STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335331	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANVILLE CENTER FOR REHABILITATION AND NURSING	17 MADISON STREET GRANVILLE, NY 12832

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 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews during the recertification survey, the facility did not ensure each resident was treated with dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 3 units and 1 (Resident #118) of 1 resident reviewed for dignity. Specifically, for Resident #118, the facility did not ensure the resident was treated with dignity and respect when he/she requested to use a bedpan. This was evidenced by: Resident #118: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 2/26/20, documented the resident was cognitively intact, could understand others and could make self-understood. The MDS documented the resident was total dependence of 2 staff for toilet use and transfer and was occasionally incontinent of urine. The Facilities Policy and Procedure titled ADL Support dated 10/2019, documented appropriate care and services will be provided for residents who are unable to carry out activity of daily living (ADL's) independently, with the consent of the resident, and in accordance with the plan of care, including support and assistance with elimination (toileting). The Comprehensive Care Plan for Activities of Daily Living related to limited mobility, dated 1/24/20, documented the resident required extensive assist of 2 for bed mobility and was totally dependent with 2-assist for toilet use. During an interview on 3/03/20 at 9:28 AM, Resident #118 stated he/she had to use the bedpan around dinner time last night and had his/her call light on. A Certified Nursing Assistant (CNA) came in and told the resident that he/she could not help because he/she was passing out dinner trays. The CNA placed an adult brief and 2 poise pads (bladder control pads) under the resident by pushing them under her from the front of her groin. The resident stated he/she did not see the CNA again, until he/she put the call light on at 7:00 PM, the CNA stopped in and asked the resident if he/she was still waiting to urinate and told the resident to urinate on the pads that he/she placed under the resident and left the room. The resident stated the nurse came into at 8:00 PM with medications and he/she told the nurse of the interaction with the the CNA. The resident could not hold the urine any longer and the pads/protective pad was wet. Care was provided by 2 Nurses and the resident was advised to fill out a grievance. During an interview on 03/04/20 at 09:14 AM, Licensed Practical Nurse (LPN) #3 stated there were 2 poise pads and an adult brief under the resident last evening. The brief and pads were bunched up under the resident and not placed properly so the protective pad was wet and they provided incontinence care. The LPN stated CNA #5 was scheduled all shift but was not on the floor half of the night and LPN #3 and another nurse assisted the resident in cleaning up. During a subsequent interview on 3/4/20 at 10:40 AM, the resident stated it made her feel awkward and weird with the brief/posie pads were shoved under her. He/she stated if the CNA took the time to do that, she could have put him/her on the bed pan. During an interview 3/4/20 at 10:28 AM, Registered Nurse Manager (RNM) #4 stated she had heard of the incident on Monday because LPN #3 called her at home and grievance was filled out. RNM#4 stated he/she could not say whether the incident was related to staffing or not, or what the CNA was thinking at the time. RNM #4 stated it was a dignity issue to place incontinence pads under a resident from the front and incorrectly and have the resident urinate on them instead of using the bedpan. During an interview on 03/05/20 at 9:43 AM, the Acting Director of Nursing (DON) stated the CNA was under the perception that the staff were not to provide care during mealtime and the CNA stated the incontinence products were placed under the resident in case of leakage, but that the way they were placed would not have worked anyways. The DON stated it was not a dignified situation and the CNA would need re-education. 10 NYCRR 415.3(c)(1)(i)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey the facility did not ensure there was evidence that all alleged violations of abuse, neglect or mistreatment were thoroughly investigated for 1 (Resident #105) of 3 residents reviewed for accidents. Specifically, for Resident #105, the facility did not ensure there was evidence of an investigation to rule out abuse, neglect, or mistreatment after the resident had an unwitnessed fall on 12/29/29 that resulted in a laceration over the left eyebrow, decreased consciousness, and a transfer to the hospital. This was evidenced by: Resident #105: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment) dated 1/27/20, documented the resident was cognitively intact and was able to understand others and make herself understood. The P&P titled Accidents-Incidents dated 8/2019, documented it was the policy of the facility to monitor and evaluate all occurrences of accidents or incidents or adverse events occurring on the facility's premises which was not consistent with the routine operation of the facility or care of a particular resident. Any unwitnessed incident or accident must be investigated for potential abuse. The P&P documented if the resident sustained [REDACTED]. review the incident/investigation and the conclusion to determine if the incident required reporting to an outside agency. During an observation/interview on 3/1/20 at 10:37AM, the resident was lying in his/her bed and touched a scar on his/her left forehead. He/She stated he/she fell and cut his/her forehead open and was unconscious a few months ago and had to go to the hospital. He/She stated he/she fell because he/she had to go to the bathroom and could not wait any longer for staff to answer his/her call bell. He/She got up from his/her bed without assistance and fell . The Comprehensive Care Plan (CCP) for Activities of Daily Living (ADL) dated 2/6/19, documented the resident required assistance related to [MEDICAL CONDITION] and muscle weakness. Interventions included: 8/9/19-limited assist of 1 staff with walker for locomotion; 1/9/20- extensive assist of 1 staff for ambulation, transfers, and bed mobility. The CCP for At Risk for Falls dated 2/19/19, documented the resident has had an actual fall related to [MEDICAL CONDITION] drug use, [MEDICAL CONDITION], poor safety awareness, history of [MEDICAL CONDITION], muscle weakness and non-compliance with ADL recommendation. Interventions included: 12/20/19 remind resident to use her walker or wheelchair for locomotion; 2/6/19 encourage to wear appropriate footwear and encourage to use call bell for assistance as needed; on 1/6/20 a bed alarm. The Fall Risk Evaluation dated 12/16/19, documented a recent fall, 1-2 falls within the last 6 months. Medication use included: Antihypertensive, benzodiazepine, narcotic, [MEDICAL CONDITION], anti-Parkinson medications. The resident's memory and recall ability were intact. The evaluation also documented the resident was frequently incontinent bladder. The resident exhibited a loss of balance while standing, used short discontinuous steps, exhibited jerking or instability when making turns, used an assistive device and had decreased in muscle coordination. The Nurse Practitioner Tele-Health Progress Note dated 12/29/19 at 6:28 PM, documented the resident had a fall and head injury (laceration 2.5 cm above left eyebrow). The fall was not witnessed, and first aid was provided to stop bleeding. No headache or dizziness, pupils equal and reactive to light. The resident was on Eliquis (anticoagulant) and at her baseline. A telephone order was given for neurological checks, body audits, steri-strip to [MEDICAL CONDITION], [MEDICATION NAME] and dressing, and to follow-up with primary physician for consideration for CT scan (computed tomography) of head. A nursing progress note dated 12/29/19 at 6:48 PM, written by a

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Registered Nurse (RN) documented the resident fell forward onto his/her forehead and had 2.5-centimeter (cm) laceration over the left eyebrow that bled profusely and had an ice pack in place. The incident occurred at 6:10 PM. The note documented the resident had previous falls and was transferred the hospital status [REDACTED]. The Nurse Practitioner Tele-Health Progress Note dated 12/29/19 at 8:37 PM, documented the resident was transferred to the emergency room for CT scan of head secondary to decreasing consciousness. The Change in Condition form (hospital transfer form) dated 12/29/19, written by the RN, documented the resident fell forward onto forehead, 2.5-centimeter laceration over the left eyebrow, bled profusely, had ice pack in place. The resident took Eliquis (anticoagulant-blood thinner), left pupil 1 millimeter (mm), right pupil 4 mm. The resident had decreased consciousness and increased or new onset weakness. The resident was transferred to the hospital. A review of the medical record did not include documentation that the facility investigated the the resident's fall with injury and decreased consciousness on 12/29/19 incident to rule out abuse, neglect or mistreatment. During an interview on 3/03/20 at 11:15 PM, the Administrator stated they were unable to find documentation that an I&A or investigation was completed for the resident's fall on 12/29/19. An I&A or investigation should have been completed. During an interview on 3/03/20 at 12:55 PM, Certified Nurse Aide (CNA) #1 stated the resident used to get up every day and sit in his/her chair, but not much anymore because of staffing. He/She will push his/her call bell and wait for help when he/she needs to get up, but if he/she had to go to the bathroom, he/she would get up by himself/herself if the call bell was not answered timely. During an interview on 03/04/20 at 11:08 AM, the Licensed Practical Nurse Manager (LPNM) #1 stated the medication nurses were responsible for overseeing resident care, when they were short staffed there were some residents who would stay in bed. She stated some residents needed to be watched closely and when they were short of staff. Resident #105 will get himself/herself up without assistance if he/she had to go to the bathroom. On 12/29/19, the Registered Nurse Supervisor was also working as a medication nurse and she only completed the SBAR Note (an assessment tool) for the resident to be transferred to the hospital. She stated an incident report and/or investigation was never completed for the fall on 12/29/19 and there should have been an incident report and/or investigation started on the day of the fall. 10 NYCRR 415.4(b)(3)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews during a recertification survey, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain personal hygiene for 2 (Resident #'s 16 and 45) of 3 residents and 1 (Resident #49) of 1 unsampled resident reviewed for Activities of Daily Living (ADLs). Specifically, for Resident #'s 16, 45 and #49, the facility did not ensure the residents, who could not independently carry out activities of daily living, received incontinence care to maintain good personal hygiene and reduce their care planned risk for impaired skin integrity. This is evidenced by: The Policy and Procedure (P&P) titled ADL- Personal Hygiene last revised 10/2019, documented peri-care would be given with each incontinence episode, with AM/PM care and shower day. The P&P documented toileting/incontinence care for a resident would occur every 2-4 hours or as needed for each individual resident per care plan and Kardex (care card). Resident #16: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 11/4/19, documented the resident had moderately impaired cognition, could usually understand others and could make self understood. The MDS documented the resident was always incontinent of bowel and bladder. During an observation on 03/01/20 at 10:28 AM, the resident was lying in bed wearing a hospital gown. A strong odor of urine was noted coming from the resident's room and the odor was stronger when standing next to the resident's bed. Based on continued observation, the resident did not receive incontinence care as of 12:08 PM and the strong smell of urine remained. The Comprehensive Care Plan (CCP) for Activities of Daily Living, last revised 1/14/20, documented the resident required a total mechanical lift (Hoyer) for transfers, was totally dependent with 2 staff for toilet use and was totally dependent with 1 staff for personal hygiene. The CCP for Risk of Impaired Skin Integrity related to Incontinence, last revised 1/14/20, documented to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets as needed. The Certified Nursing Assistant (CNA) care card, with a print date of 3/5/20, documented the resident required a total mechanical lift for transfers; was totally dependent with 2 staff for toilet use and was totally dependent with 1 staff for personal hygiene. CNA documentation on 3/1/20 at 3:37 AM and 7:54 PM, revealed the resident was toileted and personal hygiene was provided. The CNA documentation did not include that the resident was toileted or that personal hygiene was provided on the day shift on 3/1/20. During a medical record review from 2/19/20 - 3/3/20, documentation did not include that the resident received frequent incontinence care as documented on the care plan and did not include documentation of incontinence care every 2-4 hours or as needed per the facility policy. During an interview on 3/3/20 at 1:14 PM, CNA #1 stated she started her shift at 7:00 AM and she helped care for the resident on Sunday 3/1/20, but not until lunchtime around 12:00 PM (7:00 AM to 12:00 PM = 5 hours). She stated the resident was probably last changed on night shift and was not changed again until just before lunchtime on Sunday. She stated she and another CNA provided the resident with care and washed the resident up for the first time on the day shift around lunchtime on Sunday. She stated Sunday morning there were 2 CNAs on the day shift and the resident did not receive care timely. She stated the resident would normally be washed up earlier in the morning, but there was not enough staff to get all the residents washed and up Sunday morning. During an interview on 3/4/20 at 10:30 AM, the Director of Nursing (DON) stated she was aware the resident was dependent for all ADL care and although staffing was a challenge in the facility and even more so on the weekends, she had not had staff come to her saying they could not get their assignments completed timely. She stated it was unacceptable for a resident to not receive morning ADL care from approximately 7:00 AM to after 12:00 PM. She stated the 2 CNAs on the unit and the 2 Licensed Practical Nurses (LPNs) should have teamed up together to provide the care timely. She stated supervision and oversight of the CNAs was the responsibility of the unit managers on the day shift and on off hours shifts and weekends was the responsibility of the Licensed Practical Nurse (LPN) charge nurse to ensure residents were being properly cared for. She stated the nurses should be overseeing and assisting to ensure incontinence care was provided. During an interview on 3/4/20 at 12:55 PM, LPN Unit Manager #1 stated it was not acceptable for the resident to go from approximately 7:00 AM to after 12:00 PM without receiving morning care. She stated it was the facility's policy to check and change every resident every 2-4 hours and it was expected that the 2 CNAs on the unit would complete the resident care with the help of the 2 LPNs on the unit. She stated it was more often than not that there were only 2 CNAs working on the unit, especially the last couple of months and weekends tended to be even worse. She stated she was aware that residents went more than 4 hours without receiving incontinence care and when she asked the CNAs why care was not provided, the staff responded they documented the Activity Did Not Occur because there were only 2 CNAs and they did not get around to changing all the residents. During an interview on 3/5/20 at 9:17 AM, the Administrator stated the expectation was that every resident was checked every 2 hours at a minimum and if resident was found to be incontinent or soiled, the staff would take care of them at that time. She stated staffing levels were not an excuse for care not to be provided. She stated if care was not given due to resident refusal then it should be documented the resident refused, otherwise the care should be provided as documented on the care plan and care card. Resident #45: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 11/17/19, documented the resident had moderately impaired cognition, could rarely/never understand others and could rarely/never make self understood. The MDS documented the resident was frequently incontinent of bowel and bladder. During an observation on 3/1/20 from 10:37 AM to 12:11 PM, the resident was in bed wearing a hospital gown and did not receive morning ADL care during that time. At approximately 12:15 PM, CNA #5 provided morning care to the resident. The resident remained in bed and was not assisted out of bed for lunch. The CCP for Activities of Daily Living, last revised 12/4/19, documented the resident required a total mechanical lift for transfers; was totally dependent with 2 staff for bathing and was totally dependent with 1 staff for personal hygiene. The CCP for Risk of Impaired Skin Integrity, last revised 12/4/19, documented the resident was to receive incontinence care every 2-4 hours as needed and to encourage to turn and reposition every 2-4 hours. The CNA care card, with a print date of 3/3/20, documented the resident required a total mechanical lift for transfers; was totally dependent with 2 staff for toilet use and was totally dependent with 1 staff for personal hygiene. The care card documented the resident was to receive incontinence care every 2-4 hours as needed. CNA documentation on 3/1/20 at 1:28 PM, documented the resident was bathed (washed up) and personal hygiene was provided. CNA documentation at 3:41 AM and 7:54 PM documented bathing was not

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) applicable. CNA documentation at 3:41 AM, documented personal hygiene was not applicable and at 7:55 PM personal hygiene was provided. During a medical record review from 2/19/20 - 3/3/20, documentation did not include that the resident received incontinence care every 2-4 hours as needed as per the facility policy and comprehensive care plan. During an interview on 3/1/20 at 10:15AM, CNA #1 stated there were at least 6 residents on the unit who were not provided with personal care on the day shift, including Resident #45. She stated there were 2 CNAs on the unit, herself and another CNA. She stated the resident should already be out of bed but was not due to not having staffing on the unit. During an interview on 03/01/20 at 12:28 PM, CNA #5 stated she was called into work and arrived at the facility between 11:30 AM and 12:00 PM. She stated she provided the resident with his/her morning care at approximately 12:15 PM. She stated the resident was incontinent of urine, was wet, and needed to be changed. She stated the resident was supposed to be changed every 2 hours and did not know when the resident was last changed. During a subsequent interview on 3/1/20 at 12:31 PM, CNA #1 stated she started her shift at 7:00 AM and there were 2 CNAs on the unit, including her, until about 12:00 PM when CNA #5 was assigned to the unit. She stated she had been working with the other CNA to try to provide care to all the residents on the unit, but personal care and incontinence care had not been provided to Resident #45. She stated the resident had not received care since the night shift, which was before 7:00 AM, until CNA #5 provided care after 12:00 PM. She stated CNA #5 was the only staff to have provided the resident with care so far on the day shift. She stated additional staff were called in to help, but that was not the norm. During an interview on 3/4/20 at 10:30 AM, the DON stated she was aware the resident was dependent for all care and stated it was unacceptable for morning care, including incontinence care, not to be provided by 10:30 AM. She stated when there were 2 CNAs on the unit, the 2 LPNs should also help to provide the residents with care. During an interview on 3/4/20 at 1:00 PM, LPN Unit Manager #1 stated the resident should have been care for, up and out of bed by 10:30 AM. She stated the facility policy was for every resident to be checked and changed every 2-4 hours. During an interview on 3/5/20 at 9:17 AM, the Administrator stated the expectation was that every resident was checked every 2 hours at a minimum and if the resident was found to be incontinent or soiled, the staff would take care of them at that time. She stated the resident should have been washed and transferred out of bed and should have not have in bed from approximately 7:00 AM to 12:00 PM. She stated staffing levels were not an excuse for care not to be provided. She stated if care was not given due to resident refusal then it should be documented the resident refused, otherwise the care should be provided as documented on the care plan and care card. Resident #49: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment) dated 12/2/19, documented the resident had severe cognitive impairment and was usually able to understand others and make self understood. During an observation on 3/01/20 at 1:32 PM, Resident #49 was in a semi-sitting position in her bed, wearing a hospital gown and covered with a sheet. A strong odor of urine was noticeable upon entering the room and at the resident's bedside. The resident was observed again at 2:30 PM, lying in the same area of the bed and the urine odor was still present. The Comprehensive Care Plan (CCP) for: -Activities of Daily Living (ADL) dated 3/8/18, documented the resident required extensive assistance of one person for transfers, and was totally dependent on one staff for toileting, bathing, and dressing. -Risk for Impaired Skin Integrity dated 3/8/18, documented the resident had fragile skin and to apply protective and/or preventative skin care. -Bladder incontinence dated 9/4/18, documented apply incontinence devices; extra-large brief. -Bowel Incontinence dated 11/27/18, documented to check the resident every 2-4 hours and provide peri-care after each incontinence episode. The Certified Nurse Aide (CNA) care card dated 3/3/20, documented to encourage the resident to get out of bed during waking hours to prevent skin breakdown, provide peri-care after each incontinent episode, and to use an extra-large brief. The CNA documentation dated 3/01/20, documented the resident consumed her lunch meal. It did not include documentation the resident received incontinence care, and bathing or personal hygiene on the day shift (7:00 AM - 3:00 PM). During an interview on 3/01/20 at 1:32 PM, CNA #1 stated Resident #49 received incontinence care that morning, but the resident had not received incontinence care after that. She stated there were only 2 CNAs working that day and more recently, the usual number of CNAs was 2 on the day and 2 CNAs on evening shift and 1-2 CNAs on the night shift. During an interview on 3/03/20 at 12:55 PM, CNA #1 stated when the unit was short staffed, they staff had to leave some of the residents in bed. She stated Resident #49 sometimes yells out with care so the staff would leave her in bed when they were short. She stated no one followed up with CNAs to see why certain residents were left in bed or checked in with the staff to see who had or had not received care. The CNAs were told to document even if a resident does not get done. She stated on the weekends the CNAs did not have the time to document everything. During an interview on 3/04/20 at 9:50 AM, LPN #5 stated Resident #49 liked to stay in bed if she could, so the staff would leave her in bed when they were short staffed. She stated the resident should not be left in bed for three days in a row and stated she told the staff even if they were short staffed, she would help them. She stated every resident was at risk for problems when the facility was short staffed. During an interview on 3/04/20 at 10:00 AM, LPN #8 stated Resident #49 was left in bed sometimes, but she should be out of bed every day. The LPN stated there were not enough CNAs to get all the resident care completed done, and the nurses must help with care. 10 NYCRR 415.12(a)(3)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews during the recertification survey, the facility did not ensure each resident received adequate supervision for 2 (Resident #45 and #272) of 4 sampled residents and 1 (Resident #61) of 1 unsampled residents reviewed for accidents hazards. Specifically, for Resident #'s 45 and 61, the facility did not ensure the residents, with the [DIAGNOSES REDACTED].#272, the facility did not ensure the resident, who was a high fall risk and had 6 falls in the month of February, had bilateral floor mats in place next to the his/her bed. This was evidenced by: Resident #45: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 11/17/19, documented the resident had moderately impaired cognition, could rarely/never understand others and could rarely/never make self understood. The resident's comprehensive care plan documented the resident was to be up for all meals and was to eat meals in the dining room where he/she could be assisted. The Policy and Procedure (P&P) titled Modified Food Consistency Policy last revised 2/2018, documented individuals with observed indicators of dysphagia (coughing, choking, delayed swallow, pocketing food, inability to manipulate food in the mouth, wet, gurgly voice, etc.) would be referred to the Speech Language Pathologist (SLP) for evaluation of dysphagia and the SLP would work with the Registered Dietitian or designee to make appropriate recommendations for proper food and fluid consistency. During an observation on 3/1/20 at 12:50 PM, the resident was sitting in bed eating lunch. A Certified Nursing Assistant (CNA) was standing at the bedside. The Comprehensive Care Plans for: -Activities of Daily Living, last revised 12/4/19, documented the resident required limited assistance with eating, to encourage self-feeding, and was to be up for all meals. -Dysphagia, last revised 12/4/19, documented the resident was to sit upright for all meals at least 60-90 degrees and was to eat in the assist room for meals. The CNA Kardex, print date 3/3/19, documented the resident required limited assistance with eating, to encourage self-feeding and was to be up for all meals and documented the resident was to sit upright for all meals at least 60-90 degrees and was to eat in the assist room for meals. A Physician order [REDACTED]. A Speech Therapy evaluation and Plan of Treatment dated 6/3/15, documented due to the documented physical impairments and associated functional deficits, the patient was at risk for; falls, aspiration, and pneumonia. An Occupational Therapy Screen dated 1/29/20, documented the resident was a limited assist for feeding with built up utensils and covered mugs. The medical record did not include documentation that the resident declined to get out of bed on 3/1/20. During an interview on 3/3/20 at 12:33 PM, CNA #4 stated she cared for the resident on the evenings of 2/29/20 and 3/1/20 and did not get the resident out of bed for dinner on Saturday or Sunday. She stated the resident ate dinner by herself in bed those 2 evenings and it was not unusual for the resident to eat alone in her room in bed. She stated the resident was a 2 assist to transfer out of bed and when there was not enough staff or time to get all of the residents out of bed for dinner, the resident often stayed in bed for dinner. During an interview on 3/3/20 at 10:49 AM, CNA #2 stated the resident was supposed to be up for all 3 meals. She stated she knew that the evening staff did not get the resident up for dinner because she had recently helped on the evening shift. She stated when staff did not get the resident up for dinner, the resident ate in her room. CNA #2 was aware that the resident was not supposed to eat in her room at any time of the day and stated the reason was because the resident choked a lot and she needed to be supervised in the dining room. She stated it was not safe for her to eat in her room and she needed assistance to eat. She stated her care card documented the resident was to be up for all 3 meals, which she stated meant for the resident to be out of bed for all meals. She stated she helped on the evening shift

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) last Monday and Resident #45 and several other 2-assist residents were not gotten up for dinner. She stated the evening shift faced a lot of the same problems as the day shift. They did not have enough staff to care for the residents. During an interview on 03/03/20 at 1:14 PM, CNA #1 stated the resident ate breakfast in her room alone on Sunday, 3/1/20. She stated the resident did not need her assistance to eat and there were only 2 CNAs on the unit, and they could not get every resident up in time for breakfast, so the resident had breakfast in her room, in bed, unsupervised and unassisted. She stated the resident was changed around 12:30 PM after more staff where called into work and the resident was still not up for lunch. She stated the resident ate breakfast and lunch in bed on 3/1/20. During an interview on 3/4/20 at 9:38 AM, the Speech Language Pathologist (SLP) stated the resident was not supposed to eat in his/her room. She stated safest way for the resident to eat was to be out of bed and supervised. She stated the resident had a [DIAGNOSES REDACTED]. She stated the resident should be out of bed to eat for breakfast, lunch, and dinner. She stated her recommendation was for the resident to be out of bed for all meals for safety. She stated she would consider it an accident hazard for the resident to be eating in the bed, and an even bigger accident hazard if the resident was left unsupervised. She stated the resident was at risk for aspiration and choking. The SLP stated she believed it when staff reported to the surveyor that the resident was left in bed for meals unsupervised because there was a lack of staff to get residents out of bed for meals. She stated she saw that staffing was an issue, but also thought it was facility policy that any resident with dysphagia received supervision at meals. She stated she documented on the resident's care plan when a resident needed to be out of bed and supervised for meals, so all staff are aware. During an interview on 3/4/20 at 10:30 AM, the Acting Director of Nursing (DON) stated if the care plan documented the resident was to be up for all meals, then the expectation was that the resident was out of bed and up for all meals, unless it was documented that the resident declined to get out of bed. She stated it was not acceptable that the resident remained in bed on Sunday for meals because of short staff. She stated she did not necessarily see the resident eating in bed unsupervised as an accident hazard, but more as the staff not following the resident's plan of care. She stated the staff should look at the resident's care card before providing care and follow what was documented on the care card. During a subsequent interview on 3/4/20 at 11:15 AM, CNA #4 stated she knew the resident was supposed to be for meals, but they did not have enough staff to get everyone out of bed, so the resident ended up eating in her room alone. She stated the resident was a full mechanical lift which needed to staff members to get her out of bed. She stated the resident fed herself and no one was in the room with her because there was not enough staff to supervise every resident that was eating in their room that needed supervision. She stated the resident was supposed to eat in the blue room, which is the dining room where residents who needed assistance ate. She stated she was not sure why the recommendation was for the resident to be in the blue room, except probably for choking reasons. She stated the biggest issue for the resident was that he/she tended to spill her food and drinks when the top cap off the sippy cups. During an interview on 3/4/20 at 12:55 PM, LPN Unit Manager #1 stated she was never made aware that the resident ate in her room unsupervised. She stated the resident had a [DIAGNOSES REDACTED]. She stated resident could eat in their bed if they were supervised, but it should be reported to the nurse on the unit if the resident was going to be supervised while eating in bed. She was not aware if a nurse was notified that a resident ate in bed on 3/1/20. During an interview on 3/5/20 at 9:17 AM, the Administrator stated she expected the resident's care card to be followed regardless of the amount of staff on the unit and that it was not acceptable for the resident to be eating meals in bed. She stated there was a potential for an accident hazard especially if the resident was eating in his/her bed unsupervised. She stated she was not aware that residents were not getting up for meals due to staffing. Resident #272: The resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The MDS dated [DATE], documented the resident was cognitively intact, could be understood, and could understand others. The P&P titled Falls Management and Prevention dated 11/2019, documented the interdisciplinary team identified and implemented appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independent. During an observation on 3/2/20 at 8:32 AM, the resident was in his/her bed. Floor mats were not placed on either side of the resident's bed. During an observation on 3/2/20 at 1:52 PM, the resident was in his/her bed. Floor mats were not placed on either side of the resident's bed. During an observation on 3/2/20 at 2:44 PM, the resident was in his/her bed. Floor mats were not placed on either side of the resident's bed. CNA #14 placed a floor mat beside the left side of the bed. There was no other floor mat in the room to place at the right side of the resident's bed. During a record review on 03/02/20, Accident/Incident reports for Feb. 2020 documented the resident fell on ,[DATE], 2/12, 2/14, 2/19, 2/21, and 2/28/20. There were no apparent injuries from the falls, however, the resident required a [MEDICATION NAME] (mid back) spine x-ray following the 2/4/20 fall due to complaints of back pain. Nursing Progress notes dated 2/4, 2/12, 2/14, 2/19, 2/21, and 2/28/20 documented the resident's falls, and RN assessment was completed, and the medical provider was notified. The Comprehensive Care Plan (CCP) for Falls revised on 2/10/2020, documented the resident was to have floor mats at all times due to the resident had actual falls r/t incontinence, psychoactive drug use, desire to complete tasks independently, impulsive behaviors, poor safety awareness, and decline in functional mobility. The care plan documented the resident was to have floor mats at all times. The CNA Kardex on the inside of his/her closet door documented the resident was to have floor mats when in bed. During an interview on 3/2/20 at 2:39 PM, CNA #14 stated she was aware the resident had frequent falls. She stated the CNA Kardexes were on the inside of residents' closet doors. She looked at the Kardex of residents she was not familiar with every other day because sometimes the care changed. She stated for residents she knew, she'd review the Kardexes from time to time in case something had changed. The resident was supposed to have floor mats when she got out of bed and when she went back to bed. The CNA stated the mats were placed on the floor at both sides of his/her bed whenever he/she was in bed. His/her bed was to be in the lowest position and the call light within reach. Following this interview, the Surveyor went with CNA #14 to the resident's room at 2:44 PM (see observation documentation above). During an interview on 3/2/20 at 2:48 PM, Licensed Practical Nurse (LPN) #6 stated the resident was supposed to have mats on the floor beside both sides of his/her bed. Res. non-compliant with req. help to go back to bed. She stated she did room checks of her residents during the day to ensure their call lights were within reach, and other safety measures in place, such as floor mats were down. She stated she did not notice the floor mats were not on the floor while the resident was in bed. During an interview on 3/2/20 at 2:59 PM, Registered Nurse (the unit manager) #5, stated safety rounds were completed at the change of every shift. The CNAs were supposed to actually see each resident and check to ensure their call lights were within reach, their beds were in the lowest position, and if the resident had floor mats, they were in place. There was no system in place to document safety rounds were completed. She was not aware the resident's mats were not at the bedside until she was notified by LPN #6 when it was brought to her attention by the Surveyor. She stated CNAs were supposed to look at the care cards each time they went into a resident's room to provide care. She also had a notebook at the nurses' station that documented current changes made to care cards that the CNAs were supposed to review. During an interview on 3/3/2020 at 9:56, the Acting Director of Nursing (DON) stated CNAs were expected to look at resident's care cards prior to starting care. Safety rounds were done at change of shift and at least every 2 hours. The Charge Nurse made sure the rounds were being done. The CNAs did the rounds. She did not believe the safety rounds were documented. When making safety rounds, the CNAs were to look for positioning of the resident, they had call bells in reach, look for anything on the floor that would pose a tripping hazard, ensure floor mats were down, and any safety devices. Whenever a resident was bed and were care planned for floor mats, the floor mats were to be on the floor. 10NYCRR 415.12(h)(1)
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review during the recertification survey, the facility did not ensure provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility did not ensure that the minimum staffing levels for Certified Nursing Assistants was met on 14 out of 14 days from 2/17/20 through 3/1/20; the facility did not ensure there was sufficient CNA staff on 3/1/20 to provide 6 (Resident #'s 16, 36, 40, 45, 77, and #320) of 20 residents on A Wing Side-1 with personal hygiene care in a timely manner and in accordance with each resident's care plan; For Resident #49, on A Wing Side-2, the facility did not ensure the resident received incontinence care in accordance with the resident's care plan; and for Resident #'s 45 and 61, with the [DIAGNOSES REDACTED].#105, the facility did not ensure resident that have a risk to falls received adequate supervision and assistance to prevent falls. This is

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	335331	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANVILLE CENTER FOR REHABILITATION AND NURSING	17 MADISON STREET GRANVILLE, NY 12832

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) evidenced by: Finding #1: The facility did not ensure that the minimum staffing levels for Certified Nursing Assistants (CNA) was met on 14 out of 14 calendar days from 2/17/20 through 3/1/20. Upon entrance to the facility on [DATE] at 10:00 AM, there were 117 residents in the facility. The facility's total capacity was 122. The Facility Assessment, last updated 2/24/20, documented the staffing levels for CNA's was 12 on the day shift, 12 on the evening shift and 6 on the night shift. A review of the Daily Staffing Sheets for the 14 days from 2/17/20 through 3/1/20, facility's staffing levels for CNAs, were not met according to their Facility Assessment on 14 of 14-day shifts, 14 of 14 evening shifts, and 10 of 14 nights shifts. The Daily Staffing Sheets documented: 02/17/2020 - 6 CNAs on the day shift, 6.5 CNAs on the evening shift, 02/18/2020 - 7 CNAs on the day shift, 6.5 CNAs on the evening shift, 6 (4 after 12:30 AM) CNAs on the night shift 02/19/2020 - 6.5 CNAs on the day shift, 5 CNAs on the evening shift, 6 (3 after 3:00 AM) CNAs on the night shift 02/20/2020- 7 (5 after 11:00 AM) CNAs on the day shift, 5 CNAs on the evening shift, 02/21/ - 6 CNAs on the day shift, 5 CNAs on the evening shift, 5 CNAs on the night shift 02/22/2020 - 6 CNAs on the day shift, 6 CNAs on the evening shift, 5.5 CNAs on the night shift 02/23/2020 - 7.5 CNAs on the day shift, 6 CNAs on the evening shift, 02/24/2020 - 9.5 CNAs on the day shift, 6 CNAs on the evening shift, 02/25/2020 - 10 CNAs on the day shift, 7 CNAs on the evening shift, 5 CNAs on the night shift 02/26/2020 - 9 (7 after 11:00 am) CNAs on the day shift, 6 CNAs on the evening shift, 4 CNAs on the night shift 02/27/2020 - 7 CNAs on the day shift, 4.5 CNAs on the evening shift, 5 CNAs on the night shift 02/28/2020 - 6 CNAs on the day shift, 6.5 CNAs on the evening shift, 6 (4 after 3:00 AM) CNAs on the night shift 02/29/2020 - 7 CNAs on the day shift, 6 CNAs on the evening shift, 4 CNAs on the night shift 03/01/2020 - 7 (10 after 11:00 AM) CNAs on the day shift, 7 (6 after 7:00 PM) CNAs on the evening shift, 5 CNAs on the night shift During an interview on 3/4/20 at 10:44 AM, the Staffing Coordinator stated Corporate's guidance to her was that the maximum staffing levels for CNA's was 12 on the day shift, 9 on the evening shift and 6 on the night shift. She stated she could not staff the facility any higher than those staffing numbers. She stated she tried to schedule 12, 9, 6, but recently she had not been able to schedule those staffing levels. She stated the day and evening shifts had been running short. She stated she made the Administrator and Corporate aware and it was reported every morning in morning meeting what her daily staffing was and what her needs were. She stated the facility was not fully staffed Sunday, 3/1/20 and staff were called into work when the Survey team entered. She stated the facility used agency staff for CNAs and LPNs and the facility offered incentives to the staff when the schedule was not full. During an interview on 3/5/20 at 9:17 AM, the Administrator stated despite the review of the Facility Assessment on 2/24/20, the assessment should have documented staffing levels for CNAs as 12 CNAs on days, 9 CNAs on evenings, and 6 CNAs on nights. She stated the facility was not meeting those levels as staff have recently left and it was difficult to get staff in that area. She stated the facility relied heavily on agency staff. She stated Corporate was aware of the staffing issues at the facility. The facility was trying to work with agencies for staffing, offering sign-on bonuses and incentives. She stated in the meantime, the facility was utilizing ancillary staff in the facility to assist as much as possible within their scope of practice. Finding #2: The facility did not ensure there was sufficient CNA staff on 3/1/20 to provide 6 (Resident #'s 16, 36, 40, 45, 77, and #320) of 20 residents on A Wing Side-1 with personal care (hygiene) in a timely manner and in accordance with each resident's care plan. Resident #49 on A Wing Side-2 did not receive incontinence care in accordance with the resident's care plan. Refer to F-Tag 677 The Policy and Procedure (P&P) titled ADL- Personal Hygiene last revised 10/2019, documented peri-care would be given with each incontinence episode, with AM/PM care and shower day. The P&P documented toileting/incontinence care for a resident would occur every 2-4 hours or as needed for each individual resident per care plan and Kardex (care card). Resident #16: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 11/4/19, documented the resident had moderately impaired cognition, could usually understand others and could make self-understood. The MDS documented the resident was always incontinent of bowel and bladder. During an observation on 3/01/20 at 10:38 AM, Resident #16 was in bed in a hospital gown, and there was a very strong smell of urine coming from his/her room. The Comprehensive Care Plan (CCP) for Activities of Daily Living, last revised 1/14/20, documented the resident required a total mechanical lift (Hoyer) for transfers; was totally dependent with 2 staff for toilet use and was totally dependent with 1 staff for personal hygiene. The CCP for Impaired Skin Integrity related to incontinence, last revised 1/14/20, documented to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets as needed. During an interview on 3/1/20 at 10:38 AM, CNA #1 stated the resident was in bed per his/her preference but had not been provided with morning care. Resident #36: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 11/22/19, documented the resident was cognitively intact, could understand and was understood by others. The MDS documented the resident was an extensive assist of one for dressing and toilet use. During an observation on 3/01/20 at 10:37 AM, Resident #36 was in his/her room, sitting in a wheelchair wearing a hospital gown. There was a very strong smell of urine coming from the resident. He/She stated staff had gotten him/her up for breakfast, but that he/she had not been washed up for the day. The CCP for Activities of Daily Living, last revised 2/5/20, documented the resident required extensive assist of one staff member for dressing and toilet use. The CCP for Bladder Incontinence, last revised 2/5/20, documented to apply pull-ups, monitor signs and symptoms of urinary tract infections including urinary frequency and foul-smelling urine, and to document and report any changes in incontinence to the physician as needed. During an interview on 3/1/20 at 11:39 AM, Resident #36 stated there were only 2 CNAs for 40 people. And he/she did not get washed up and dressed by staff until after 10:45 AM. The resident liked to get washed and dressed earlier than 10:45 AM in the morning and always ate breakfast in his/her room, but this morning he/she ate breakfast in a hospital gown and before he/she had received morning care. During additional observations on 3/1/20: 10:23 AM, Resident #40 was in bed and stated he/she had not received assistance for morning care and that he/she needed it. 10:28 AM, Resident #320 was out of bed and had placed himself/herself on the toilet in his/her room. The resident stated he/she needed assistance to get cleaned up because he/she had to put himself/herself on the toilet. There was a very strong odor of a bowel movement. 10:37 AM, Resident #77 was in a hospital gown lying in bed. Supplies and clean linen to provide morning care were on the resident's bedside stand. He stated he had not been washed up. 10:37 AM, Resident #45 was in bed in a hospital gown. Interviews: During an interview on 3/1/20 at 10:15 AM, CNA #1 stated there were at least 6 (Resident #'s 16, 36, 40, 45, 77, and #320) of 20 residents on A Wing Side 1 who had not been provided with morning personal care on the day shift that started at 7:00 AM. She stated there were 2 CNAs on the unit, herself and another CNA. She stated the residents should be washed and up, but were not, due to staffing. During an interview on 03/01/20 at 12:28 PM, CNA #5 stated she was called into work and arrived at the facility between 11:30 AM and 12:00 PM to work on A Wing. She stated the residents were supposed to be changed every 2 hours. She did not know when the residents were last changed, but she was called in to work to help. During an interview on 3/2/20 at 9:46 AM, the Resident Council (6 out of 6 residents who attended) stated there was not enough staff working in the facility on a regular basis. The 5 members of the Council stated that while the lack of staff was not necessarily an issue for them to get up and to get assistance because they could speak for themselves, they stated it was an issue for the residents who could not speak for themselves. The Council stated most of the residents who stayed in bed all day and who were not supposed to stay in bed also could not speak for themselves. The Council stated the residents were left in bed all day because there was not enough staff to get them up. During the Resident Council Interview, Resident #97, stated she was independent and could do things for herself, but her roommate (Resident #36) was not independent and often had to wait long periods of time for staff to come help. She stated her roommate often waited up to an hour and half for assistance after putting the call bell on. She stated her roommate often needed to be changed because she was wet with urine, but had a difficult time getting staff to help her timely when there was not enough staff on the unit. During an interview on 3/4/20 at 10:30 AM, the Director of Nursing (DON) stated she was aware staffing was a challenge in the facility and even more so on the weekends. She stated she had not had staff come to her saying they could not get their assignments completed timely and it was unacceptable for morning care, including incontinence care, not to be provided by 10:30 AM. She stated the 2 CNAs on the unit and the 2 Licensed Practical Nurses (LPNs) should have teamed up together to provide the care timely. She stated supervision and oversight of the CNAs was the responsibility of the unit managers on the day shift and on off hours shifts and weekends was the responsibility of the LPN charge nurse to ensure residents were being properly cared. She stated the nurses should be overseeing and assisting to ensure incontinence care was provided. During an interview on 3/5/20 at 9:17 AM, the Administrator stated the expectation was that every resident was checked every 2 hours at a minimum and if resident was found to be incontinent or soiled, the staff would take care of them at that time. She stated staffing levels were not an excuse for care not to be provided. She stated if care was not given due to resident refusal then it should be documented the resident refused, otherwise the care should be provided as documented on the care plan and care card. Resident #49: The resident was admitted to the facility

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment) dated 12/2/19, documented the resident had severe cognitive impairment, was usually able to understand others and make him/herself understood and was always incontinent of urine and bowel. During an observation on 03/01/20 01:32 PM, Resident #49 was in a semi-sitting position in her bed, wearing a hospital gown and covered with a sheet. A strong odor of urine was noticeable upon entering the room and at the resident bedside. The resident was observed again at 02:30 PM, lying in the same area of the bed. The odor of urine was still present. The Comprehensive Care Plan (CCP) titled Activities of Daily Living (ADL) dated 3/8/18, documented the resident required extensive assistance of one person for transfers, and was totally dependent on one staff for toileting, bathing, and dressing. The CCP titled Bowel Incontinence and dated 11/27/18, documented check every 2-4 hours, provide peri-care after each incontinence episode. The CCP titled Bladder incontinence and dated 9/4/18 documented apply incontinence devices, extra-large brief. The Certified Nurse Aide (CNA) care card dated 3/3/20, documented encourage to get out of bed during waking hours to prevent skin breakdown, provide peri-care after each incontinent episode, extra-large brief. The CNA documentation dated 03/01/20, documented the resident consumed her lunch meal. There was no documentation that the resident received incontinence care, bathing or personal hygiene on the day shift. During an interview on 03/01/20 at 01:32 PM, CNA #1 stated Resident #49 had received incontinence care that morning, but she had not received care after that. There were only 2 CNAs working that day. The usual number of CNAs is 2 on the day and evening shifts and 1-2 CNAs on the night shift. When there are only two CNAs the residents receive care once and they do not get changed again on that shift. During an interview on 03/03/20 at 12:55 PM, CNA #1 stated when we are short staffed, we leave some of the residents in bed. Resident #49 sometimes screams with care so we will leave her in when we are short. No one follows up with CNAs to see why certain residents are in bed or who had or had not received care. The CNAs are told to document even if a resident does not get done. On the weekends we do not have the time to document everything. During an interview on 03/04/20 at 10:00 AM LPN #8 stated the Resident #49 is left in bed sometimes, but she should be out of bed every day. There are not enough CNAs to get all the residents done, the nurses help when they can. During an interview on 03/04/20 at 10:23 AM CNA #8 stated Sunday 3/1/20, there were only two CNAs and we worked as a team. Each resident gets one time of care and there is no time to document. It was impossible to go back to a resident to turn and position or change again. Working with two CNAs happens a lot lately and showers do not get done either. During an interview on 03/04/20 at 10:50 AM, CNA #3 stated working a unit with two CNAs happens often. No one monitors or asks the CNAs which residents did or did not receive care. When there is only two CNAs on a shift, each resident will only get one session of care, there is no further care, turn and position and little to no toileting. During an interview on 03/04/20 at 11:08 AM, the Licensed Practical Nurse Manager (LPNM) stated the medication nurses were responsible for overseeing resident care, when they were short staffed there were some residents who would stay in bed. She stated some of the residents needed to be watched closely and when they were short of staff it could be scary. She did not know that each resident received only one session of care when there were only two CNAs on a unit. There are certain residents who will stay in bed when staffing is short. Resident #49 should get up during the day and if not, she should be turned and positioned throughout the shift. We just started looking at the CNA documentation for completion, we do not look at the actual care each resident received. No one was looking to see what was done and not done when a shift was short staffed. Finding #3: Refer to F-Tag 689 For Resident #'s 45 and 61, the facility did not ensure the residents, with the [DIAGNOSES REDACTED]. Resident #45: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 11/17/19, documented the resident had moderately impaired cognition, could rarely/never understands others and could rarely/never make self-understood. During an observation on 3/01/20 at 10:37 AM, Resident #45 was in bed in a hospital gown and was supposed have been up for breakfast in the assist dining room (the dining area where residents who required assistance to eat ate their meals) according to CNA #1. The Comprehensive Care Plans for: -Activities of Daily Living, last revised 12/4/19, documented the resident required limited assistance with eating and was to be up for all meals. -Dysphagia, last revised 12/4/19, documented the resident was to sit upright for all meals at least 60-90 degrees and was to eat in the assist room for meals. Resident #61: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 12/23/19 documented the resident had severely impaired cognition, could sometimes understand others and could sometimes make self-understood. The CCPs for: -Activities of Daily Living, last revised 10/16/19, documented the resident required limited assistance with eating, out of bed for all meals and to supervise and assist as needed and was a total mechanical lift for transfers. -Dysphagia, last revised 10/16/19, documented to encourage the resident to remain as upright as possible during meals. Interviews: During an interview on 3/3/20 at 12:33 PM, CNA #4 stated it was not unusual for residents to eat alone in their rooms in bed if the resident was a 2 assist to transfer out of bed. She stated when there was not enough staff or time to get all of the residents out of bed for dinner, the 2 assist residents often stayed in bed for dinner even when they were care planned to be up out of bed for meals. During an interview on 3/3/20 at 10:49 AM, CNA #2 stated she knew that the evening staff did not get residents up for dinner because she had recently helped on the evening shift. She stated when staff did not get residents up for dinner, the residents ate in their rooms unsupervised. She stated it was not safe for every resident to alone in their rooms due to possible choking risks. She stated when a care card documented the resident was to be up for all meals that meant the resident was to be out of bed for all meals. She stated the evening shift faced a lot of the same problems as the day shift. They did not have enough staff to care for the residents. During an interview on 3/4/20 at 9:38 AM, the Speech Language Pathologist (SLP) stated Resident #'s 45 and 61 were not supposed to eat in their rooms. She stated the safest way for the residents to eat was to be out of bed and supervised. She stated the residents had a [DIAGNOSES REDACTED]. She stated her recommendation was for the residents to be out of bed for all meals for safety. She stated she would consider it an accident hazard for the residents to be eating in the bed, and an even bigger accident hazard if the residents were left unsupervised. She stated the residents were at risk for aspiration and choking. The SLP stated she believed it when staff reported to the surveyor that residents were left in bed for meals unsupervised because there was a lack of staff to get residents out of bed for meals. She stated she saw that staffing was an issue, but also thought it was facility policy that any resident with dysphagia received supervision at meals. During an interview on 3/4/20 at 10:30 AM, the Acting Director of Nursing (DON) stated if the care plan documented the resident was to be up for all meals, then the expectation was that the resident was out of bed and up for all meals, unless it was documented that the resident declined to get out of bed. She stated the staff should look at the resident's care card before providing care and follow what was documented on the care card. During an interview on 3/5/20 at 9:17 AM, the Administrator stated she expected the resident's care card to be followed regardless of the amount of staff on the unit. She stated there was a potential for an accident hazard especially if the resident was eating in his/her bed unsupervised. She stated she was not aware that residents were not getting up for meals due to staffing. Finding #4: For Resident #105, who had a history of [REDACTED]. Resident #105: The resident was admitted to the facility with the [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment) dated 1/27/20 documented the resident was cognitively intact and was able to understand others and make herself understood. The Daily Staffing Sheet dated 12/29/19 documented there were 7 CNAs on the day shift and 7 CNAs on the evening shift. During an observation/interview on 3/1/20 at 10:37AM, Resident #105 was lying in bed and touched a scar on his/her left forehead. He/she stated he/she fell and cut his/her forehead open and was unconscious a few months ago and had to go to the hospital. He/she fell because he/she had to go to the bathroom and could not wait any longer for staff to answer his/her call bell so got up without assistance and fell . The comprehensive care plan (CCP) titled Activities of Daily Living (ADL) dated 2/6/19, documented the resident required a limited assist of 1 staff for ambulation, transfers, and bed mobility. The CCP titled At risk for falls dated 2/19/19, documented the resident had actual falls. Interventions included: 12/20/19 remind resident to use her walker or wheelchair for locomotion; 2/6/19 encourage to wear appropriate footwear and encourage to use call bell for assistance as needed; on 1/6/20 a bed alarm. The nursing progress note dated 12/29/19 at 6:48 PM, a Registered Nurse (RN) documented the resident fell forward onto his/her forehead and had 2.5-centimeter (CM) laceration over the left eyebrow that bled profusely and had an ice park in place. The incident occurred at 6:10 PM. The note documented the resident had previous falls and was transferred the hospital status [REDACTED]. The Nurse Practitioner Tele-Health Progress Note dated 12/29/19 at 8:37 PM, documented the resident was transferred to emergency room for CT scan of head secondary to decreasing consciousness. The Change in Condition form (hospital transfer form) dated 12/29/19, RN documented the resident fell forward onto forehead, 2.5-centimeter laceration over the left eyebrow, bled profusely, had ice pack in place. The resident took Eliquis, left pupil 1 millimeter (mm), right pupil 4 mm. The resident had decreased consciousness and increased or new onset weakness. The resident was transferred to the hospital. During an interview on 03/03/20 at 12:55 PM, Certified Nurse Aide (CNA) #1 stated the resident used to get up every day and sit in his/her chair, but not much anymore because of staffing. He/she

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	335331	A. BUILDING _____ B. WING _____	03/05/2020

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) will push his/her call bell and wait for help when he/she needs to get up, but if he/she had to go to the bathroom, he/she would get up by himself/herself if his/her call bell was not answered timely. During an interview on 03/04/20 at 09:50 AM, Licensed Practical Nurse (LPN) #5 stated she told the staff she would help with resident care when they were short staffed because when the facility was short staffed it felt like every resident was at risk of falls. Resident #105 would get up by himself/herself if he/she needed to go to the bathroom. The LPN stated the facility should have been more alert to him/her after his/her previous falls and he/she should not be left in his/her bed all day. During an interview on 03/04/20 at 11:08 AM, the Licensed Practical Nurse Manager (LPNM) #1 stated the medication nurses were responsible for overseeing resident care, when they were short staffed there were some residents who would stay in bed. She stated some residents needed to be watched closely and when they were short of staff it could be scary. Resident #105 will get himself/herself up without assistance if he/she has to go to the bathroom. On 12/29/19, the Registered Nurse Supervisor was also working as a medication nurse and she only completed the SBAR (assessment) Note for the resident to be transferred to the hospital. 10NYCRR415.13(A)(1)(i-iii)
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review during a recertification survey, the facility did not ensure performance reviews of every nurse aide were completed at least once every 12 months and regular in-service education was provided based on the outcome of the reviews, and that the in-service training complied with the requirements of 483.95(g) for 5 (CNA #'s 1, 2, 3, 6, and #7) of 5 randomly selected Certified Nurse Aides (CNA's). Specifically, the facility did not ensure that CNA #'s 1, 2, 3, 6, and #7 had performance reviews at least once every 12 months and based on the review of the CNA education files, did not ensure at least 12 hours per year of in-service education that complied with the requirements of 483.95(g) related to dementia management training was provided. This is evidenced by: Refer to F tag 947 - In-service training must comply with the requirements of 483.95(g). The Policy and Procedure titled Inservice Programming/Training CNA, dated 9/2019, documented the facility must provide and track a minimum of 12 hours of continued education to the CNAs and to address areas of weakness as determined in the nurse aide's performance reviews. On 3/5/20 at 8:50 AM, the Administrator provided CNA education files for CNA's 1, 2, 3, 6, and #7: Review of the CNA files included the following: -CNA #1's yearly tracking record dated 11/12/19, did not include documentation that 12 hours of CNA in-service education was provided. -CNA #2's education file did not include a yearly tracking record. -CNA #3's yearly tracking record dated 11/11/19, did not include documentation that 12 hours of CNA in-service education was provided. -CNA #6's yearly tracking record dated 11/12/19, did not include documentation that 12 hours of CNA in-service education was provided. -CNA #7's yearly tracking record dated 11/11/19, did not include documentation that 12 hours of CNA in-service education was provided. On 3/5/20 at 9:15 AM, a facility staff member from Human Resources provided Certified Nurse Aides Evaluation forms for: -CNA #1's evaluation with a prepared date of 2/18/17 was not signed and dated by the CNA. -CNA #2's evaluation with a prepared date of 1/18/18 was signed and dated by the CNA on 3/15/18. -CNA #3's evaluation with a prepared date of 5/15/19 was signed and dated by the CNA on 5/15/19. -CNA #6's evaluation with a prepared date of 1/2/19 (documented wrong year) was signed, but not dated by the CNA. -CNA #7's evaluation with a prepared date of 5/15/19 was signed and dated by the CNA on 5/15/19. On 3/5/20 at 11:00 AM, additional CNA education records were provided for CNA #'s 1, 2, 3, 6, and #7. The CNA files included documentation of in-services the CNAs attended, but did not include documentation that the CNA's were provided with twelve hours of in-service education per year based on their individual performance review. During an interview on 3/5/20 at 8:25 AM, CNA #2 stated she had never had a performance review and had never had annual dementia care training. During an interview on 3/5/20 at 8:36 AM, CNA #3 stated she had performance review in May 2019, but did not receive a review yearly and stated she did not know when she last reviewed dementia training as part of her yearly trainings. During an interview on 3/5/20 at 8:56 AM, CNA #1 reviewed the CNA Yearly In-Service Tracking Record with her name on it and stated she did not recall sitting through 4-5 hours of training on 11/12/19. She stated I think I would remember something like that. She stated she had not had a yearly performance review and did not know when she last received dementia training. During an interview on 3/5/20 at 9:00 AM, Human Resources (HR) stated the CNA evaluations were based on the CNA's performance and were completed every 18 months. She stated the evaluations corresponded with when the facility gave staff raises in pay every 18 months. She stated evaluations were not completed on a yearly basis. During an interview on 3/5/20 at 9:10 AM, Licensed Practical Nurse (LPN) #2 stated she had been assisting with education in the facility and was recently made responsible for providing general orientation to new hires or agency staff. She stated she was not responsible for tracking that the CNA staff received 12 hours of in-service every 12 months. She stated general orientation touched on dementia care with a brief overview. During an interview on 3/5/20 at 9:17 AM, the Administrator stated she was aware the facility was lacking in education and there would an issue with education records during survey. She stated her goal was to have the staff complete one hour of in-service each month and there would be a monthly calendar of in-services. She stated as the Administrator, since there was not an Assistant Director of Nursing, she would be picking up the education piece for the staff to ensure 12 hours of in-services every 12 months. She stated the Regional Educator came into the facility and in-serviced all the staff on the same day back in November. She reviewed the CNA Yearly In-Service Tracking Records and stated if there was not documentation in the CNA's education file, then the CNA did not receive the required yearly education or trainings. She stated Corporate told the facility to do performance reviews every 18 months and was not aware the reviews had to be done annually. 10NYCRR 483.35(d)(7)
F 0812 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and staff interview during the recertification survey, the facility did not store, prepare, distribute or serve food in accordance with professional standards for food service safety. Refrigerators are to be equipped with thermometers, food temperature thermometers are to be kept calibrated, and equipment and surfaces are to be kept clean. Specifically, thermometers were missing or not in calibration, and food contact equipment and non-food contact surfaces were not clean. This is evidenced as follows. The kitchen and unit kitchenettes were inspected on 03/01/2020 at 10:49 AM. The A Wing kitchenette refrigerator did not have a thermometer, and the B Wing refrigerator thermometer was broken. When checked for calibration in an ice bath, metal stem food temperature thermometers read 35 degrees Fahrenheit (F) and 36 F. In the main kitchen, the ceiling vent was soiled with dust and the floor behind cooking equipment was heavily soiled with food particles and a dark build-up. The microwave oven, cupboards, drawers, cabinets, and floor main dining room kitchenette soiled and required cleaning. The Food Service Director stated in an interview on 03/01/2020 at 11:40 AM, that she will place thermometers in refrigerators, ensure food temperature thermometers are calibrated, and will have the kitchen and Main Dining Room items cleaned. 10 NYCRR 415.14(h); 10 NYCRR Chapter 1, Subpart 14-1.44, 14-1.85, 14-1.110, 14-1.170, 14-1.171
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observation and staff interview during the recertification survey, the facility did not dispose of garbage and refuse properly. Specifically, dumpsters were not closed. This is evidenced as follows. The garbage dumpsters were inspected on 03/01/2020 at 11:42 AM. The side doors of both dumpsters were open. Refuse was found in the dumpsters The Maintenance Director stated in an interview on 03/01/2020 at 11:42 AM, that he will speak with housekeeping about keeping the dumpsters closed. 10 NYCRR 415.14(h)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews during the recertification survey, the facility did not ensure it maintained an infection control program designed to help prevent the development or transmission of infection for 1 (Resident #19) of 2 residents reviewed for wound care. Specifically, for Resident #19, the facility did not ensure that standard precautions to include hand hygiene, and glove use were maintained during a dressing change. Also, the facility did not ensure the table was cleansed to prevent the transmission of infectious agents prior to the placement of dressing supplies on the table. This is evidenced by: Resident #19: The resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS- as assessment tool) dated 2/10/20, documented the resident was cognitively

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) intact, could be understood, and could understand others. The Policy and Procedure dated 12/2019 for Sterile Dressings, documented the bedside stand was to be cleaned and a clean field established. Wash hands, wear clean gloves, and remove the soiled dressing, pull glove over dressing and discard into plastic bag. Wash hands, put on gloves, cleanse wound from center outward, per orders and pat dry with gauze. Apply the ordered dressing and secure with tape. Discard disposable items, remove gloves and wash hands. Clean the bedside stand and then wash hands again. Observed wound care for Resident #19 on 03/04/20 at 11:12 AM. Licensed Practical Nurse (LPN) #3 washed her hands and put on clean gloves. She did not cleanse the over the bed table prior to placing the clean field. The right lower leg dressing was removed followed by the removal of the left lower leg dressing. The scissors used to remove both dressings were not cleansed before or after each use. LPN #3 did not change gloves or wash/sanitize hands between the removal of the dressings on each leg. LPN #3 removed her gloves and washed her hands after the dressings were removed, donned (put on) clean gloves, completed the treatment to the right and left lower legs without changing gloves or performing hand hygiene between the dressing changes to each leg. A Comprehensive Care Plan (CCP) for Alteration in Skin Integrity- stasis ulcers both lower extremities, revised on 2/9/20, documented to assess wound weekly, document wound measurements, wound bed appearance, odor, drainage, and surrounding tissue. A Medical Doctor (MD) order dated 2/14/20, documented to cleanse both lower legs with wound cleanser, pat dry, cover wound beds with medi honey, wrap with gauze kling and secure with Coban with 50% tension toes to 2 finger breadths below knee. During an interview on 3/4/20 at 11:29 AM, LPN #3 stated she probably should have changed her gloves between wound care to the right lower leg and the left lower leg. During an interview on 3/4/20 at 11:54 AM, the Acting Director of Nursing stated LPN #3 should have cleaned the over the bed table prior to setting up her clean field and she should have changed her gloves after completion of wound care on one leg, before starting the wound care on the other leg. 10NYCRR415.19(b)(1-3)
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on record review and interviews conducted during the recertification survey, the facility did not ensure required in-service training for nurse aides included dementia management training. Specifically, for 5 (CNA #'s 1, 2, 3, 6, and #7) of 5 randomly selected Certified Nurse Aides (CNA's), the facility did not ensure the required yearly in-service trainings included dementia management training. This is evidenced by: The Policy and Procedure titled Inservice Programming/Training CNA, dated 9/2019, documented the facility must provide and track a minimum of 12 hours of continued education to the CNAs with certain components including dementia management training. On 3/5/20 at 8:50 AM, a review of the CNA education files provided by the Administrator included the following: -CNA #1's yearly tracking record dated 11/12/19, did not include documentation that the CNA received dementia management training. -CNA #2's education file did not include a yearly tracking record and did not include documentation that dementia training was provided or received within the yearly requirement period. It included a Dementia Training Certificate dated 3/14/18. -CNA #3's yearly tracking record dated 11/11/19, did not include documentation that the CNA received education on dementia management training. -CNA #6's yearly tracking record dated 11/12/19, did not include documentation that the CNA received education on dementia management training. -CNA #7's yearly tracking record dated 11/11/19, did not include documentation that the CNA received education on dementia management training. During an interview on 3/5/20 at 8:25 AM, CNA #2 stated she had never had annual dementia care training and had been employed at the facility 25+ years. During an interview on 3/5/20 at 8:36 AM, CNA #3 stated she did not know when she last reviewed dementia training as part of her yearly trainings and had been employed at the facility 15+ years. During an interview on 3/5/20 at 8:56 AM, CNA #1 stated she did not know when she last received dementia training. She stated she had been employed at the facility for more than 5 years. During an interview on 3/5/20 at 9:10 AM, Licensed Practical Nurse (LPN) #2 stated she had been assisting with education in the facility and was recently made responsible for providing general orientation to new hires or agency staff. She stated general orientation touched on dementia care with a brief overview, but she was not responsible for the annual Dementia Training. During an interview on 3/5/20 at 9:17 AM, the Administrator stated she was aware the facility was lacking in education and there would an issue with the education records during survey. She stated the regional educator came into the facility and in-serviced all the staff on the same day back in November 2019. She reviewed the CNA Yearly In-Service Tracking Records and stated if there was not documentation of dementia management training then the CNAs did not receive it. 10NYCRR415.26(c)(1)(iv)