| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335538 | A. BUILDING _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| CONCORD NURSING AND REHABILITATION CENTER | 300 MADISON STREET BROOKLYN, NY 11216 |

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) |
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| F 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interviews during a Focused Infection Control Survey (FICS) and Complaint investigation (Complaint #NY 037), the facility did not ensure residents rights were honored in the form of communication with persons outside the facility. Specifically, the facility did not provide assistance in helping a resident communicate with their family when requested. This was evident for 1 of 3 residents reviewed for residents rights and communication with persons outside the facility (Resident #2). The finding is. The facility policy and procedure titled, Coronavirus (COVID 19) (Dated ,[DATE] and [DATE]) was reviewed. The policy documented the facility had restricted visitation and will offer alternative means of communication such as phone-video-communications. Virtual communication includes residents that have personal devices will be assisted by staff in downloading programs/applications. Residents with no personal devices should be informed of available devices. Families are notified of skype name associated with device for video calls. A letter dated [DATE] that was sent to the family documented methods for families and residents to communicate with each other include telephone, email, text, WhatsApp, Skype, and other social media means. The facility suspended visitation on [DATE]. A ROBO call script dated [DATE] and [DATE] included the following message: Activity staff are making sure all residents are visited with 1 on 1 visits and are proud to offer skype calls for the residents and loved ones. The recreation director can be contacted to arrange a call. A letter dated [DATE] that was sent to the family documented residents who have tested positive for COVID-19 and mitigation risks put in place. A second page of questions was also provided which documented how families can stay in contact with the residents which includes use of tablets to skype, WhatsApp, and Face Time. It also documented the recreation director as the contact person to reach out to arrange a session. Resident #2 was admitted to the facility on [DATE] and expired in the facility on [DATE]. Resident had [DIAGNOSES REDACTED]. The Minimum Data Set 3.0 (MDS) Admission assessment (Dated [DATE]) documented the resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 9 out of 15. The resident had unclear speech but sometimes made self understood and understood others. On [DATE] at 02:15 PM and on [DATE] at 11:50 PM, the complainant (primary contact) was interviewed. She stated her main concern was the lack of communication. Specifically, the facility did not let the resident speak with the family. The sister stated she was only able to video chat with the resident one time on [DATE] and was never given the opportunity to video chat before then. The sister stated she requested the nursing staff to speak with the resident a couple of days before that one time but was not given the opportunity. The sister also stated she was in a conference call on [DATE] with the facility staff following a letter sent to the facility and was not satisfied with how they addressed her concerns. The Comprehensive Care Plan (CCP) titled, COVID-19 Recreation Care Plan (Initiated and Updated on [DATE]) documented interventions which included 1:1 (one-to-one) visits, provide assistance or adaptive equipment as needed, and provide independent leisure supplies/material. The CCP titled, COVID 19 Psychosocial Care Plan (Initiated and Updated on [DATE]) documented interventions which include: (1) Encourage alternative communication with visitors (2) Monitor psychosocial changes (3) Observe and report any changes in mental status caused by the situational stressor of having visitation restricted (4) Provide opportunities for expression of feelings related to visitation restriction. An electronic mail dated [DATE] sent from the Social Worker to Recreation was made in regard to a video call request. A progress note dated [DATE] by the social worker (SW) documented she had spoken with resident's sister (secondary contact) on [DATE] who a requested video call. The RT was made aware to schedule video calling with family. There was no documented evidence that the facility made attempts or arrangements prior to [DATE] for the resident to communicate with their family. The Virtual Communication Log Forms were reviewed from [DATE] to [DATE] were reviewed. There was no documented evidence that the facility assisted the resident and family with communication. On [DATE] at 10:35 AM and on [DATE] at 10:45 AM, the Administrator stated Recreation began offering residents the option to video chat with loved ones on a daily basis around March. The Administrator stated a grievance and investigation was filed and completed when he received a complaint letter from the resident's sister. He further stated all concerns were addressed. On [DATE] at 02:30 PM and on [DATE] at 11:15 AM, the SW stated the primary contact visits and calls frequently. She stated the sister knows to contact her if there are issues. The SW further stated she had not had any difficulty contacting the sister. The SW further stated the resident had at least one video call with family member and was not aware of any requests made prior to that call. The SW stated the facility received a letter from someone on behalf of the family. The SW contacted the primary contact along with other disciplines to discuss the concerns indicated on the letter. The SW further stated the sister was satisfied with the discussion of the resident's capitulation of their stay including treatment and communication. On [DATE] at 03:40 PM, the Recreation Director was interviewed. She stated she notifies families via phone that they can communicate with their loved ones through video calls throughout the week. The director also stated that she recalls setting up a video call on [DATE] with the sister. She then stated that she had previously set up calls with the family prior to [DATE], but she was not documenting it. 483.10(a)(1)(2)(b)(1)(2) |
| F 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews and interviews during an Infection Control Focused Survey and Complaints Investigation (NY 356), the facility did not notify the primary contact family member of the residents' change in condition. Specifically, the resident's family was not notified when the resident developed a cough and subsequently was treated with multiple drugs and treatments. This was evident for one (1) of 3 residents interviewed for notification of change in condition. (Resident # 1). The finding is: The facility policy and procedure titled Clinical Operations, dated ,[DATE], documented, the facility shall promptly notify representative of changes, in the residents medical /mental condition and or status, except in emergencies, notifications will be made within 24 hours of a change occurring. Resident #1 had [DIAGNOSES REDACTED]. The resident expired on [DATE] at the facility. Review of the Quarterly Minimum Data Set (QMDS) Assessment Reference Date (ARD) of [DATE] documented the resident had intact cognition. The resident's daughter was interviewed at 8:00AM on [DATE] and stated that she never received a call from the doctor about the resident's change in condition. She said that she received maybe two calls. One call was about the fall. Another call was from the NP introducing herself and telling her that her father had a cold. She started making several calls to the facility for information, but no one would answer the phone on the unit. She stated that she was concerned about her father who suffered from Asthma. The Pertinent Resident [DIAGNOSES REDACTED]. Other bacterial infections of unspecified site, identified on [DATE]. The Nursing Note dated [DATE] |

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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| **CONCORD NURSING AND REHABILITATION CENTER** | **300 MADISON STREET BROOKLYN, NY 11216** |

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| F 0580<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>documented that the resident was observed sitting on the floor. The resident denied falling and claimed he was looking for his money. The resident was noted wheezing on inspiration and expiration and oxygen was given. The resident's oxygen saturation was 99 %, and oxygen was ordered. The Medical Doctor (MD) was notified and ordered a chest x-ray. The resident's daughter was notified that the resident had a fall. The Nurse Practitioner (NP) Note dated [DATE] documented the resident was assessed at bedside for fall and wheezing. The note documented: Communication: spoke with family, informed of fall, no injuries The NP note dated [DATE] documented a follow-up visit due to s/p fall. The resident was noted with shortness of breath, (sob) and intermittent wheezing. The resident was diagnosed with [REDACTED]. The NP recommended [MEDICATION NAME] 20 mg by mouth daily and [MEDICATION NAME] every 6 hours. The Medical note dated [DATE] documented the resident was seen at bedside. The resident had wheezing and occasional cough and no fever. The Assessment/Plan (A/P) was to start [MEDICATION NAME] for 5 days from [DATE]. Start [MEDICATION NAME] 20 milligram (mg) for 5 days from [DATE]. Discontinue [MEDICATION NAME] when Chest X-ray shows no infiltrate. The plan was discussed with nursing. Nursing note dated [DATE] documented [MEDICATION NAME] for bacterial infection was discontinued due to no infiltrate, effusion or pneumothorax identified in the chest x ray. The Medical note dated [DATE] documented resident still has cough and sob. The resident was seen at bedside and was positive for rhonchi and wheezing. The resident was diagnosed with [REDACTED]. from [DATE], and Diabetic [MEDICATION NAME] for 10 days from [DATE]. The note documented [MEDICATION NAME] should be discontinued when the chest x-ray showed no infiltrate. Due to [MEDICAL CONDITION], the recommendation was to discontinue [MEDICATION NAME] to decrease chance of infection of [DIAGNOSES REDACTED]-cov-2 (COVID-19) and start Proair 2 puffs every 6 hours as needed. The plan was discussed with nursing. A Medical note dated [DATE] documented, resident developed chills today, still has cough and sob. mild distress. Positive for rhonchi and wheezing. The resident was diagnosed with [REDACTED]. The plan was to monitor temperatures and oxygen saturation. Continue [MEDICATION NAME] 500 mg daily until [DATE]. Intravenous fluids (IV) ,[DATE] normal saline for 2 days was started [DATE]. The plan was discussed with nursing. The NP note dated [DATE] documented the resident had suspected COVID-19 and was started on treatment. The noted documented the NP communicated the plan with family. There was no documented evidence in the medical record that the family was immediately informed of changes in the resident's medical condition since symptoms began on [DATE] until [DATE]. The resident expired on [DATE] at the facility. The Death Certificate documented the immediate cause of death as Cardiopulmonary Arrest. The nurse supervisor was interviewed on [DATE] at 11:40 AM and stated that family notification calls are to me made within 24 hours when there is a change in resident condition. She stated that she called the daughter to notify her of a fall. She stated that family notifications are usually made by the medical staff. She stated that it is important for family to be involved and made aware so that they can be on board and have a voice with the plan of care and treatment. The NP was no longer employed at the facility. No telephone number was made available. Interview with the MD on [DATE] at 1:00 PM stated that the resident had a change in condition and that COVID -19 was always suspected when a residents develops a cough. The resident had no fever. We were not testing at the time. The daughter has my phone number and she could call me anytime. The MD stated that he spoke to the daughter, could not say when but that he assumed that because the daughter had his number, it was up to her to call him. He stated that it is important for the family to know about a resident's change in condition because they might say no to treatments. He stated that the resident had poor appetite which is why he ordered IV fluids. The MD stated that the daughter had his telephone number and she could have called him at any time. The Director of Nursing (DON) was interviewed at 1:15 PM and stated that family notification of change in resident condition done within 24 hours. The medical staff usually will notify the family, or the NP. Sometimes the Nurse Managers will call and must document to call. The family has a right to be notified and may not agree with the plan of care or treatment. 415.3(e)(2)(ii)(b) |