| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335565 | A. Building<br>B. Wing | 06/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Grand Rehabilitation and Nursing at Barnwell | 3230 Church Street<br>Valatie, NY 12184 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805<br><br>Based on observations, record reviews, and interviews during the recertification and abbreviated survey (Case #NY00341467), the facility did not ensure each resident was treated with respect, dignity, and cared for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 5 (Residents #s 26, 66, 71, 108, and 180) of 37 residents observed in 4 of 6 dining rooms reviewed for respect and dignity. Specifically, Resident #s 26, 66, 71,108, and 180 were served with disposable utensils during meals. This is evidenced by:<br><br>A facility policy titled, Food and Nutrition Services and dated 1/2024, documented residents were provided with a nourishing, palatable, well-balanced diet that met their daily nutritional and special dietary needs, taking in consideration the preferences of each resident. Additionally, the policy stated, a resident-centered diet and nutrition plan would be based on an assessment of the resident's needs, likes and dislikes and eating habits.<br><br>Resident #26 was admitted with diagnoses of chronic obstructive pulmonary disease with (acute) exacerbation (narrowing of airways in the lungs making it difficult to breathe), unspecified cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), and dysphagia (difficulty swallowing). The Minimum Data Set (an assessment tool) dated 5/31/2024, documented the resident had minimal cognitive impairment, could be understood, and could understand others.<br><br>Resident #66 was admitted with diagnoses of metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood), cystitis (inflammation of the bladder), and pleural effusions (an unusual amount of fluid around the lung). The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could rarely be understood, and understand others.<br><br>Resident #71 was admitted with diagnoses of sepsis (a condition that arises when the body's response to infection causes injury to its own tissues and organs), chronic obstructive pulmonary disease (narrowing of airways in the lungs making it difficult to breathe), and spinal enthesopathy, lumbar region (a disorder involving the attachment of a tendon or ligament. The Minimum Data Set, dated dated dated [DATE], documented the resident had minimal cognitive impairment, could be understood and understand others.<br><br>48744<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #108 was admitted to the facility with the diagnoses of chronic osteomyelitis of an extremity (an infection of the bone), morbid obesity (weight more than 80-100 pounds above ideal body weight), and paraplegia (an impairment in motor or sensory function of the lower extremities. The Minimum Data Set, dated dated dated [DATE] documented was cognitively intact, could be understood, and understand others.<br><br>Resident #180 was admitted with diagnoses of Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), degenerative disease of nervous system (chronic conditions that damage and destroy parts of the nervous system over time), adult failure to thrive. The Minimum Data Set, dated dated dated [DATE], documented resident had significant cognitive impairment, could sometimes be understood and sometimes understand others.<br><br>During general lunch observations on 6/20/2024 at 12:30 PM on the first floor, residents were served their meals on plastic lunch trays with plastic forks and spoons. No knives, plastic or otherwise, were noted to be on the trays. Resident #180 was observed attempting to cut a hamburger with a plastic fork and plastic spoon.<br><br>During breakfast observations on 6/21/2024 at 9:21 AM on the first floor, residents' meals were served on trays with plastic utensils and no knives.<br><br>During a lunch observation on 6/26/2024 at 12:47 PM on the third floor, residents meals were served on trays with plastic utensils.<br><br>During a lunch observation on 6/27/2024 at 12:42 PM on the third floor, residents' meals were served on trays with plastic utensils.<br><br>During a lunch observation on 6/27/2024 at 1:16 PM on the fourth floor, Resident #26 was served lunch on a plastic tray, food on a paper plate, and with plastic utensils.<br><br>During an in interview on 6/27/2024 at 1:00 PM, Resident #108 stated they always received plastic utensils and did not know why.<br><br>During an interview on 6/27/2024 at 12:56 PM, Licensed Practical Nurse #4 stated they did not know why the residents were given plastic utensils. They stated there were no residents care planned or order for plastic utensils or assessed as a safety risk.<br><br>50996<br><br>During an interview on 6/28/2024 at 10:14 AM, Director of Food Service #1 stated the kitchen had to use plastic utensils because the facility ran out of real utensils. Additionally, Director of Food Service #1 stated the facility needed to order real cutlery almost weekly because they did not come back to the kitchen after meals. Director of Food Service #1 stated all residents should have real utensils.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 6/28/2024 at 11:49 AM, Director of Nursing #1 stated they did not know why the residents did not have cutlery, nor did the interviewee know why the first-floor residents were not provided knives. Director of Nursing #1 stated they assumed there was some sort of safety concern, however they had not heard that there was an issue regarding plastic cutlery or the lack of knives.<br><br>10 New York Code of Rules and Regulations 415.5(a) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>48615<br><br>Based on observation, record review, and interviews during a Recertification and abbreviated survey (Case #NY00335134), the facility did not ensure residents were assessed by an interdisciplinary team to determine their ability to safely self-administer medication when clinically appropriate for 1 (Resident #35) of 1 resident reviewed for medication administration. Specifically, Resident #35 was observed with a cup containing 7 pills and a cup of medicine mixed in water at their bedside, without being evaluated as to whether they could safely self-administer their medication. This is evidenced by:<br><br>Resident #35 was admitted to the facility with diagnoses of chronic diastolic congestive heart failure (heart does not pump blood well enough to give the body a normal supply), morbid obesity ( weight is more than 80 to 100 pounds above ideal body weight), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The Minimum Data Set (an assessment tool) dated 4/11/2024, documented the resident was cognitively intact, could be understood, and could understand others.<br><br>The facility policy titled, Self-Administration of Medications, dated 1/2024, documented Residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident. Self-administered medications must be stored in a safe and secure place, which was not accessible by other residents. If safe storage was not possible in the resident's room, the medications of residents permitted to self-administer would be stored on a central medication cart or in the medication room. Nursing would transfer the unopened medication to the resident when the resident requested them. Nursing staff would review the self-administered medication record on each nursing shift, and they would transfer pertinent information to the medication administration record kept at the nursing station, appropriately noting that the doses were self-administered.<br><br>During an observation and interview on 6/24/2024 at 10:35 AM, Resident #35 was noted to have a cup containing 7 pills along with cup of medicine mixed in water sitting on overbed table at their bedside. Resident #35 stated the nurse left medication for them to take. They stated nurse often would leave medication at the bedside and they eventually would take them.<br><br>During an interview on 6/24/2024 at 10:40 AM, Licensed Practical Nurse #11 stated the protocol for passing medications was to: check chart and pull medications needed; knock on door announce themself; proceed to administer medications as ordered; follow precautions on door; give patient pills; hand pills to patient and go over what's in cup. Licensed Practical Nurse #11 stated medications left in Resident 335's room was their mistake. They left medications at bedside when they left the room to answer a call light.<br><br>During interview on 6/24/2024 at 10:45 AM, Licensed Practical Nurse #2 stated no resident on 5th floor was cleared to self-administer medications. If a resident wanted to self-administer medications, the physician would assess and provide the order for resident to self-medicate.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 6/26/24 2:30 PM, Director of Nursing #1 stated there were no residents at this facility that self-medicate. If a resident wanted to self-administer medications, the physician would assess and provide the order for resident to self-medicate. The care plan would also be updated.<br><br>Upon review of Resident #35's electronic medical record, there was no documented evidence that the resident was assessed to safely self-administer medications; there was no physician order or care plan in place for the resident to self-administer medications.<br><br>10 New York Codes, Rules, and Regulations 415.3 (e)(1)(vi) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35228<br><br>Based on observations, record review and interviews during a recertification survey, the facility did not ensure a comprehensive person-centered care plan was developed and implemented for each resident consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 (Residents #108, 118 and 376) of 37 residents reviewed for comprehensive care plans. Specifically, for (a)Resident #108, a comprehensive care plan addressing oxygen use was not developed; for (b) Resident #118, a care plan to address the diagnosis of post-traumatic stress syndrome and a trauma informed comprehensive care plan were not developed; and for (c) Resident #376, a person-centered care plan to meet their psychosocial needs related to their history of depression as documented in the facility medical provider's admission history and physical was not developed. This is evidenced by:<br><br>The Policy and Procedure titled, Care planning - Interdisciplinary Team, dated 1/2024, documented the interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident.<br><br>The Policy and Procedure titled, Trauma Informed Care Plan, dated 1/2024, documented care plans would be developed that were person centered and interdisciplinary, to help improve resident engagement, treatment adherence, decrease incidents of re-traumatization and health outcomes. Plans would include interventions to help residents feel safe physically and psychologically throughout the organization.<br><br>Resident #108 was admitted with the diagnoses of chronic osteomyelitis (infection of the bone) of an extremity, morbid obesity (weight more than 80-100 pounds above ideal body weight), and paraplegia (paralysis of the legs and lower body). The Minimum Data Set (an assessment tool) dated 5/23/2024, documented the resident was cognitively intact, could be understood, and understand others. Resident #108 was receiving oxygen therapy and non-invasive mechanical ventilation while in the facility.<br><br>A Physician's Order dated 5/16/2024 documented oxygen 4 liters per minute continuously via nasal cannula (a tube placed into a person's nostrils).<br><br>A Physician's Order dated 5/16/2024 documented BiPAP (non-invasive mechanical ventilation) at bedtime for sleep apnea.<br><br>During an interview on 6/27/2024 at 11:38 AM, Resident #108 stated they were admitted to the facility wearing oxygen.<br><br>During an interview on 6/27/2024 at 12:53 PM, Registered Nurse Unit Manager #2 stated the resident was ordered to receive oxygen continuously. They stated that when a resident received oxygen or used a BiPAP, they should have had a care plan to address that.<br><br>During an interview on 6/28/2024 at 11:36 AM, Director of Nursing #1 stated there should have been a respiratory care plan for oxygen administration and use of bilevel positive airway pressure.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #118 was admitted with diagnoses of post-traumatic stress disorder (a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety.), wedge compression fracture of first lumbar vertebra (a bone fracture occurring when the bone collapses, and the front part of the vertebral bone forms a wedge shape), and Wernicke's encephalopathy (a neuropsychiatric disorder which arises as a result of thiamine deficiency). The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, could be understood, and understand others.<br><br>Review of Resident #118's medical record did not have documented evidence of a comprehensive care plan addressing the resident's post-traumatic stress disorder.<br><br>Review of the medical record did not have documented evidence of trauma-informed comprehensive care plan or interventions.<br><br>During an interview on 6/26/2024 at 12:12 PM, Director of Social Work #1 stated they asked the resident about any trauma history on admission. They stated Resident #118 did not disclose any trauma history, so a trauma-centered care plan was not developed. They stated a trauma-centered care plan should have been developed for Resident #118 because they had a diagnosis of post-traumatic stress disorder.<br><br>During an interview on 6/28/2024 at 11:36 AM, Director of Nursing #1 stated they would consider a diagnosis of post-traumatic stress disorder as a documented history of trauma and a person-centered care plan should have been implemented.<br><br>43805<br><br>Resident #376 was admitted with diagnoses of a fractured (broken) neck, fractured back, and depression (a mood disorder that may cause a persistent feeling of sadness and loss of interest). The Minimum Data Set, dated dated dated [DATE], documented the resident had moderate cognitive impairment, could be understood, and could understand others.<br><br>The comprehensive care plan for Psychotropic Medications related to depression initiated on 5/3/2024, documented to give medications as ordered by physician. Monitor/document for effectiveness. There was no documented evidence of person-centered care plan for Resident #376 for their depression prior to their verbalization of suicidal ideation on 6/21/2024. A person-centered care plan for depression was initiated on 6/24/2024.<br><br>The Admission Note dated 5/05/2024 at 9:47 AM, documented the Medical Doctor examined the resident. The resident was on an antidepressant for a diagnosis of depression.<br><br>The May 2024 Medication Administration Record documented Duloxetine Hydrochloride (a medication to treat depression) 60 milligrams, 1 capsule once a day for depression. The resident received their first dose on 5/04/2024 at 9:00 AM.<br><br>A Nurse Practitioner Note dated 6/21/2024 at 12:20 PM, documented they spoke with the Psychiatric Nurse Practitioner and the Licensed Practical Nurse Unit Manager regarding the resident's suicidal ideations, and it was decided to transfer the resident to the emergency room due to suicidal ideation with an actual plan.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 6/21/2024 at 10:41 AM, Resident #376 stated they wanted to kill themselves and had been thinking of ways to do it. The resident stated they had lost everything. Their kids would have nothing to do with them, their ex-spouse took everything they had, they lost their house and had nothing to live for.<br><br>During an interview on 6/26/2024 at 9:48 AM, Director of Social Work #1 stated the resident did not have a diagnosis of depression.<br><br>During an interview on 6/26/2024 at 9:54 AM, Social Worker #1 stated Resident #376 had requested a Social Work visit on 6/19/2024. The resident did not express they were depressed.<br><br>During an interview on 6/26/2024 at 10:41 AM, Director of Nursing #1 stated either Social Work, the Assistant Director of Nursing or Registered Nurse Unit Manager developed the resident's comprehensive care plans.<br><br>10 New York Codes, Rules, and Regulations 415.11 (c)(1) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538<br><br>Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised based on changing goals, preferences, and needs by the interdisciplinary team after each assessment for 3 (Residents #64, 75, and 200) of 37 residents reviewed for care plans. Specifically, (a) Resident #64 was identified as high risk for falls on admission and fell (witnessed) on 7/01/2023 while ambulating without a walker. The comprehensive Care Plan for Falls was not revised to include interventions initiated or implemented to prevent further accidents following the fall. Subsequently, on 9/26/2023, Resident #64 fell and sustained a cervical 1 vertebrae fracture (broken neck); (b) for Resident #75, the facility did not include the resident in care planning and did not hold a care plan meeting during the comprehensive assessment; and (c) for Resident #200, the comprehensive care plan was not revised after enteral feedings were discontinued on 5/02/2024. This is evidenced by:<br><br>A review of policy and procedure titled, Care Planning-Interdisciplinary Team, last revised in January 2024, documented the Interdisciplinary Team was responsible for development of an individualized Comprehensive Care Plan for each resident. A Comprehensive Care Plan for each resident was to be developed within seven days of completion of the resident assessment.<br><br>Resident #64 was admitted to the facility with diagnoses of unspecified displaced fracture of first cervical vertebra (neck fracture), metabolic encephalopathy (a brain disorder that occurs when a chemical imbalance in the blood caused by an illness or organ dysfunction impairs brain function), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Minimum Data Set, dated dated dated (an assessment tool) dated 7/13/2023 documented resident had moderately impaired cognition, could be understood, and could understand others.<br><br>The Comprehensive Care Plan documented the diagnosis Actual fall related to increased agitation, cognitive deficit, decreased mobility, and gait problems, last revised on 4/09/2024. Actual falls were documented on the following dates:<br><br>-7/01/2023 witnessed fall.<br><br>-9/26/2023- witnessed fall, head strike.<br><br>-9/30/2023 unwitnessed fall, no injury.<br><br>There was no documented evidence on the care plan that nursing interventions were put in place after these actual falls to prevent further accidents.<br><br>The facility's Incident and Accident Investigation Summary dated 7/01/2023 at 12:45 PM, documented Resident #64 walked from unit two (2) to reception area without a walker, lost their balance and fell . It The report documented contributing factors were loss of balance and repeated falls. It further documented fall risk assessment was completed and identified resident as high risk. Recommended steps to prevent recurrence was: to remind the resident to use walker.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no documented evidence on the care plan the interventions were put in place after the actual fall to prevent further accidents.<br><br>The facility's Incident and Accident Investigation Summary dated 9/26/2023 documented Resident #64 tripped on an intravenous pole and fell , striking the left side of head. Resident was transported to the hospital. It further documented Resident #64 returned from the hospital on 9/29/2023 with diagnosis of cervical 1 vertebra fracture with a cervical collar (a medical device used to support and immobilize a person's neck) in place. Recommended steps to prevent recurrence was to remove clutter from resident areas to prevent tripping.<br><br>There was no documented evidence on the care plan the interventions were put in place after this actual fall to prevent further accidents.<br><br>During an interview on 6/27/2024 at 11:55 AM, Assistant Director of Nursing #2 stated they were responsible for updating the fall care plans after a resident had a fall. They stated every fall had to have an intervention and their main goal was for the resident not to get injured. They stated they did not see an intervention on the care plan for Resident #64 after the fall on 7/01/2023 and there should have been a revision with intervention on the care plan.<br><br>During an interview on 6/27/2024 at 12:07 PM, Director of Nursing #1 stated after a resident fall the Registered Nurse Supervisor would be notified and the resident would be assessed. The care plan would be updated with interventions after each fall and would be done at the time of the incident. They stated Assistant Director of Nursing # 2 ensured the interventions were on the care plan after each fall. They stated they met with Assistant Director of Nursing # 2 after a resident fell and made sure interventions for prevention were discussed and put on the care plan. They stated every actual fall had to have an intervention in place after the incident. They stated Resident #64 fell on [DATE] and was sent to the hospital. Resident #64 sustained cervical 1 vertebra fracture and returned with cervical collar. Director of Nursing #1 looked on Resident #64's fall care plan and could not find the interventions that were put in after the fall on 7/01/2023. They stated there should have been interventions in place for the 7/01/2023 fall.<br><br>43805<br><br>Resident #75<br><br>Resident #75 was admitted to the facility with the diagnoses of chronic systolic (congestive) heart failure (long-term condition where the heart can't pump blood well enough to give the body a normal supply), end stage renal failure (the final stage of kidney disease where kidneys can no longer support the body's needs) and type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels). The Minimum Data Set, dated dated dated [DATE] documented resident had no cognitive impairment, could be understood, and could understand others.<br><br>A progress note dated 4/26/2024 documented an initial meeting with Resident #75 with Social Work.<br><br>During an interview on 6/21/2024 at 9:59 AM, Resident #75 stated they had not been involved in care planning, had not been invited to any care planning meeting and not been told when they could be discharged .<br><br>(continued on next page) |

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| The Grand Rehabilitation and Nursing at Barnwell | 3230 Church Street<br>Valatie, NY 12184 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 6/26/2024 at 12:12 PM, Director of Social Work #1 stated the resident did not yet have a care plan meeting and should have had one by now. They stated they did not know why it took 11 days for a social Worker to initially meet with the resident.<br><br>48615<br><br>Resident #200<br><br>Resident #200 was admitted to the facility with diagnoses of dysphagia (difficulty swallowing) following cerebral infarction (stroke), metabolic encephalopathy (a brain disorder that occurs when a chemical imbalance in the blood caused by an illness or organ dysfunction impairs brain function), and gastrostomy status (feeding tube). The Minimum Data Set, dated dated dated [DATE] documented resident had moderate cognitive impairment, could be understood, could understand others, and received 51% or more calories through a feeding tube. The Minimum Data Set, dated dated dated [DATE] documented a feeding tube was not used.<br><br>A Physician's Order for tube feeding documented the resident was to be given Jevity (formula) at 29 milliliters per hour from 4:00 PM to 8:00 AM every day with 150 milliliters of water flushes once daily. The order was discontinued on 5/02/2024.<br><br>Review of the medical record revealed no current orders for tube feeding.<br><br>A Comprehensive Care Plan titled, Potential risk for complication during evacuation process related to gastrostomy tube with enteral feeding, was last updated 02/20/2024. There was no current care plan interventions for the maintenance and care of the feeding tube.<br><br>During an interview on 6/28/2024 at 9:53 AM, Licensed Practical Nurse #6 stated the resident no longer received tube feeds but still had a feeding tube. They also stated a feeding tube that was not used should still be flushed and skin care provided daily.<br><br>During an interview on 6/28/2024 at11:03 AM, Director of Nursing #1 stated there was no current care plan for the feeding tube, it appeared the ones that were in place have been resoved instead of being updated.<br><br>10 New York Codes, Rules and Regulation 415.11(c)(2)(i-iii) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41795<br><br>Based on observation, record review, and interview during the recertification survey, the facility did not ensure a resident received adequate supervision and assistive device to prevent accidents for 1 (Resident #64) of 6 residents reviewed for accidents. Specifically, Resident #64, who was identified as high risk for falls on admission, had a witnessed fall on 7/01/2023 while ambulating without a walker. There were no interventions initiated or implemented following the fall to prevent further accidents. Subsequently, on 9/26/2023 Resident #64 fell and sustained a cervical 1 vertebrae fracture (broken neck). This resulted in actual harm for Resident #64 that is not immediate jeopardy.<br><br>This is evidenced by:<br><br>The Policy and Procedure titled Falls and Fall Risk management dated 10/1997, revision dates; 3/2022, 1/2023 and last revised on 1/2024 documented based on previous evaluations and current data, staff would identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and minimize complications from falls. Staff, with the input of the attending physician, would identify appropriate interventions to reduce the risks of falls. It also documented if falls recur despite initial interventions, staff will implement additional or different interventions. If underlying causes could not be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of fall until falls were reduced or stopped. Staff would monitor and document each resident's response to intervention intended to reduce falls or the risk of falling.<br><br>The Policy and Procedure titled Accidents or Incidents dated 1/2024, documented all accidents or incidents involving a residents would be investigated, and any corrective action taken would be documented. Incident/accident reports would be reviewed by the safety committee for trends related to accident or safety hazards in the facility and analyze any individual resident vulnerabilities.<br><br>Resident #64 was admitted to the facility with diagnoses of unspecified displaced fracture of first cervical vertebra, metabolic encephalopathy (a brain disorder that occurs when a chemical imbalance in the blood caused by an illness or organ dysfunction impairs brain function), and depression. Minimum Data Set, dated dated dated (an assessment tool) dated 7/13/2023 documented resident had moderately impaired cognition, could be understood, and could understand others.<br><br>The Comprehensive Care Plan Titled Actual fall related to increase agitation, cognitive deficit, decreased mobility, and gait problems last revised on 4/09/2024 documented actual falls on the following dates:<br><br>-7/1/2023 witnessed fall.<br><br>-9/26/2023- witnessed fall, head strike.<br><br>-9/30/2023 unwitnessed fall, no injury.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | There was no documented evidence on the care plan that interventions were put in place after these actual falls to prevent further accidents.<br><br>The facility's Incident and Accident Investigation Summary dated 7/01/2023 at 12:45 PM documented Resident #64 walked from unit 2 to reception without a walker, lost balance and fell . It documented contributing factors were loss of balance and repeated falls. It further documented fall risk assessment was completed and identified resident as high risk. Recommended steps to prevent recurrence was to remind the resident to use walker.<br><br>There was no documented evidence on the care plan the intervention was put in place after this actual fall to prevent further accidents.<br><br>The facility's Incident and Accident Investigation Summary dated 9/26/2023 documented Resident #64 tripped on an intravenous pole and fell striking the left side of head. Resident was transported to the hospital. It further documented Resident #64 returned from the hospital on 9/29/2023 with diagnosis of cervical 1 vertebra fracture with a cervical collar (a medical device used to support and immobilize a person's neck) in place. Recommended steps to prevent recurrence was to remove clutter from resident areas to prevent tripping.<br><br>There was no documented evidence on the care plan the intervention was put in place after this actual fall to prevent further accidents.<br><br>Resident #64's Fall Risk Evaluation dated 8/15/2023 at 4:13 PM, documented resident has had multiple falls within last six months.<br><br>Resident #64's Fall Risk Evaluation dated 9/16/2023 at 8:30 PM, documented resident has had multiple falls within last six months.<br><br>Health Status Note dated 9/16/2023 at 9:04 PM written by Licensed Practical Nurse #12 documented they were notified by assigned staff that Resident #64 was observed on the floor in the resident's room. It documented the resident stated they struck their head. Neuro checks were started and on call physician made aware.<br><br>Health Status Note dated 9/26/2023 at 9:30 AM written by Registered Nurse #4 documented they were called to the unit for a witnessed fall for Resident #64. It documented on arrival resident was observed sitting on the floor alongside Licensed Practical Nurse #13 holding pressure on the left side of the head laceration with minimal bleeding. It further documented, per Licensed Practical Nurse #13, the resident tripped on an intravenous pole and struck the left side of their head on a desk chair. Resident was transported to the hospital.<br><br>Nurse Practitioner Notes dated 9/26/2023 at 9:42 AM written by Nurse Practitioner #3 documented they were asked to assess resident for a fall while ambulating. Resident stated they tripped on an intravenous pole and fell forward and struck their head. It was documented the resident had a small laceration to their left eyebrow. Resident had complaint of headache. Resident was sent to the hospital for further examination and monitoring.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #64's History and Physical from the hospital dated 9/26/2023 documented resident presented from nursing home after sustaining a mechanical fall resulting with a cervical 1 vertebra fracture at the posterior arch (a break in the vertebra). Cervical collar on at all times.<br><br>Resident #64's computed tomography angiogram (a diagnostic test) of the neck dated 9/26/2023 from the hospital documented there was a [NAME] fracture of the cervical 1 vertebral body (a bone fracture of the anterior and posterior arches of cervical 1 vertebra).<br><br>Admission Note dated 9/29/2023 at 4:01 PM written by Registered Nurse #3 documented resident was admitted from the hospital. The reason for admission was resident had a mechanical fall from standing while using a walker. Resident #64 had a cervical collar due to cervical 1vertebra fracture.<br><br>The was no documented evidence Resident #64's care plan for falls was updated with interventions after their return from the hospital.<br><br>Physicians Progress Note dated 10/02/2023 at 10:54 AM, documented Resident #64 had a fall with head strike on 9/26/23. Resident was transferred to the emergency room for evaluation due to head strike, laceration, and the need for further evaluation. Resident found to have cervical 1 vertebra fracture bilateral posterior arch acute fractures, soft tissue hematoma (bruise) measuring 2.4 centimeters at the lateral left hip soft tissue without underlying osseous (bone) fracture. Patient returned to facility on 9/29/23 with cervical collar and recommendation for Ortho spine follow up. Resident did not have surgery.<br><br>During an interview on 6/27/2024 at 11:55 AM, Assistant Director of Nursing #2 stated they were responsible for updating the fall Care plans after each fall. They stated every fall had to have an intervention and their main goal was for the resident not to get injured. They stated they did not see an intervention on the care plan for Resident #64 after the fall on 7/01/2023 and there should have been one on the care plan. They stated they did not know why interventions were not on the care plan.<br><br>During an interview on 6/27/2024 at 12:07 PM, Director of Nursing #1 stated after a resident fall the Registered Nurse Supervisor would get notified and the resident would be assessed. The care plan would be updated with interventions after each fall and would be done at the time of the incident. They stated the Assistant Director of Nursing ensured the interventions were on the care plan after each fall. They stated they met with the Assistant Director of Nursing after falls and made sure interventions were discussed and put on the care plan after each fall to prevent it from happening again. They stated every actual fall had to have an intervention in place after the incident. They stated Resident #64 fell on [DATE] and was sent to the hospital. Resident #64 sustained cervical 1 vertebra fracture and returned with cervical collar. Director of Nursing #1 looked on Resident #64's fall care plan and could not find the interventions that were put in after the fall on 7/01/2023. They stated there should have been interventions in place for the 7/01/2023 fall.<br><br>During an interview on 6/27/2024 at 12:10 PM, Regional Clinical Director of Nursing #1 stated there should be interventions on the care plan after each fall to prevent further accidents.<br><br>On 6/28/2024 multiple attempts were made to get in contact with facility's physician for interview but no response.<br><br>(continued on next page) |

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| F 0689<br>Level of Harm - Actual harm<br>Residents Affected - Few | 10 New York Codes, Rules, and Regulations 415.12(h)(1) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538<br><br>Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure resident with a percutaneous endoscopic gastrostomy tube (a tube placed in the stomach through the abdominal wall to provide a means of feeding when oral intake is not adequate) received the appropriate treatment and services to prevent complications for 1 (Residents # 200) of 1 resident reviewed for tube feeding. Specifically for Resident #200 care and maintenance of the percutaneous endoscopic gastrostomy tube was not provided after enteral feedings were discontinued on 5/02/2024. This is evidenced by:<br><br>Resident #200 was admitted to the facility with diagnoses of dysphagia following cerebral infarction (stroke), metabolic encephalopathy (brain dysfunctions due to problems with metabolism), and gastrostomy status (feeding tube). The Minimum Data Set (an assessment tool) dated 4/30/2024 documented resident had moderate cognitive impairment, could be understood, could understand others, and received 51% or more calories through a feeding tube. The Minimum Data Set, dated dated dated [DATE] documented a feeding tube was not used.<br><br>A Physician's Order for tube feeding documented the resident was to be given Jevity (formula) at 29 milliliters per hour from 4:00 PM to 8:00 AM every day with 150 milliliters of water flushes once daily. The order was discontinued on 5/02/2024.<br><br>Review of the medical record revealed no current orders for tube feeding, maintenance of the percutaneous endoscopic gastrostomy, or skin care of the insertion site.<br><br>Review of the medical record revealed no current Care Plan for the maintenance and care of the percutaneous endoscopic gastrostomy tube.<br><br>During an interview on 6/28/2024 at 9:53 AM, Licensed Practical Nurse #6 stated the resident no longer received tube feeds but still had the tube. They also stated a feeding tube that was not used should still be flushed and skin care provided daily. Current orders were reviewed and there were no orders for the care of the percutaneous endoscopic gastrostomy tube.<br><br>During an interview on 6/28/2024 at 9:59 AM, Registered Nurse #2 stated, a percutaneous endoscopic gastrostomy tube that's not being used should be flushed daily and skin care to the site should be done. No orders were found in the electronic medical record and Registered Nurse #2 stated they did not know what happened, but would call the doctor right now and get orders.<br><br>During an interview on 6/28/2024 at11:03 AM, Director of Nursing #1 stated percutaneous endoscopic gastrostomy tube that was not used should be flushed and daily skin care. There were no current Care Plans or orders for care and maintenance of the percutaneous endoscopic gastrostomy tube. The order for flushes was attached to the feeding order and when that was discontinued the flushes were too. There were no policies that addressed the care of a feeding tube that was no longer used.<br><br>10 New York Codes, Rules, and Regulations 415.12(g)(2) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>35228<br><br>Based on record review and interviews during a recertification survey and abbreviated surveys (Case #NY00337074), the facility did not ensure parenteral fluids (delivery of fluid or nutrition through an intravenous (into a vein) route) was administered consistent with professional standards of practice and in accordance with physician orders for 1 (Resident #224) of 1 resident reviewed for parenteral fluids. Specifically, Resident #224's Medical Doctor orders were not followed when their total parenteral nutrition was not started at 5:00 PM on 03/08/2024 stopped on 03/09/2024 at 9:00 AM as ordered. This is evidenced by:<br><br>Resident #224 was admitted to the facility with diagnoses of pneumonia, severe malnutrition, and a stroke. The Minimum Data Set (an assessment tool) dated 1/14/2024, documented the resident was cognitively intact, could be understood, and could understand others.<br><br>The Policy and Procedure titled, Total Parenteral Nutrition dated January 2024, documented Nursing would confirm a physician order was in place that included frequency.<br><br>The Comprehensive Care Plan for Implanted Left Chest Access Port (a needle is place in the port to infuse the total parenteral nutrition into the vein) related to resident Receives Total Parenteral Nutrition initiated 7/13/2023, documented to administer total parenteral nutrition per orders.<br><br>A Physician's order dated 2/26/2024, documented total parenteral nutrition for a 16-hour cycle, starting at 5:00 PM and ending an 9:00 AM.<br><br>A late entry Physician's Progress Note created on 03/10/2024 at 6:21 PM, for an event that occurred on 03/09/2024 at 3:09 PM, written by Nurse Practitioner #1 documented Nursing stated the patient was on total parenteral nutrition, and was scheduled from 5:00 PM- 9:00 AM, but the total parenteral nutrition was never taken down at 9:00 AM (on 03/09/2024) as ordered by the physician. Nurse Practitioner #1 advised the Registered Nurse to call the pharmacy regarding the next infusion and how to administer it as it was to be administered in 2 hours.<br><br>During an interview on 6/28/2024 at 10:57 AM, Assistant Director of Nursing #2 stated they did not recall the 3/09/2024 incident, but the provider orders should have been followed and the total parenteral nutrition taken down at the time ordered. Technically the order was not followed. Anything outside of the order, the provider should have been notified.<br><br>During an interview on 6/28/2024 at 11:28 AM, Licensed Practical Nurse #7 stated they recalled the resident, but could not recall whether they took down the total parental nutrition at 9:00 AM per the medical doctor order on 3/09/2024. They stated the resident was sent out to the hospital on 3/10/2024.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/28/2024 at 12:20 PM, Director of Nursing #1 stated there was a problem with the documentation. It was likely the incident occurred on 3/10/2024 because Licensed Practical Nurse #7 documented that at 9:25 AM on 3/10/2024, the resident refused to allow them to take down the total parenteral nutrition. It was explained to Director of Nursing #1 that the late entry written by Nurse Practitioner #1 on 3/10/2024 at 6:21 PM, documented that on 03/09/2024 at 3:09 PM the Registered Nurse reported the resident's total parenteral nutrition had not been taken down at 9:00 AM that morning. Nurse Practitioner #1 advised the Registered Nurse to call the pharmacy since the resident's next administration was due in 2 hours (5:00 PM). On 3/10/2024, it was documented at 2:25 PM the resident was very ill, and their condition was rapidly declining. 911 was called and the resident sent to the hospital. It was further discussed with Director of Nursing #1 that since Resident #224 was acutely ill and sent to the hospital on 3/10/2024, it would not be logical that Nurse Practitioner #1 would have advised a nurse to call the pharmacy on 3/10/2024 since the resident was not at the facility to receive the total parenteral nutrition. It was logical the date and time of Nurse Practitioner #1's late entry was correct, and that the total parenteral nutrition was not taken down on at 9:00 AM on 3/09/2024 per the physician's order. Director of Nursing #1 stated on 3/08/2024, Resident #224's total parenteral nutrition was started at 6:52 PM, which was a late start. It was ordered to be started at 5:00 PM.<br><br>10 New York Codes, Rules, and Regulations 415.12(k)(3) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>48744<br><br>Based on observation, record review, and interviews during the recertification survey, the facility did not ensure that a resident who needs required respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences were provided by a qualified professional for the assessment, treatment, and monitoring of residents with deficiencies or abnormalities of pulmonary function for 2 (Resident #108 and 473) of 3 residents reviewed for respiratory care. Specifically, for (a) Resident #108 was not provided with oxygen at 4 liters per minutes via nasal cannula every shift as ordered by the physician and interventions for resident's oxygen use were not implemente; and (b) Resident # 473 did not have a physician's order for oxygen administration, however Resident # 473 received oxygen for at least the 5 days prior to the oxygen order being written in the resident's medical chart. This is evidenced by:<br><br>The Policy and Procedure titled Oxygen Administration, dated 1/2024, documented a physician's orders was required to be verified to initiate oxygen therapy, except in an emergency. Additionally, the policy documented that a review of the physician's orders or facility protocol for oxygen administration should be completed prior to administration.<br><br>Resident #108 was admitted to the facility with the diagnoses of chronic osteomyelitis of the left ankle and foot (an infection of the bone), morbid obesity (weight more than 80-100 pounds over ideal body weight) , and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease).The Minimum Data Set (an assessment tool) dated 5/23/2024 documented the resident was cognitively intact, could be understood, and understand others. The Minimum Data Set documented Resident #108 was receiving oxygen therapy and non-invasive mechanical ventilation while in the facility.<br><br>During observations on 6/26/2024, 6/27/2024, and 6/28/2024, Resident #108 was not wearing supplemental oxygen.<br><br>A Physician's Order dated 5/16/2024 documented oxygen 4 liters per minute continuously via nasal cannula.<br><br>A Physician's Order dated 5/16/2024 documented BiPAP (a bilevel positive airway pressure -non-invasive mechanical ventilation) at bedtime for sleep apnea.<br><br>Review of Resident #108's Comprehensive Care Plans did not have documented evidence of oxygen or BIPAP (a bilevel positive airway pressure -non-invasive mechanical ventilation) use.<br><br>During an interview on 6/27/2024 at 11:38 AM, Resident #108 stated they were admitted to the facility wearing oxygen. They stated they only wore the oxygen at night or when in bed and rarely wore the bilevel positive airway pressure (BiPAP) as they were not comfortable with the mask.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/27/2024 at 12:53 PM, Registered Nurse Unit Manager #2 stated the Resident #108 was ordered to receive oxygen continuously. They stated that when a resident receivesd oxygen or usesd a bilevel positive airway pressure (BiPAP), they should have a care plan to address both. They stated that if a resident refused to wear oxygen as ordered, there should be a non-compliance or refusal care plan and the doctor should be informed. They stated the respiratory care plan should have had interventions addressing the use of oxygen and BiPAP.<br><br>During an interview on 6/28/2024 at 11:36 AM, Director of Nursing #1 stated there should have been a respiratory care plan for oxygen administration and use of bilevel positive airway pressure (BiPAP). They stated the oxygen should have been administered as ordered and if not, the doctor advised of the refusal to wear the oxygen so orders and care plans could have been adjusted accordingly.<br><br>Resident # 473 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease with (acute) exacerbation (narrowing of airways in the lungs making it difficult to breathe), chronic respiratory failure with hypoxia (shortness of breath with inability to breath), and emphysema (a chronic respiratory disease). The Minimum Data Set (an assessment tool) dated 6/22/2024, documented resident had minimal cognitive impairment, could be understood, and understand others.<br><br>The Comprehensive Care Plan titled Alteration in Respiratory system dated 6/12/2024 documented Resident # 473 required oxygen and medications in the event the resident had to evacuate the home, related to their pulmonary status. Additionally, the Comprehensive Care Plan documented that resident had an alteration in respiratory system related to chronic obstructive pulmonary disorder with acute exacerbation, chronic respiratory failure with hypoxia, obstructive sleep apnea, dependence on supplemental oxygen and emphysema. Interventions included observe for signs and symptoms of poor airway clearance and gas exchange and provide oxygen per medical doctor's orders.<br><br>During an observation of the third-floor unit on 6/20/2024 at 3:02 PM, Resident # 473 was noted to be wearing 3 liters of oxygen via nasal cannula. There was no oxygen order in the medical record.<br><br>During an observation of the third-floor unit on 6/21/2024 at 11:30 AM, Resident # 473 was again observed wearing 3 liters of oxygen via nasal cannula. There was no oxygen order in the medical record.<br><br>During an observation of the third-floor unit on 6/26/24 at 11:15 AM, Resident # 473 was again observed wearing 3 liters of oxygen via nasal cannula without an order for oxygen in the medical record.<br><br>During an observation of the third-floor unit on 6/27/2024 at 10:35 AM, Resident #473 was observed sleeping wearing oxygen at 3 liters via nasal cannula.<br><br>Physician Orders dated 6/27/2024 at 10:54 AM documented continuous oxygen to be delivered at 4 liters per minute via nasal cannula.<br><br>Review of the Treatment Administration Record and Medication Administration Record, dated June 2024, did not include documentation of the use of oxygen for Resident # 473 until 6/27/2024, after an interview with the Unit Manager.<br><br>Progress Notes dated 6/13/2024 at 10:11 AM, documented Resident #473 was dependent on oxygen.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Progress Notes dated 6/18/2024 at 8:21 PM, documented Resident #473 agreed to wear a nasal cannula with 3 Liters of oxygen. When their oxygen saturation was noted to be 94%.<br><br>During an interview on 6/27/2024 at 10:42 AM, Certified Nurse Aide #6 stated if a resident who previously was not wearing oxygen, and then suddenly had oxygen, they would ask a nurse on the unit if the situation should be the way it was or if something new happened.<br><br>During an interview on 6/27/2024 at 10:44 AM, Registered Nurse Unit Manager #2 stated when a resident was on oxygen, there should be orders in Point Click Care. Additionally, Registered Nurse Unit Manager #2 stated they run a report to check which residents need specific treatments. If there was a new situation unfolding with a resident, they would document the situation and made sure the order was entered into the chart and given to the doctor. If a change of status occurred, they would adjust orders and notify the Medical Doctor of the need to sign new orders. They further stated they should check to make sure the oxygen orders were correct for the residents on oxygen because the conversation made them nervous.<br><br>During an interview on 6/27/2024 at 10:53 AM, Certified Nurse Aide #7 stated if they came into<br><br>work and saw a resident wearing oxygen that had not previously wore worn oxygen, they would check with the nurse if there was a new order for oxygen.<br><br>During an interview on 6/27/2024 at 10:56 AM, Licensed Practical Nurse #5 stated all residents with oxygen should have orders in Point Click Care for the oxygen being delivered.<br><br>During an interview on 6/28/2024 at 11:49 AM, Director of Nursing #1 stated residents using oxygen should have oxygen orders in Point Click Care.<br><br>10 New York Codes, Rules and Regulations 415.12(k)(6) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>43805<br><br>Based on record review and interviews during the recertification survey, the facility did not ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 (Resident #75) of 2 residents reviewed for dialysis care. Specifically, for Resident #75, was not monitored for complications before and after dialysis treatments were not completed consistently completed and communicated to the dialysis center through the dialysis communications log. This is evidenced by:<br><br>Resident #75 was admitted to the facility with the diagnoses of chronic systolic (congestive) heart failure (condition where the heart can't pump enough blood to satisfy the normal needed supply), end stage renal failure) final stage of kidney disease, when the kidneys no longer co0mplete their function) and type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels ), cerebral infarction (stroke), metabolic encephalopathy, and gastrostomy status (feeding tube). The Minimum Data Set (an assessment tool) dated 4/22/2024 documented resident had no cognitive impairment, could be understood, and could understand others.<br><br>A Policy and Procedure titled Dialysis dated 1/2024 documented a communications log would be used for each resident who left the building for dialysis, in order to communicate the resident's needs and response to the dialysis treatments.<br><br>A Physician's Order dated 5/04/2024 stated documented dialysis vitals should be taken before and after dialysis and documented in dialysis binder.<br><br>The dialysis communications log for 4/18/2024-6/20/204 was reviewed on 6/26/2024 at 12:27 PM.<br><br>The dialysis intercommunication form was left blank by the facility for pre-dialysis vital signs, dialysis access site condition, medication changes (yes/no), infections, acute condition documentation and nurse signature for the following dates: 4/20/2024, 4/30/2024, and 5/11/2024.<br><br>The dialysis intercommunication form was left blank by the facility for post-dialysis vital signs, dialysis access site condition, medication changes (yes/no), infections, acute condition documentation and nurse signature for the following dates: 4/20/2024, 4/23/2024, 4/25/2024, 4/30/2024, 5/2/2024, 5/07/2024, 5/11/2024, 5/14/2024, 5/18/2024, 5/23/2024, 6/06/2024, 6/08/2024, 6/15/2024 and 6/20/2024.<br><br>During an interview on 6/26/2024 at 12:45 PM, Registered Nurse Unit Manager #2 stated the dialysis communication sheets should be completely filled out before and after dialysis treatments by the nurses. They stated they did not know why it was not done.<br><br>During an interview on 6/28/2024 at 11:36 AM, Director of Nursing #1 stated it was the expectation that monitoring of a resident going to and returning from dialysis should be completed and documented. They stated the form provided for the dialysis communication sheet, should be completed and kept in the resident's dialysis communications log and sent with resident to each dialysis appointment.<br><br>10 New York Code of Rules and Regulations 415.12 |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>35228<br><br>Based on record review and interviews during a recertification survey, the facility did not ensure to it provided medically related social services to attain or maintain the highest practicable, mental, and psychosocial well-being of each resident for 1 (Resident #376) of 37 residents reviewed for medically related Social Services. Specifically, Resident #376 who had a documented history of depression was not assessed by a Social Worker when they were admitted to the facility. This is evidenced by:<br><br>Resident #376 was admitted to the facility with diagnoses of a fractured neck, fractured back, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set (an assessment tool) dated 6/10/2024, documented the resident had moderate cognitive impairment, could be understood, and could understand others.<br><br>The Policy and Procedure titled, Care Planning-Interdisciplinary Team dated January 2024, documented the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan based on the resident's comprehensive assessment. The Social Services Worker responsible for the resident was part of the team.<br><br>There was no Social Work assessment completed by a Social Worker for the resident's admission or subsequent readmissions.<br><br>The comprehensive care plan for Psychotropic Medications related to depression initiated on 5/03/2024, documented to give medications as ordered by physician. Monitor/document for effectiveness. There was no documented person-centered care plan for Resident #376 for their depression prior to their verbalization of suicidal ideation on 6/21/2024.<br><br>The Admission Note dated 5/05/2024 at 9:47 AM, documented the Medical Doctor examined the resident. The resident was on an antidepressant for a diagnosis of depression.<br><br>The May 2024 Medication Administration Record documented Duloxetine Hydrochloride capsule (a medication to treat depression) 60 milligrams 1 capsule once a day for depression. The resident received their first dose on 5/04/2024 at 9:00 AM.<br><br>A Nurse Practitioner Note dated 6/21/2024 at 12:20 PM, documented they spoke with the Psychiatric Nurse Practitioner and the Licensed Practical Nurse Unit Manager regarding the resident's suicidal ideations, and it was decided to transfer the resident to the emergency room due to suicidal ideation with an actual plan.<br><br>During an interview on 6/21/24 at 10:41 AM, Resident #376 stated they wanted to kill themselves and had been thinking of ways to do it. The resident stated they had lost everything. Their kids would have nothing to do with them, their ex-spouse took everything they had, they lost their house and had nothing to live for.<br><br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/26/2024 at 9:48 AM, Director of Social Work #1 stated the initial social service assessment form was in the electronic medical record under the tab for evaluations. They stated the assessment included screening for depression and cognitive function. They stated the Social Workers tried to complete it within 48 hours. It was also done on readmission.<br><br>During an interview on 6/26/2024 at 9:54 AM, Social Worker #1 stated on 6/21/2024, they were requested to visit Resident #376 who stated they felt very depressed, they did not want to be at the facility any longer and did not have any reason to live. They stated the resident told them they had tried to cut their wrists with the plastic cutlery provided them and stated they understood why the residents were not provided with silverware. Social Worker #1<br><br>stated they asked the resident if they wanted to speak with the psychiatrist and the resident stated they would. They stated psychiatrist saw the resident and the resident was sent to the hospital for psychiatric evaluation.<br><br>During an interview on 6/26/2024 at 10:41 AM, Director of Nursing #1 stated the form for Social Work initial assessments was in the evaluation section of the electronic medical record. They stated a Social Worker had not completed an assessment for Resident #376. They stated a Social Worker was supposed to do an assessment on admission or roughly around admission.<br><br>10 New York Codes, Rules, and Regulations 415.5(g)(1)(i-xv) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>48615<br><br>Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that drug records were in order; and that an account of all controlled drugs was maintained and periodically reconciled on 2 (Units #s 5 and 6) of 6 units reviewed. Specifically, the shift-to-shift staff signature form for controlled drugs (untitled) on Units # 5 and Unit #6, did not consistently include the signatures of staff members at each shift change, validating the correct narcotic count. This is evidenced by:<br><br>A review of the Controlled Substances policy dated 1/2024 documented that nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make sure they counted together documenting and reporting any discrepancies to the Director of Nursing Services.<br><br>A review of the Administering Medications policy dated 1/2024 documented the individual administering the medication must sign the resident's electronic administration record after giving the resident medication and before administering the resident medication.<br><br>A review of the shift-to-shift reconciliation of narcotics forms on unit #6 revealed three days, 6/23/2024, 6/24/2024, and 6/25/2024, of missing staff reconciliation for controlled drugs forms of missing staff reconciliation for controlled drugs forms.<br><br>During an observation of medication administration for Resident #186 on 6/25/2024 at 10:45 AM, Licensed Practical Nurse #8 was witnessed giving the resident their prescribed Lacosamide 100 milligram tablet from their medication blister pack, a controlled substance. Licensed Practical Nurse # 8 did not sign out the medication when they removed the medication and did not sign the administration record immediately after administration,<br><br>During a review of medication administration documentation for Resident #45 on 6/25/2024 at 11:31 AM, Licensed Practical Nurse #9 gave the resident their prescribed Lacosamide 100 milligrams tablet from their medication blister pack, a controlled substance. Licensed Practical Nurse # 9 did not sign out the medication when they removed the medication. There were 27 medications counted in the blister pack and 28 medications listed on the controlled substance logbook. Licensed Practical Nurse #9 stated that they should have signed the controlled substance log when they removed the medication. The electronic records signed by Licensed Practical Nurse #9 showed that they administered the resident's medication at 9:00 AM.<br><br>During a review of medication administration documentation for Resident #14 on 6/25/2024 at 11:31 AM, Licensed Practical Nurse #9 had documented in the medication log for Resident # 14's Fentanyl patch 75 micrograms, topical application every 72 hours, documented that there should have been 9 medication patches in the medication cart.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation of the Fentanyl patches 75 micrograms, there were only 8 patches accounted for present in the medication cart. Licensed Practical Nurse # 9 stated they were not sure of the missing Fentanyl patch. Resident #14 was observed to have a medication patch on their right lower abdominal area placed on 6/23/2024 by Licensed Practical Nurse #10.<br><br>During an interview on 6/26/2024 at 2:30 PM, Director of Nursing #1 stated every time there was a shift change the nurse were expected to sign the shift-to-shift documentation form verifying the count was correct. Director of Nursing # 1 also stated that the unit managers were responsible for monitoring the narcotic count sheets and contacting the staff involved immediately, to resolve any issues. They stated the policy on narcotic administration is to sign out the narcotics once removed from the medication package and sign the electronic records immediately after administration of the controlled substance medication. Director of Nursing #1 stated that all Registered Nurses and Licensed Practical Nurses have annual face-to-face competencies which included medication administration and the correct handling and documentation of all controlled substances. They stated this was done annually on their anniversary date or unit-specific if needed.<br><br>10 New York Codes, Rules and Regulations 415.18(b)(3) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>48615<br><br>Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for 6 out of 6 medication carts and 2 of 3 medication storage rooms reviewed. Specifically, (a.) opened medications had no open and/or expiration dates; (b.) controlled substances were not kept secured in a double locked cabinet; (c.) multiple loose pills were found in medication cart, and (d.) medications were found pre-poured on one medication cart. This is evidenced by:<br><br>The facility's Medication Administration Policy and Procedure, revised 01/2024, documented The expiration / beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened should be recorded on the container. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the Medication Administration Record may be flagged. After completing the medication pass, the nurse would return to the missed resident to administer the medication.<br><br>A review of the Controlled Substances policy dated 1/2024 documented Schedule I, II, III, IV, and V Controlled Substances must be stored under a double lock system.<br><br>During an observation and interview on 6/25/2024 at 10:45 AM, the 5th floor medication cart B was noted to have several loose pills throughout top drawer of cart. Licensed Practical Nurse #8 stated they were stock medications that spilled. They discarded the loose pills and found additional loose pills further back in the drawer and discarded those as well. Licensed Practical Nurse #8 stated it was the responsibility of each nurse to keep medication cart clean and orderly.<br><br>The 5th floor Medication cart B was also observed to have the following open medications without an open and expiration date after opening; two (2) bottles of Ketorolac eye drop 4%; one (1) bottle Systane eye drops; one bottle of sodium chloride ophthalmic solution 5%; and one bottle of deep-sea nasal spray. The following stock medications had no open dates: One (1) A bottle of Iron, one (1) bottle of Vitamin B1 and one (1) bottle of acetaminophen. The following had no expiration date after opening: two (2) Basaglar insulin Kwik pens; one (1) lispro insulin vial and one (1) glargine insulin pen with no expiration date after opening.<br><br>During an observation on 6/25/2024 at 11:20 AM, the 5th floor medication room, Narcotic lock box A, inside lock was found unlocked, although it was a functioning lock.<br><br>During an observation and interview on 6/25/2024 at 11:31 AM, of the 6th floor Medication Cart A, the following medications had no open and no expiration date after opening: two (2) bottles of brimonidine tartrate eye drops; one (1) bottle of systane eye drop; one (1) inhaler of ventolin HFA. The following had no expiration date after opening; one (1) Lispro insulin vial. Licensed Practical Nurse #9 stated the expiration date after opening insulin was 30 days. They stated they were not aware of pharmacy or manufacturer guidelines for shortened expiration dates.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 6/25/2024 at 11:45 AM, the 6th floor medication room refrigerator was noted to have one (1) open vial bottle of tubersol, tuberculin purified protein derivative with no open date.<br><br>During an observation on 6/25/2024 at 12:30 PM, the 5th floor medication room, Narcotic lock box A, inside lock was found unlocked; although it was a functioning lock.<br><br>During an observation and interview on 6/25/2024 at 12:40 PM, the 3rd floor Medication Cart A contained the following open medications without an open date and without an expiration date after opening: one (1) humalog insulin kwik pen; one (1) basaglar insulin kwik pen; one (1) vial of lispro insulin; one (1) glargine insulin pen. Licensed Practical Nurse #10 stated they would discard the unlabeled insulin and obtain new medication since insulin were not dated. They stated they were not aware of pharmacy or manufacturer guidelines for shortened expiration dates.<br><br>During an observation and interview on 6/26/2024 at 10:41 AM, the 2nd floor Medication Cart A, was noted to have unlabeled pre-poured medications in back of top drawer. Licensed Practical Nurse #7 stated resident was not in their room when they went to pass medication, and they held medication on cart awaiting resident's return. The following had no expiration date after opening: one (1) lispro insulin vial; One (1) lantus kwik pen.<br><br>During an observation and interview on 6/26/2024 at 10:50 AM, the 2nd floor Medication Cart B contained the following with no expiration date after opening: one (1) FIASP insulin kwik pen; one (1) lantus vial. Licensed Practical Nurse #6 stated they discarded insulin after 30 days and were was not aware of pharmacy or manufacturer guidelines for shortened expiration dates. They stated pharmacy came in once a month and checked cart for expired medications. It was also the nurse's responsibility to label medication upon opening.<br><br>During an observation and interview on 6/26/2024 at 2:16 PM, the 4th floor Medication Cart A, contained the following medications without an expiration date after opening: one (1) bottle of refresh eye drops; one (1) vial of lispro insulin; one (1) FIASP insulin pen.<br><br>During an interview on 6/26/24 at 2:30 PM, Director of Nursing #1 stated nursing staff should follow policy and procedure when passing medications. Staff were to check expiration dates prior to administering medication. Nursing staff should label insulin with open and discard dates upon opening a new vial or insulin pen. They stated pharmacy did not provide a grid of shortened expiration dates. Nursing staff are prohibited from pre-pouring medications. Licensed Practical Nurses and Registered Nurses have annual face to face competencies which included medication administration.<br><br>10 New York Codes, Rules and Regulations 415.18(d) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538<br><br>Based on observations, record reviews, and interviews during recertification survey, the facility did not ensure that food and drink were palatable and attractive for 10 (Resident #s 26, 53, 59, 71, 75, 86, 107, 108, 111, and 161) of 37 residents reviewed for palatable and attractive food and drink. Specifically, residents complained of food being cold, unattractive, and not palatable in general during resident council meeting. Additionally, 3 floors (2, 3, and 4) of 6 floors served food that was not palatable and was not at appetizing temperature. This is evidenced by:<br><br>A facility policy titled Food and Nutrition Services dated 1/2024, documented that the facility would provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br><br>Resident #71 was admitted with diagnoses of sepsis (a serious condition resulting from infection that can cause multiple organ failure), chronic obstructive pulmonary disease (narrowing of airways in the lungs making it difficult to breathe) , and spinal enthesopathy (inflammation of the connections of bones and muscles causing pain and mobility issues). The Minimum Data Set (an assessment tool) dated 5/16/2024, documented that the the resident had minimal cognitive impairment, could be understood, and understand others.<br><br>Resident #86 was admitted with diagnoses of orthopedic aftercare(aftercare provided after a joint replacement) , displaced fracture of medial malleolus of left tibia (an unstable break of the lowest part of the tibia (leg) bone), and patellar tendinitis of right knee (an inflammation of the tendon that attaches the kneecap to the shin bone). The Minimum Data Set, dated dated dated [DATE], documented the resident had minimal cognitive impairment, could be understood, and understand others.<br><br>Resident #111 was admitted with diagnoses of flaccid hemiplegia affecting left dominant side (inability to move the left side of the body), chronic obstructive pulmonary disease with (acute) exacerbation (narrowing of airways in the lungs making it difficult to breathe ), and personal history of transient attack and cerebral infarction without residual deficits (history of blood clots on the brain). The Minimum Data Set, dated dated dated [DATE], documented that the resident could be understood, and understand others.<br><br>During lunch observation on 6/20/2024 at 12:53 PM, the first-floor staff were observed pouring resident beverages without wearing gloves. Food was served on trays and left on the trays while the residents ate. Plastic cutlery was provided; however, no residents were given plastic knives. They were only given spoons and forks.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335565 | A. Building<br>B. Wing | 06/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Grand Rehabilitation and Nursing at Barnwell | 3230 Church Street<br>Valatie, NY 12184 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 6/21/24 of the breakfast tray in the Resident #71's room at 11:15 AM, a plastic tray with food covered by a plastic cloche was observed. There was also a plastic spoon and fork on the tray. Resident #71 was interviewed about the meal. Resident #71 stated I did not eat it. The resident stated, look at it, it was cold when they brought it in and there is no way to warm it up. Observation of the meal revealed 2 slices of uneaten bread/ French toast, and what appeared to be 2 uneaten ham slices. There were also two packages of syrup on the tray. There appeared to be congealed (semisolid) fat on the top slice of ham. Temperature of the ham was 74.8 degrees Fahrenheit. The french toast temperature was 87.6 degrees Fahrenheit. Resident #71 stated the food was usually cold when served in room because it took a long time to bring the food up on the elevators. Resident # 71 stated hot food should be hot, and cold food should be cold.<br><br>During a test tray on 6/27/2024, temperature and taste were performed on multiple units. Lunch was served on the second floor at 12:34 PM. The hamburger served on a bun was temped at 129 degrees and had no taste. Baked beans were temped at 120 degrees and tasted as expected. Non plastic cutlery was provided. Lunch was served on the third floor at 12:56 PM. The tray ticket stated chopped grilled chicken was to be served, however the tray had chopped hamburger on it and was temped at 95.2 degrees Fahrenheit. The baked beans was temped at 114.9 degress Fahrenheit and tasted like canned pork and beans. The cutlery served was plastic and the food was served on a tray and left on the tray while the residents were eating. Lunch was served on the fourth floor at 1:16 PM. The hamburger was precut and was temped at 100.6 degrees Fahrenheit. The burger was bland and chewy. The coffee served smelled burnt and was temped at 132.6 degrees Fahrenheit. Plastic cutlery was provided, and the food was served on a paper plate and left on the tray.<br><br>During an interview on 6/27/2024 at 12:56 PM, Licensed Practical Nurse #4 stated they did not know why the residents were given plastic utensils. They stated there were no residents care plannned or had an order for plastic utensils or assessed as a safety risk.<br><br>During an interview on 6/28/2024 at 10:14 AM, Director of Food Service #1 stated the kitchen had to use plastic utensils because the facility ran out of real utensils. Additionally, the Director of Food Service #1 stated the facility had to order real cutlery almost weekly because they did not come back to the kitchen after meals. The Director of Food Service #1 stated all residents should have real utensils. They stated the building only had one elevator with a rear door to use. The trays could be cold when they get to the floor due to delays.<br><br>During an interview on 6/28/2024 at 11:49 AM Director of Nursing #1 stated that they did not know what the issue was with cutlery, nor did they know why the first-floor residents were not provided knives at all. They stated that they assumed there was some sort of safety concern, however they had not heard that there was an issue regarding plastic cutlery or the lack of knives.<br><br>10 New York Code of Rules and Regulations 415.14(d)(1)(2)<br><br>43805<br><br>48615<br><br>50996 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>21414<br><br>Based on observation and staff interview during the recertification survey, the facility did not prepare and store food in accordance with professional standards for food service safety in the main kitchen and 1 of 6 kitchenettes. Specifically, ground chicken was not cooled safely, and the Unit #1 kitchenette was not clean. This is evidenced by:<br><br>The document titled (Hazard Analysis Critical Control Points) HACCP Cooling Step by Step Process and dated 6/03/2020 and the document titled Temperatures Cooking and Cooling and dated 4/2024 both documented the cooked food was to be cooled from 140 degrees Fahrenheit to 70 degrees Fahrenheit within 2 hours then to 41 degrees Fahrenheit within 4 hours.<br><br>During observations on 6/20/2024 at 10:54 AM, ground chicken in hotel pan found in the walk-in refrigerator was 52 degrees Fahrenheit.<br><br>During an interview on 6/20/2024 11:24 AM, Assistant Director of Food Service #1 stated the chicken was ground and placed in the walk-in refrigerator at 7:00 AM this morning.<br><br>During an interview on 6/20/2024 at 11:26 AM, Chef #1 stated the chicken was cooked on 6/19/2024.<br><br>During an interview on 6/20/2024 at 11:33 AM, Director of Food Service #1 stated all chicken that was grounded that morning would be disposed.<br><br>During an observation on 6/20/2024 at 11:30 AM, the ground chicken was observed disposed by facility staff.<br><br>During an interview on 6/21/2024 at 11:21 AM, Regional Manager [food service vendor] #1 stated that the kitchen staff would receive training on food temperatures and safe cooling procedures.<br><br>During an interview on 6/21/2024 at 12:19 PM, Administrator #1 stated that they would re-train all cooks on the proper cooling procedures for food and that the housekeeping staff would be asked to clean the Unit #1 kitchenette freezer and cabinets.<br><br>10 New York Codes, Rules, and Regulations 415.14(h) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>21414<br><br>Based on observation, record review, and interview during the recertification survey, the facility did not ensure food brought for residents by family or visitors (food) was stored safely and in a way that is either separate or easily distinguishable from facility food on 3 of 6 resident units. Specifically, resident and personal food stored in the resident unit kitchenette refrigerators was not properly labeled. This is evidenced by:<br><br>During an observations on 6/20/2024 at 12:43 PM, in the Unit #1 kitchenette refrigerator, deli sandwiches labeled with the name of Resident #109 and their room number was not dated.<br><br>During an interview on 6/20/2024 at 12:44 PM, Registered Nurse Unit Manager #1 stated the food brought in for Resident #109 should have been dated by the nursing staff.<br><br>During an observations on 6/20/2024 at 2:55 PM, in the Unit #6 kitchenette refrigerator, lactose-free milk and orange tonic were not labeled.<br><br>During an interview on 6/20/2024 at 2:57 PM, Licensed Practical Nurse #1 stated that the milk and orange tonic were brought in by family members for a resident on the unit and should have been labeled with the resident name, room number, and date.<br><br>During observations on 6/20/2024 at 3:14 PM, in the Unit #3 kitchenette refrigerator, food found in a green re-useable lunch bag was not labeled.<br><br>During an interview on 6/20/2024 at 3:16 PM, Certified Nurse Aide #1 stated the food in green bag was their personal food.<br><br>The undated document posted on the resident unit kitchenette refrigerators documented that all food must be labeled with the resident name and be dated.<br><br>During an interview on 6/20/2024 at 12:40 PM, Administrator #1 stated that the nursing staff would be re-educated on labeling personal food and food brought to residents.<br><br>10 New York Codes, Rules, and Regulations 415.14(h) |