broken, and the resident was unable to state what happened due to confusion. The form documented the motion sensor did not alarm and the care plan was not followed. That documentation was crossed out and it was documented the motion sensor was working and the care plan was followed. The resident had a diagnosis of a urinary tract infection and made attempts to self-transfer. The staff brought the resident into the common area and a new intervention was to have a floor mat on the floor when the resident was in bed. A physical therapy referral was requested to assess for safety of the floormat.</p> <p>Statements obtained by the facility and included in the facility investigation documented:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 12/8/2023 at 7:00 AM, certified nurse aide #18 documented they were assigned to Resident #1's care and last observed them at 2:00 AM lying down. They last provided incontinence care at 1:30 AM. They went to check on Resident #1 at 6:40 AM and found them on the ground lying down.</p> <p>- On 12/8/2023, registered nurse #21 documented they were notified by certified nurse aide #18 at 6:40 AM Resident #1 was found on the floor. Resident #1 was in the middle of the room, on their right side with a moderate amount of dried blood on the floor under their head, in their hair and clotted blood across the forehead over the laceration. The treatment cabinet had tipped over and personal items and batteries scattered on the floor. The resident was unable to state what happened and the walker was close by. They asked the resident if the motion sensor alarmed, and the resident stated it had not. They asked certified nurse aide #18 when they last saw the resident, they reported around 4:30 AM and the resident was sleeping in bed. They checked the motion sensor at that time, it sounded, the bed was in the lowest position, and they were not sure if the floor mat was in place. They completed a neurological assessment, cleaned the area, applied ice and a bandage around the head. The resident was brought to the common area for close observation. They notified Director of Nursing #22 and registered nurse #23 of the incident and that the sensor alarm did not activate prior to the resident being found on the floor.</p> <p>The 12/7/2023 to 12/8/2023 certified nurse aide form documented the resident had incontinence care completed at 6:17 AM on 12/8/2023.</p> <p>The facility investigation did not identify if the sensor alarm sounded as planned or if the fall mat was in place at the time of the fall. The resident reported the alarm did not sound and registered nurse #21 documented the alarm was not sounding and they were not sure if the fall mat was in place at the time of the incident. There was no documentation Resident #1 was provided incontinence during the 11:00 PM to 7:00 PM shift until 6:17 AM.</p> <p>During a telephone interview on 4/25/2024 at 10:09 AM, certified nurse aide #18 stated Resident #1 fell in their room on 12/8/2023 at 6:40 AM and they notified the Supervisor. They did not recall if the sensor alarm was sounding when they found the resident on the floor or if the floor mat was in place. They did not recall if they toileted or checked on the resident for incontinence care after 1:30 AM.</p> <p>During a phone interview on 5/2/2024 at 8:53 AM, registered Nurse #21 stated they were notified by certified nurse aide #18 at 6:40 AM on 12/8/2023 that the resident fell . They found the resident on the floor in the middle of the room. They asked certified nurse aide #18 when they last checked on the resident due to the blood being dried. The certified nurse aide stated at 4:00 AM. They asked if the motion sensor sounded, and the aide stated no. They initiated an investigation and documented the care plan was not followed and the motion sensor did not alarm. They did not cross that information out on the report and did not know who did. They did not recall if the fall mat was in place and did not review when incontinence care was last provided as part of the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 5/2/2024 at 11:21 AM registered nurse #1 stated certified nurse aides were expected to completed hourly rounding on all residents on the unit. They were to look for the residents' location, safety, and ensure incontinence care was evaluated and provided. If an incident occurred on an off shift, the Supervisors were responsible to initiate an investigation, obtain statements from whoever was involved in the incident write a progress note and update the care plan as needed. They were to review the Incident/Accident report, and the care plan to ensue any interventions were reviewed and if needed, revisions were made. They did not review incidents all the time. Once the information was gathered with a quick review, they ensured all the information was present. The report then went to the Director of Nursing for a second review. The Director of Nursing or Administrator would determine if more information was needed. They stated on 12/8/2023, Resident #1 fell . They were not involved in the investigation and were only asked to obtain further statements from staff regarding the television being broken. They did not complete the Incident/Accident Report.</p> <p>During a telephone interview on 5/2/2024 at 8:09 AM, the Director of Nursing stated the Nurse Managers and supervisors were responsible to complete facility incident reports and update the care plans after any incident. If a resident fell , they expected staff to document a note, evaluate interventions and add new intervention when needed. The nursing staff briefly discussed incidents during morning report and a weekly fall review was done with the interdisciplinary team. The nursing staff were expected to ensure a care plan was reviewed and followed at the time of the incident. Facility reportable incidents included abuse, neglect, and injuries of unknow origin. The looked to ensure abuse, and neglect and mistreatment was ruled out. The Unit Mangers were responsible to complete the investigations. After they completed their part the Director of Nursing and Administrator reviewed the reports to ensure all the information was added and abuse did not occur. All staff were educated on how to investigate. If a resident sustained a bruise the expectation was staff were to obtain statements for the past 24 hours from other shifts. The Supervisor was expected to look at the incident and all the information to determine if the care plan was followed or if disciplinary action was needed. During the following incidents they stated:</p> <p>- on 11/25/2023 at 8:20 AM, Resident #1's bruise was determined to be from the dining room table, the resident was found that morning with their head on the table. They were not aware the bruise was identified at 5:00 AM by certified nurse aide #18 and were not aware the aide reported the incident to licensed partial nurse #19. They expected when the bruise was reported to licensed practical nurse #19, the Supervisor would be notified, an assessment be completed, an Incident/Accident Report be completed to rule out abuse. They did not look into that during their investigation. They stated the investigation was not complete and they were unable to rule out abuse neglect and mistreatment.</p> <p>- On 12/8/2023 at 6:40 AM, Resident #1 was found on the floor in their room by certified nurse aide #18. An investigation was initiated by registered nurse #21 and during interview, certified nurse aide #18 stated they last saw the resident at 4:00 AM in bed. They did not interview certified nurse aide #18 to find out what saw the resident meant and they were not sure if the resident was provided incontinence care at that time. They did not determine when the resident was last toileted and did not know if the residents care plan was followed for toileting. They did not interview registered nurse #21 to find out why there were inconsistencies in their statement or why they crossed out the care plan was not followed as part of the investigation. They stated the investigation was not complete and they were not able to determine if abuse, neglect, or mistreatment occurred.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Resident #2 had diagnosis including dementia, heart failure, and diabetes. The 1/26/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not wander, and used a wheelchair for locomotion. They required extensive assistance with most activities of daily living; had more than 2 falls at the facility, and took medications including antipsychotics, antidepressants, antianxiety, diuretics (fluid pills), and anticoagulants (blood thinners). A sensor motion alarm and wander alarm were in place and the family was involved in the resident's care.</p> <p>The 2/28/2022 initial comprehensive care plan documented the resident was at risk for falls. Fall interventions included fall mats, a motion sensor, 30-minute checks, and the resident was to be toileted every 2 to 4 hours. The care plan was revised on 10/21/2023 and it was documented that it remained appropriate and ongoing.</p> <p>Incident #1</p> <p>The 1/1/2024 to 1/2/2024 activities of daily living form by certified nurse aide #5 did not document toileting was completed from 11:00 PM to 7:00 AM.</p> <p>The 1/2/2024 facility Accident/Incident Form by registered nurse #1 at 7:30 AM, documented:</p> <ul style="list-style-type: none"> <li>- certified nurse aide #5 found Resident #2 on the fall mat next to the bed while completing morning rounds on another resident.</li> <li>- Resident #2's feet were towards the bathroom door; their head was towards the bed, and the resident was not in any distress.</li> <li>- Registered Nurse #1 completed an assessment, with no reports of pain. The resident was unsure if they hit their head and neurological checks were initiated.</li> <li>- The resident was clearly soiled, assisted back to the wheelchair, and brought to the bathroom for incontinence care.</li> <li>- Nurse practitioner #4 was notified and ordered neurological checks. The designated representative was notified, no rehabilitation referral was made.</li> <li>- At the time of the incident the resident was attempting to go to the bathroom and the care plan was followed.</li> </ul> <p>Statements obtained by the facility included in the facility's 1/2/2024 investigation documented:</p> <ul style="list-style-type: none"> <li>- certified nurse aide #5 documented they were assigned to the resident's care and last observed Resident #2 at 7:15 AM. They heard someone yell for help and found the resident on the floor. They did not provide care to the resident for the past 24 hours, and the resident was last toileted on the night shift.</li> <li>- Certified nurse aide #6 documented they were assigned to the resident's care, and last observed Resident #2 at 7:15 AM. They heard someone screaming help and found the resident on the floor. They did not provide care to the resident for the past 24 hours, and the resident was last toileted on the night shift.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility investigation did not document when the resident was last provided incontinence care, if the sensor alarm sounded at the time of the incident as the staff heard the resident yelling for help, or whether the 30-minute checks were performed for the resident per the care plan.</p> <p>During a telephone interview on 5/2/2024 at 11:21 AM, registered nurse #1 stated the certified nurse aides were expected to completed hourly rounding on all residents on the unit. They were to look for the residents' location, safety and ensure incontinence care was evaluated and provided. On 1/2/2024, they completed the investigation; the report documented the resident was clearly incontinent, and they did not review incontinence care as part of the investigation and did not look to see when the resident was last toileted.</p> <p>Incident #2</p> <p>The 1/5/2024 facility Accident/Incident report by registered nurse #7 documented at 5:20 PM:</p> <ul style="list-style-type: none"> <li>- Resident #2 was in another resident's room and fell .</li> <li>- The resident reported they were trying to pick something off the floor.</li> <li>- Certified nurse aides #8 and 9 were assigned.</li> <li>- The resident did not have injuries and their vital signs were stable. Neurological checks were initiated, and the staff suspected a urinary tract infection. A slight red area was noted on the right hip and the resident complained of hip and buttock pain. No internal or external rotation was noted, and the legs were equal in length. X-rays were ordered by nurse practitioner #10.</li> <li>- The resident was incontinent at the time of the incident, the care plan was followed, and the facility did not suspect abuse, neglect, or mistreatment.</li> <li>- Resident #2 had dementia, was legally blind, had poor safety awareness, and frequent falls.</li> <li>- The resident was brought to the dining room for observation and the plan of care continued.</li> <li>- An interdisciplinary review was conducted on 1/11/2024 and documented the resident had dementia, poor safety awareness, weakness, and the incident was unavoidable.</li> </ul> <p>Statements obtained by the facility and included in the facility 1/5/2024 investigation documented:</p> <ul style="list-style-type: none"> <li>- certified nurse aide #9 documented on 1/5/2024 at 5:20 PM, they were not assigned to Resident #2 and did not provide assistance or care to the resident in the past 24 hours. The statement documented incontinence care was not applicable, and they last observed the resident at 7:00 PM finishing dinner.</li> <li>-Certified nurse aide #8 documented on 1/5/2024 at 5:20 PM, they did not provide assistance or care to the resident in the past 24 hours. They last observed the resident at 7:00 PM after finishing dinner and it was not applicable if the resident was incontinent or was attempting to toilet himself.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 4/26/2024 at 8:35 AM, registered nurse #7 stated they worked as a Supervisor. Rounding by staff was to be completed every 1 to 2 hours and if the resident was at risk for falls, they were to be observed more frequently, every 30 minutes. Toileting residents was to occur every 2 hours. When a resident fell , they reported to the incident, assessed the resident, initiated an investigation, and obtained statements from the staff on duty. Whoever reviewed the facility investigation after they started it would have to follow through and obtain other statements. Once the information was completed, it was reviewed by the interdisciplinary team, they determined if there was a care plan violation or if abuse/neglect occurred. They were not a part of that review. Resident #2 was at risk for falls, had interventions including to be out in a common area and checked on frequently (every hour). The staff observed the residents on the unit a lot. They did not know if Resident #2's care plan documented to be observed every 30 minutes however they felt that was being done. They did not document any specific form of the checks. The care plan would be completed by them at the time of an incident and if a fall occurred a new intervention would be added to the care plan. They did not recall the specific incident with Resident #2 or what happened that day and did not recall if they added a new intervention on the care plan.</p> <p>During a telephone interview on 5/2/2024 at 11:21 AM, registered nurse #1 stated on 1/5/2024, Resident #2 was incontinent at the time of the fall. They did not look when the resident was last provided incontinence care as part of the investigation. The investigation was not complete enough to rule out abuse, neglect, or mistreatment.</p> <p>During a telephone interview on 5/2/2024 at 8:09 AM, the Director of Nursing stated the Nurse Managers and supervisors were responsible to complete facility incident reports and update the care plans after any incident. If a resident fell , they expected staff to document a note, evaluate interventions and add new intervention when needed. The nursing staff briefly discussed incidents during morning report and a weekly fall review was done with the interdisciplinary team. The nursing staff were expected to ensure a care plan was reviewed and followed at the time of the incident. Facility reportable incidents included abuse, neglect, and injuries of unknow origin. The looked to ensure abuse, and neglect and mistreatment was ruled out. The Unit Mangers were responsible to complete the investigations. After they completed their part the Director of Nursing and Administrator reviewed the reports to ensure all the information was added and abuse did not occur. All staff were educated on how to investigate. During the following incidents they stated:</p> <ul style="list-style-type: none"> <li>- on 1/2/2024, the incident with Resident #2 occurred at 7:30 AM. The investigation documented the resident was clearly incontinent at the time of the fall. They did not review Resident #2's care plan to see if incontinence care was provided per the care plan as part of the investigation. They were not aware there was no documentation Resident #2 received incontinence care on the 11:00 PM to 7:00 AM shift or before the time they fell . They were unable to rule out abuse, neglect, or mistreatment.</li> <li>- On 1/5/2024 at 5:20 PM, Resident #2 fell in another resident's room. The Incident/Accident Form documented the resident was incontinent at the time of the fall. They did not review the resident's incontinence care to ensure the care plan was followed as part of the investigation.</li> </ul> <p>10NYCRR 415.4(b)</p>		