STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335564	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ONTARIO CENTER FOR REHABILITATION AND HEALTHCARE	3062 COUNTY COMPLEX DRIVE CANANDAIGUA, NY 14424

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during an Abbreviated Survey (complaint #NY 349) it was determined that for one (Resident #1) of one resident reviewed for notification of changes, the facility did not immediately inform the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status. Specifically, the designated representative was not immediately notified when Resident #1 expired in the facility on [DATE]. This is evidenced by the following: The facility policy, Notifications, dated [DATE], included that the facility must immediately notify the resident's physician and designated representative when there is a significant improvement or decline in the resident's physical, mental, or psychosocial status. The notification is documented in the nurse's notes and reflects the name of the person notified and the change in condition and/or treatment. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated [DATE], revealed the resident had moderately impaired cognition with a with a Brief Interview for Mental Status score of 12. Review of the Discharge Summary, date [DATE] at 10:09 a.m., revealed the resident was found without respirations or pulse and had expired. The summary did not include that the designated representative was contacted regarding the resident's death. Review of progress notes revealed that on [DATE] at 12:00 p.m. the Director of Nursing (DON) documented a late entry for [DATE] that included at 10:15 a.m. the nurse on duty reported that the resident had stopped breathing, was not responding to any form of stimuli, no vital signs appreciated, no chest rise for an entire minute, and the Medical Doctor was made aware of the resident's death. There was no documented evidence in the progress notes that the designated representative was contacted regarding the resident's death on [DATE]. On [DATE] at 10:55 a.m. the Administrator documented that the Administrator and DON spoke with the resident's sister about the resident's passing and belongings. When interviewed on [DATE] at 2:45 p.m., the Administrator stated that she had been notified by Licensed Practical Nurse (LPN) #1 on [DATE] between 8:00 p.m. and 8:30 p.m. that the resident's remains had not been picked up from the facility by the funeral home. She said the family contacted the facility that evening and were upset that they had found out about the resident's passing from the funeral home and not the facility. She stated when there was a resident death, she would expect the charge nurse to contact the family or follow through to ensure that the family has been notified. She said the family should have been notified by the facility not the funeral home. When interviewed on [DATE] at 12:50 p.m., LPN #1 stated that on [DATE] she was scheduled to work a double shift when the resident passed away. On that morning, she notified the DON and the Nurse Practitioner (NP) of the resident's condition, the NP assessed the resident and determined the resident had passed away. She asked the DON if there was anything she needed to do, the DON said, No, I got it and she continued to pass medications. She said at approximately 4:30 p.m., she noticed that the resident's remains were still in the facility. She said she attempted to contact the DON, Assistant DON (ADON), and the Administrator at that time. LPN #1 said she then contacted the funeral home to see when they would be picking up the remains and was informed that no one from the facility had notified them of the resident's death. She stated she received a call from the resident's niece who said she had been informed by the funeral home that the resident had died and wanted to know why the facility had not notified the family. She stated that when there was a resident death, the team (nurse, DON, and ADON) worked together. She said that was the second death she had experienced while working in the facility, and after the first death, the DON handled everything including contacting the family and the funeral home. When interviewed on [DATE] at 3:09 p.m., the DON stated that he was called to evaluate the resident on the morning of [DATE] as the resident was actively dying between 9:30 a.m. and 10:00 a.m. He said he was informed of the resident's passing at approximately 2:00 p.m. but was not informed that the family had not been notified. He said the family was notified at about 8:00 p.m. but he could not recall if the family was notified by the facility or the funeral home. The DON said he was not sure what had gone on that day, but there was some miscommunication. He stated that the nurse should be calling families when a resident expires. (10 NYCRR 415.3(e)(2)(ii)(b))
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during an Abbreviated Survey (complaint #NY 850 and #NY 829) it was determined for three (Resident #1, #2, and #3) of three residents reviewed, the facility did not ensure residents received care and treatment consistent with professional standards to promote healing and prevent new pressure ulcers from developing. Specifically, Resident #3 was observed without a pressure ulcer dressing, and Residents #1, #2, and #3 lacked documentation that pressure ulcer treatments were being completed as ordered. This is evidenced by the following: The facility policy, Wound Care, dated April 2019, included that it was recommended to chart on a Treatment Administration Record (TAR) or other location that the dressing is intact every shift that a dressing change is not performed. 1. Resident #3 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated 4/15/20, revealed the resident had severely impaired cognition and skin conditions including one Stage 3 (full thickness tissue loss, subcutaneous fat may be visible) pressure injury, one Stage 4 pressure injury, and three venous or arterial ulcers. Review of physician's orders [REDACTED]. Review of the Comprehensive Care Plan, dated 10/22/19, revealed that the resident had an actual Stage 4 pressure ulcer to the sacrum and was totally dependent on two staff for toileting, bed mobility, and transfers. Interventions included to administer treatment per physician orders [REDACTED]. Review of the June 2020 TAR and progress notes revealed there was no documented evidence that the wound care for the sacral pressure ulcer was completed for 4 of 30 opportunities. Additionally, there was no documented evidence that the wound care was done on an as needed basis for the entire month. Review of the July 2020 TAR and progress notes revealed no documented evidence that the wound care for the pressure ulcer was completed on 3 of 9 opportunities. When observed on 7/8/20 at 10:40 a.m., Resident #3 did not have a dressing in place to the sacral pressure ulcer. Pressure ulcer care was completed at that time. When interviewed at that time, Certified Nursing Assistant (CNA) #1 stated that the soiled dressing came off in the resident's brief while performing incontinence care when she arrived that morning (the day shift starts at 6:00 a.m.). When interviewed on 7/2/20 at 1:17 p.m., Licensed Practical Nurse (LPN) #2 stated that she was the only nurse scheduled on the third floor until 12:30 p.m. and was responsible for 49 residents at that time. She said that she takes care of Resident #3 often but could not recall how many times during the last two months the dressing had not been changed. She said she was not able to do the wound care for the resident on that shift and would pass it on to the evening shift to complete because she was leaving early. LPN #2 stated that there have been a few times that she has reported to the evening shift that she was unable to get to the resident's dressing change. 2. Resident #1 had [DIAGNOSES REDACTED]. The MDS Assessment, dated 4/4/20, revealed the resident had moderately impaired cognition and skin conditions including one unstageable (wound covered with slough or eschar therefore unable to stage) pressure injury and three venous or arterial ulcers. Review of physician's orders [REDACTED]. Review of

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335564	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ONTARIO CENTER FOR REHABILITATION AND HEALTHCARE	**3062 COUNTY COMPLEX DRIVE CANANDAIGUA, NY 14424**

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the Comprehensive Care Plan, dated 3/27/20, revealed that the resident had an actual pressure ulcer to the left heel (DTI). Interventions included to apply treatment per physician orders, to monitor dressing daily to ensure it was clean, dry, and intact, and to monitor wound daily for signs or symptoms of infection. Review of the May 2020 TAR did not include documented evidence that wound care for the left heel DTI was completed for 10 of 31 opportunities. On six occasions (5/6/20, 5/11/20, 5/18/20, 5/25/20, 5/27/20, and 5/29/20) the treatment was not completed and there was a follow-up code documented that directed to, See Nurse Notes. Review of progress notes for May 2020 included that a LPN documented on 5/6/20, 5/20/20, 5/21/20, Healed, and on 5/11/20, Done with treatment. On 5/5/20, 5/12/20, and 5/19/20 the Director of Nursing (DON) documented wound measurements and characteristics for the Left Heel DTI. There was no documentation regarding wound care on 5/18/20. On two occasions (5/25/20 and 5/29/20), LPN #2 documented not done, only one nurse on the floor. There were no Wound Evaluation and Management Summary visit notes provided by the facility for May 2020. 3. Resident #2 had [DIAGNOSES REDACTED]. The MDS Assessment, dated 5/5/20, revealed the resident had severely impaired cognition, was frequently incontinent of bowel, and had skin conditions including two Stage 4 pressure injuries. Review of the Comprehensive Care Plan, dated 1/23/20, revealed the resident had an actual Stage 4 pressure ulcer to the sacrum and right lateral foot. Interventions included to apply treatment per physician orders [REDACTED]. Review of the medical record revealed the resident was hospitalized from [DATE] to 5/1/20. Following a change of condition on 5/5/20, the resident was transferred back to the hospital. A hospital wound consult note, dated 4/30/20, revealed the resident had a Stage 4 sacral wound and a Stage 2 to the right fifth toe. The sacral wound measured 3.7 centimeters (cm) x 2.5 cm x 1.0 cm with undermining (a pocket beneath the skin at the wound's edge) measuring 3.5 cm and included treatment recommendations to be changed every other day and as needed. The right fifth toe measured 1.0 cm x 0.8 cm x 0 cm with macerated (softening and breaking down of skin resulting from extended exposure to moisture) tissue and included treatment recommendations to be changed every three days and as needed. Review of the April 2020 TAR and progress notes included wound care orders for a left hip DTI, Stage 4 right lateral foot, and a Stage 4 sacral wound. There was no documented evidence that wound care was completed for any of the wounds on 5 of 12 opportunities. Review of the May 2020 TAR did not include physician's orders [REDACTED]. There was no documentation in the progress notes that any type of treatment was completed for 5/1/20, 5/2/20, or 5/3/20. When interviewed on 7/9/20 at 2:20 p.m., LPN #3 stated that if a treatment cannot be completed on the day shift, the day shift nurse will let the evening shift nurse know during shift change report or that information would be written on the 24-hour report sheet. She said the treatment should then be completed on the evening shift. She said the nurse should enter in the EMR yes or no to the treatment being completed. She said if the nurse does not enter a response then the treatment will not be seen by the next shift. In an interview on 7/10/20 at 2:53 p.m., the Assistant Director of Nursing (ADON) stated that she could not recall any reports from nurses that they have been unable to get treatments done on their shift. She said the facility has a lot of wounds and treatment schedules were recently adjusted so that some could be done on days and some done on evenings. When interviewed on 7/10/20 at 3:09 p.m., the Director of Nursing stated that he expects the nurse to sign the TAR every time a treatment was completed. He said if he was reviewing the TAR two to three months later and there was missing documentation, he would not know if the treatment was done. He said during the height of COVID-19 the facility had some challenges with wound care, and the wound care physician came in to monitor high risk wounds twice weekly to ensure they were not deteriorating. He said when the oncoming shift opens the electronic TAR, the nurse would only see orders for their own shift. He said the nurse would not know if a treatment was not done on the previous shift. When interviewed on 7/2/20 at 2:45 p.m., the Administrator stated the expectation was that wound care was completed per the physician's orders [REDACTED]. She said she knows that the provider has been notified in some instances when treatments were not able to be completed, but she does not know if the provider was specifically notified for Residents #1, #2, or #3. She said if a treatment was ordered daily, she would expect the nurse to communicate to the on-coming shift that the treatment was not done. She said the treatment should then be completed on the next shift. The Administrator stated if a treatment was not signed, then she would have to assume that it was not done. (10 NYCRR 415.12(c)(2))