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 _____	09/02/2020

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (Case #NY 073), the facility did not ensure sufficient fluid intake to maintain proper hydration and health for 1 (Resident #1) of 3 residents reviewed for nutrition/hydration. Specifically, for Resident #1 the facility did not evaluate the resident's fluid intake when the resident consistently consumed less than 50% of the estimated daily fluid goal (1,225 ml) from 1/22/2020 through 1/30/2020. This is evidenced by: Resident #1: Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 1/15/20, documented Resident #1 had severe cognitive impairment, was sometimes able to understand others and was sometimes able to be understood. The MDS also documented Resident #1 received a mechanically altered diet and required extensive assistance of one person for meals. The Policy & Procedure (P&P) titled Food and Nutrition Services: Hydration, last revised on 6/2019, documented the Interdisciplinary Team (IDT) had the responsibility to provide fluids to residents to maintain adequate hydration status. The purpose of the P&P was to prevent signs and symptoms of dehydration and to provide fluids of appropriate consistencies to maintain adequate hydration and quality of life. Risk factors for altered hydration were documented as decline in oral intake, BMI (body mass index; a measure of body fat based on weight and height) less than or equal to 18.5 (underweight), and cognitive impairment. The Dietician and Nursing Staff were to review daily consumption records on regular intervals to ensure adequate hydration status of residents. The Dietician was to review/reassess fluid needs as needed. The P&P titled Nutrition Services: Supplement dated 4/2014, documented a supplement was intended to add further nutritional value to the present diet. Nursing staff was to inform the Dietician of a resident's poor intake and refer to the physician for appropriate orders and evaluations. Nursing and Dietary staff were to monitor residents with poor intake (less than or equal to 50% of fluids/food) if caloric and protein needs were not met and residents were to be flagged on the 24-hour report for increased observation. Any refusals and poorly accepted supplements were to be documented on the MAR (medication administration record). The Comprehensive Care Plan (CCP) for Nutritional Strengths and Risks, last updated on 1/23/20, documented the resident was at risk due to dementia, poor PO (by mouth) intake, required thickened liquids and required total assistance with feeding. The goal was for the resident to be adequately nourished and hydrated via intake from meals, fluids, and nourishments, greater than 50%. Staff were to provide a regular diet with a pureed texture and nectar thickened liquids, provide nutritional supplements per physician order, encourage meal intake and completion, and monitor meal consumption records. The CCP for Activities of Daily Living (ADLs), last updated 1/23/20, documented the resident was totally dependent on staff for assistance with eating. The Kardex Report (CNA Care Card) as of 1/23/2020, documented staff were to provide assistance with meals and feeding and were to monitor the resident's intake and output. The Hospital Discharge Summary dated 1/8/2020, documented the patient had advanced dementia and required full assistance with eating and drinking. The Admission/Readmission Evaluation Form dated 1/8/2020 at 6:08 PM, by Registered Nurse Supervisor (RNS #1), documented the resident's usual food intake pattern was very poor. The resident never ate a complete meal and had poor fluid intake. The resident did not assist with feeding her/himself and was totally dependent on staff to assist for eating. The Admission Progress Note dated 1/8/2020 at 8:30 PM, by Registered Nurse Manager (RNM #1), documented the resident declared an advanced directive that included a trial period of intravenous fluids (fluids given by a small plastic tube inserted into the vein). The resident required the assistance of one person for eating. The Dietary Progress Note dated 1/9/20 at 8:34 AM, written by Registered Dietician (RD #2), documented a Nutritional Assessment was completed on 1/9/20 at 12:00 AM. The resident weighed 76.5 lbs. on 1/8/2020 and had a BMI of 17.1. The resident's estimated fluid needs was 1,225 ml of fluids daily and was at risk for malnutrition related to dependence on staff for eating/mobility (resident needed to be fed all meals/fluids), acute illness within the past 3 months, dementia, consumed 50% or less, and had a BMI less than 18.5. RD #2 recommended the following: 3 types of nutritional supplements, monitor weight, intake and labs as available. The Order Summary Report dated 2/13/2020, documented the following physician's orders [REDACTED]. A physician progress notes [REDACTED].#2), documented the resident was admitted for further therapy evaluation and care. The resident had advanced dementia and required help with all activities of daily living (ADL). The Hospital General Chemistry Tests results report dated 1/14/2020, documented electrolytes (sodium, potassium, and chloride), blood urea nitrogen (BUN) and creatinine levels (tested to evaluate kidney function) were in normal range. Progress Notes dated 1/24/2020, by Licensed Practical Nurse (LPN #2), documented the resident refused the fortified milk shake at 8:37 AM and 2:19 PM, and at 4:22 PM refused the fortified ice-cream like snack. There was no documentation Nursing and/or the Dietician was notified. Review of the Plan of Care (POC) Response History report dated 1/22/2020 through 1/30/20 for amount of fluids (ml) taken and the MAR dated January 2020 for nutritional supplements given, documented the resident consumed less than 50% of the estimated daily fluid goal (1,225 ml) from fluids and supplements on the following days: 1/22/2020: consumed 120 ml from fluids and 298 ml from supplements, for a total of 418 ml 1/24/2020: consumed 360 ml from fluids and 220 ml from supplements, for a total of 580 ml 1/26/2020: consumed 140 ml from fluids and 360 ml from supplements, for a total of 500 ml 1/28/2020: consumed 240 ml from fluids and 210 ml from supplements, for a total of 450 ml 1/30/2020: consumed 60 ml from fluids and 210 ml from supplements, for a total of 270 ml There was no documentation Nursing and/or the Dietician were informed when the resident consumed less than 50% of the estimated daily fluid goal, and there was no documentation the physician was notified. A Progress Note dated 1/31/2020 at 12:00 PM, by RNM #1, documented the resident's family expressed concerns that the resident was acting off and could be dehydrated. The family was informed the resident had been accepting fluids. The family requested an evaluation by the physician and was in agreement to wait until Monday (2/3/2020) when MD #2 would be in the facility. RNM #1 documented staff were notified to encourage additional fluids and the information was placed in the MD book for evaluation. A Progress Note dated 1/31/2020 at 2:05 PM, by RNM #1, documented the resident's HCP was insistent the resident be transferred to the hospital for evaluation. The MD was notified and gave the order to send the resident to the hospital. The Progress Note dated 2/1/2020 at 8:38 AM, by LPN #4, documented the resident was admitted to the hospital. The Hospital Discharge Summary Dated 2/12/2020, documented the resident presented to the emergency department (ED) on 1/31/2020. The family reported the resident had not been eating or drinking at the nursing home and was brought in because of lethargy and concerns over dehydration. Initial laboratory results on 1/31/2020, documented the resident had a critical sodium level of 176 (normal 136-145), a critical chloride level of 131 (normal 100-108), and an acutely elevated BUN of 64 (normal 7-24) and creatinine of 1.9 (normal range of 0.60 - 1.0). The provider documented the BUN and creatinine were up from 11.4 and 0.64 respectively, just 2 weeks prior. The provider documented the following assessment: hypernatremic (too much sodium in the blood), hyperchloremic (too much chlorine in the blood) dehydration due to significantly decreased PO intake, and acute kidney injury due to dehydration from poor PO intake. The resident was admitted , received IV Fluid rehydration and was and was discharged back to the facility. During an interview on 2/12/2020 at 11:00 AM, RNM #1 stated administration of nutritional supplements was documented on the Electronic Medication Administration Record (eMAR) to allow for better documentation of consumption and/or refusals. She said she had not reviewed the eMAR and would have expected the Licensed Practical Nurse staff to have brought the

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.

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident's refusals of the nutritional supplements to her attention. RNM #1 stated the facility had other staff available and could have assisted in providing the nutritional supplements to Resident #1. During an interview on 2/12/2020 at 1:00 PM, Registered Dietician (RD #2) stated Resident #1's [DIAGNOSES REDACTED].#1 more susceptible to dehydration. RD #2 stated she followed up on a resident's fluid intake if she was notified of decreased fluid intakes or fluids refusals. RD #2 stated she did not receive any notifications about decreased fluid intake for Resident #1. She said staff should have brought the decreased fluid intake and refusals to her attention so that she could have done an evaluation and made changes. During an interview on 2/13/20 at 1:00 PM, MD #2 stated, Resident #1 was at risk for dehydration due to the [DIAGNOSES REDACTED]. Facility staff should have reviewed the fluid intakes of Resident #1. During an interview on 2/13/2020 at 1:15 PM, RD #2 stated Resident #1's elevated levels of BUN, creatinine, and sodium on the hospital laboratory report dated 1/31/2020, coincided with dehydration. During an interview on 2/13/2020 at 2:45 PM, (CNA #1) stated fluids provided to Resident #1 were entered into the EMR and said CNAs did not have to report the information to nurses because the information was directly available to them in the computer. She said Resident #1 was not able to obtain fluids without staff assistance. During an interview on 2/13/2020 at 3:00 PM, RNM #1 stated the facility should have reviewed the fluid intakes of Resident #1 at least weekly due to the repeated decreased oral intake and refusals. She said she would not have been aware of Resident #1's decreased fluid intake because the EMR system only generated an alert when a resident accepted less than 50% consecutively, over 3 days. RNM #1 said Resident #1 oral intakes would have required an actual review to see the overall decreased fluid intake. She said she was not aware of a facility policy to report decreased oral intake to the MD. During an interview on 2/13/2020 at 3:15 PM, the Director of Nursing (DON) stated staff should have reported consistent declines in fluid intakes or refusals of fluids to the RNM or RD for evaluation. Oral intakes for new admissions were supposed to be monitored for 72 hours to establish a baseline for a resident. 10 NYCRR 415.12(j)