STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **335382**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE COMMONS ON ST ANTHONY, A S N F & SHORT T R C	**3 ST ANTHONY STREET AUBURN, NY 13021**

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 0638 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the recertification survey the facility did not ensure assessment of residents using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services (CMS) not less frequently than once every 3 months for 6 of 7 residents (Residents #1, 2, 3, 5, 6 and 7) reviewed for resident assessments. Specifically, Residents #1, 2, 3, 5, 6 and 7's Minimum Data Set (MDS) assessments were completed later than 14 days following the Assessment Reference Date (ARD). Findings include: The facility policy Resident Assessment documented the facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment for each resident's functional capacity. The Minimum Data Set (MDS) assessment will be conducted per the guidelines set in the Resident Assessment Instrument (RAI) Manual. The first comprehensive assessment must be within 14 calendar days after admission, thereafter a quarterly assessment must be within 92 days from the assessment reference date of the previous assessment. 1) Resident #2 had [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment documented an Assessment Reference Date (ARD) of 1/17/20 and completion date of 2/26/20. 2) Resident #6 had [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment documented an Assessment Reference Date (ARD) of 1/10/20 with noted completion date of 2/21/20. 3) Resident #7 had [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment documented an Assessment Reference Date (ARD) of 1/3/20 with a noted completion date of 2/21/20. During an interview with MDS Coordinator #1 on 3/5/20 at 9:16 AM, she stated Resident #2's 1/17/20 assessment should have been completed within 14 days of that date and it was not completed until 2/25/20. Resident #6's 1/2020 MDS assessment was not completed until 2/21/20 and it should have been submitted in January. Resident #7's quarterly ARD was 1/3/20. She stated they were short-staffed in the MDS department, so assessments had not been completed timely. 10NYCRR 415.11(a)(4)
F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the recertification survey the facility did not ensure residents received the necessary care and services to ensure that a resident's abilities in activities of daily living (ADLs) did not diminish for 1 of 1 resident (Resident #55) reviewed for rehabilitation and restorative services. Specifically, there was no documentation Resident #55 was ambulated by staff as care planned; in addition staff reported the resident had a decline in ambulation and it was not re-assessed timely. Findings include: The 1/2019 Ambulation Program: Walk Around the Clock policy documents the facility is to ensure that all residents with functional ability to ambulate maintain that ability. Ambulation goals could be achieved by walking the resident from the bed to the bathroom and back, from the resident's room to the unit lounge, from the lounge to the dining room and so on. The CNA (certified nurse aide) would document all ambulation in the ADL section. Resident #55 was admitted with [DIAGNOSES REDACTED]. The 7/22/19 Physical Therapy Nursing Plan of Care documented Please ambulate to and from meals and restroom with rolling walker and wheelchair to follow. The 12/13/19 comprehensive care plan (CCP) documented staff were to do range of motion (ROM) and the resident tended to refuse assistance from staff for care and ambulation and staff were to continue to encourage. The CCP did not document a further plan or goal for ambulation for the resident. The ADL Charting records dated between 11/2019 and 12/23/2019 documented the resident occasionally walked in the corridor independently up to requiring extensive assistance by staff. There was no ADL charting documenting the distance the resident had been walking. Between 12/24/19-3/4/20, ADL Charting documented walking did not occur. A 12/19/19 nursing progress note documented the resident was ambulated to breakfast and refused to ambulate back to bedroom or to lunch. The resident was reminded by CNAs to ring the call bell to ambulate to lunch. There was no further documentation the resident had declined to participate in ambulation or had difficulty with ambulation following this date through 3/4/20. The 3/3/20 CNA care instructions documented staff were to ambulate the resident with stand-by assistance of 1 staff at least 200 feet to bathroom and to/from meals with wheelchair to follow. During an interview on 3/2/20 at 11:49 AM the resident stated staff were supposed to be walking the resident, but they would tell the resident there was not always enough staff to do it. The resident felt there had been a decline in the resident's ability to walk. The resident had not been to PT in a long time and wanted to be able to walk better. During an interview with CNA #7 on 3/5/20 at 11:42 AM, she stated the resident used to be able to walk back and forth to the dining room (approximately 200 feet) and now was only able to walk as far as the nursing station (approximately 50 feet). If the resident declined to participate in walking the CNAs were not supposed to record a refusal but were to document walking did not occur. She stated there was no location to document why the walking did not occur or how far the resident had walked. She stated if walking did occur it would have numerical numbers like 1/2 and 2/2 showing the resident walked and what level of assistance had been provided. The CNA reviewed the CNA care instructions for the resident and stated the CNA instructions noted the resident was to walk 200 feet. CNA #7 reiterated the resident had not walked that far in quite some time. During an interview with registered nurse (RN) Unit Manager #8 on 3/5/20 at 11:58 AM, she stated the resident's plan was to be walked to and from meals. She stated sometimes the resident did not walk to breakfast as the resident liked to sleep in longer. When the resident finished eating in the dining room the resident would wheel back to the room. She stated she was not aware the resident used to walk 200 feet and was now only walking as far as the nursing station. She stated that would be a decline in the resident's ability to ambulate and would be good reason for PT to re-evaluate. She reviewed the resident's record and said the resident was last seen by PT on 7/22/19. At that time, PT recommended the resident walking to and from meals and 200 feet. She did not know what the staff were supposed to document in the ADL charting record, but if the resident had declined to participate in ambulation it should be reported to nursing and would be documented in nursing progress notes. She reviewed the nursing progress notes and stated there was no documentation in the last 3 months the resident had any concerns related to ambulation. During an interview with physical therapist (PT) #9 on 3/5/20 at 12:36 PM, he stated he had seen the resident in 2019 for a functional decline in ambulation. Walking had depended on the resident's arthritic pain level. He stated some floors had an ambulation program and he thought that the resident was on the ambulation program. When asked about the recommended distance of 200 feet on the last resident evaluation, the PT could not consistently answer the resident was to be walked up to 200 feet. He stated if the resident had a decline in the distance they were able to ambulate that would be a good reason for therapy to re-evaluate. 10NYCRR 415.12(a)(3)
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.**

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

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NAME OF PROVIDER OF SUPPLIER **THE COMMONS ON ST ANTHONY, A S N F & SHORT T R C**		STREET ADDRESS, CITY, STATE, ZIP **3 ST ANTHONY STREET AUBURN, NY 13021**	

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **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 residents with limited range of motion received the appropriate treatment and services to increase or prevent decrease in range of motion (ROM) for 2 of 6 residents (Residents #96 and 282) reviewed for range of motion. Specifically, Resident #96 was provided a palm guard (a device used for hand contractures) with no parameters for use. Resident #282 did not have interventions in place to prevent further decline in a neck contracture. Findings include: The facility policy Range of Motion, dated 1/21/20, documents the facility will provide the services, care and equipment to ensure: - A resident maintains or improves to their highest level of range of motion (ROM) and mobility, unless a reduction is clinically unavoidable. - A resident with limited range of motion and mobility maintains or improves function unless reduced ROM/ mobility is unavoidable based on the resident's clinical condition. - The therapy department will perform an assessment and recommend any ROM and/or equipment if necessary, for the resident and document this on the plan of care. - Recommendations for contracture devices including palm guards, hand rolls or splints, will be transcribed onto the certified nursing assistant (CNA) assignments for documentation by the CNA once completed. 1) Resident #96 had [DIAGNOSES REDACTED]. The 12/12/19 Minimum Data Set (MDS) assessment documented the resident had intact cognition, required extensive assistance of two staff for activities of daily living (ADLs) and had both upper and lower extremity impairment to one side of the body. The comprehensive care plan (CCP), dated 2/7/19, documented the resident had self-care deficits, required extensive to total assistance for ADLs, had contractures to bilateral upper and lower extremities, and received ROM during resident care, bathing, ADLs, and toileting. There was no documentation the resident had any contracture management devices or splints. The resident care assignment sheet (care instructions), dated 3/2/20, documented the resident had left [MEDICAL CONDITION] and required total assistance for ADLs. There was no documentation the resident had any contracture management devices or splints. The 12/31/19 nurse practitioner (NP) note documented the resident had left-sided weakness, diminished strength and tone, left hand and finger contractures and complained of pain and swelling of the left arm. On 1/7/20, the NP documented a request for a skilled occupational therapy evaluation and treatment services for the resident related to increased swelling, discomfort and pain to affected left upper extremity while the resident was up in the wheelchair. The 1/14/20 NP progress note documented the resident had left-sided weakness, diminished strength and tone, had left hand and finger contractures and was working with occupational therapy regarding wheelchair modifications to elevate the left arm. The 1/14/20 occupational therapy discharge summary documented the resident had decreased swelling and pain in the left upper extremity and additional modifications/equipment for the resident's wheelchair were ordered. The discharge summary did not address any equipment or devices for contractures. During an interview on 3/3/20 at 9:09 AM, the resident stated occupational therapist (OT) #3 provided a palm guard during the last therapy session (in 1/2020). The resident wore it sometimes during the day or night when the resident requested staff place it on the affected hand. The resident was observed with a closed left hand and no palm guard or device in the hand: - On 3/3/20 at 9:09 AM, seated in the wheelchair in their room. - On 3/4/20 at 8:45 AM, seated in the wheelchair eating breakfast in their room and at 9:21 AM, seated in the hallway. - On 3/5/20 at 12:11 PM, lying in bed eating lunch. During an interview with certified nursing assistant (CNA) #2 on 3/5/20 at 12:00 PM, she stated assistive devices and instructions for devices were listed on the resident care assignment sheets. She stated Resident #96 had contractures and did not use any devices. At 12:09 PM, she entered Resident #96's room and when shown the device on the nightstand, the CNA stated it was a palm guard and she did not know it was in the room. The observed palm guard appeared to be without signs of wear and tear. During an interview with OT #3 on 3/5/20 at 12:38 PM, he stated Resident #96 was recently discharged from skilled therapy and was seen for wheelchair modifications to elevate the left arm due to reported swelling. He was unsure if the resident had any contractures. At 12:47 PM, when shown the device in the resident's room, he stated the device was a palm guard. The palm guard had the resident's name and room number written on it and OT #3 stated that was his writing. He did not recall why he provided it to the resident. He stated the palm guard should have been on the care plan and there should have been instructions for use. During an interview with registered nurse (RN) unit manager #4 on 3/5/20 at 12:57 PM, she stated the resident had left-sided contractures and did not use any assistive devices. When shown the palm guard on the nightstand, she said she was unaware the resident had a palm guard. There were no medical orders for the palm guard and the resident was not care planned for the palm guard. She stated the therapy department should have notified her that the resident was provided a palm guard so the plan of care could have been updated and medical made aware of the device. During an interview with the NP at 1:12 PM, she stated the resident had contractures of the left arm, wrist and fingers and was recently referred to therapy for wheelchair modifications. The NP stated she would expect to be notified if the resident was given a new device and there should be a medical order for the device. She was unaware the resident was provided a palm guard from occupational therapy. During an interview with the Director of Therapy on 3/5/20 at 1:58 PM, she stated she was aware the resident had contractures, and did not have any recommendations for devices. She was unaware the resident was recently given a palm guard by OT #3. She said if therapy staff provided a resident with new equipment or devices, there should be instructions for use and nursing staff should have been notified of any changes to the plan of care. 2) Resident #282 was admitted with [DIAGNOSES REDACTED]. The 1/3/20 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment, required extensive assistance with eating and hygiene, had limited range of motion (ROM) on both sides of the upper and lower extremities and the resident was not on a restorative or routine therapy treatment plan. Physical (PT) and occupational therapy (OT) progress notes dated between 1/1/2019 and 12/28/19 had no documentation regarding a plan to address the resident's neck contracture. The 10/8/19 speech language pathologist (SLP) progress note and recommendations to care givers documented that the resident was pocketing food due to neck contracture. The speech therapist recommended to discontinue verbal cues to the resident to hold their head up as the resident was now unable to correct posture with verbal cues. The resident was unable to feed self due to upper extremity weakness. The 10/15/19 nurse practitioner (NP) progress note documented the resident was evaluated and treated by the SLP for oral phase dysphagia (difficulty swallowing) and neck contracture causing pocketing of food. The plan was to continue to provide all activities of daily living (ADLs) and supportive care; and the resident would receive PT, OT and speech therapy as needed. A 10/24/19 social services progress note documented a team meeting was held and the team felt the resident had a general decline. There was no documentation what the decline entailed. A 12/28/19 PT screening note documented the resident's ROM was within functional limits. There was no documentation the resident's neck contracture was assessed or that a plan was implemented for direct care staff to monitor and provide support to the contracture. The 1/16/20 comprehensive care plan (CCP) documented the resident had a self-care deficit related to [MEDICAL CONDITION], weakness, [MEDICAL CONDITION] disorder and TBI. Staff were to perform ROM during routine resident care, bathing, ADLs, toileting and ambulation. The resident used a high back wheelchair, had a history of [REDACTED]. The CCP had no documentation the resident had a neck contracture or interventions for positioning. The 3/3/20 resident care instructions had no documentation the resident had a contracture or interventions were implemented or ROM was to be provided by direct care staff to prevent future contracture. The resident was observed in a wheelchair with their head tilted to the left side touching the shoulder. There were no supportive devices in place: - On 3/2/20 at 12:36 PM and 2:28 PM, on 3/3/20 at 8:37 AM; and - During meals on 3/3/20 at 1:11 PM, 3/4/20 at 9:33 AM, and 3/5/20 at 12:45 PM. The resident was being fed by staff and had food debris falling from the corner of the left side of the mouth (in the direction the resident's head was tilted). The resident's clothing protector had multiple stains visible. During an interview on 3/4/20 at 12:32 PM with CNA #10, she stated the resident could lift their head upright if asked. She stated the resident used to have a pillow for positioning and she did not know what happened to the pillow. The resident did not have any positioning devices in place between the neck and shoulder. CNA #10 stated it was difficult to feed the resident as food would come out of the left side of the resident's mouth. She thought it was reported to Unit Manager #11 and the Unit Manager said everyone was aware of the resident's leaning. During an interview on 3/5/20 at 9:46 AM with the Director of Therapy, she stated she thought an occupational therapist had attended a training in 2017-2018 to address the resident, but she did not recollect who that would have been. She did a quarterly assessment in 12/2019 with the Unit Manager, and she did not recall the Unit Manager discussing any change in the contracture or any difficulties with feeding. During an interview on 3/4/20 at 4:00 PM with registered nurse (RN) Unit Manager #11, she stated if staff reminded the resident to lift the head upwards the resident would do so. She had not made any referrals for positioning as she felt the resident would straighten the neck when the resident wanted to. The staff had not reported any difficulties with feeding the resident. During an interview on 3/5/20 at 11:45 AM with OT #13, she stated she worked with the resident in the past. and she had not received any recent referrals for the

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) resident. During an interview on 3/5/20 at 11:45 AM with SLP #14, she stated the SLP the resident had worked with was not available to interview, but she was familiar with the resident. She stated she could not speak for the other SLP and why another discipline was not referred to assess the resident's contracture. She thought if the SLP had felt a therapy referral was needed, it would have been noted. 10NYCRR 415.12 (e)(2)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the recertification survey, the facility did not ensure residents who needed respiratory care were provided such care consistent with professional standards of practice for 1 of 2 residents (Resident #155) reviewed for respiratory care. Specifically, Resident #155 had orders for a Continuous Positive Airway Pressure machine ([MEDICAL CONDITION], a machine used to deliver constant and steady air pressure to people with sleep apnea) and scheduled care and cleaning of the equipment was not provided. Findings include: The 2/2020 [MEDICAL CONDITION]/[MEDICAL CONDITION]/Trilogy Non-Invasive Policy documented the purpose is to provide non-invasive ventilatory support in patients with compromised airway or chronic [MEDICAL CONDITION]/[MEDICAL CONDITION]. The policy documented the C-PAP must have: - A physician order [REDACTED]. - The headgear/mask be stored in a dated, ventilated bag when not in use. Resident #155 was admitted to the facility with [DIAGNOSES REDACTED]. The [DATE] Minimum Data Set (MDS) assessment documented the resident had intact cognition and required extensive assistance with activities of daily living (ADL). The MDS did not document any respiratory treatments. A physician order [REDACTED]. There was no documentation what the settings were or orders for care of the [MEDICAL CONDITION] machine. The 6/14/19 comprehensive care plan (CCP) did not document any care and maintenance instructions for the [MEDICAL CONDITION] equipment. There was no documentation on the 3/2020 Treatment Administration Record (TAR) for the care and maintenance of the [MEDICAL CONDITION] equipment. During an interview on 03/03/20 at 02:35 PM, Resident #155 stated they had a [MEDICAL CONDITION] machine and was concerned the machine was not being cleaned properly. The resident asked the staff several times to clean the machine and they told the resident they did not have time. The resident did not remember when it was last cleaned, and the only mask received was the one on admission. The [MEDICAL CONDITION] machine was observed sitting on resident's bedside stand with a mask attached, which was undated and not stored in a ventilated bag. The inside of the mask was unclean and contained dried, mucous-like debris. During an interview on 3/5/20 at 10:59 AM with registered nurse (RN) Unit Manager #10, she reviewed the resident's (NAME)2020 TAR and physician order. She stated there was no documentation for the care and maintenance of the [MEDICAL CONDITION] equipment. There should be orders per the facility policy which include the care and maintenance of the [MEDICAL CONDITION] equipment, changing and cleaning the tubing/mask and checking the proper setting. She thought the resident was caring for the [MEDICAL CONDITION] them self and stated if the resident was, then it should have been documented on the care plan. The care and maintenance of the [MEDICAL CONDITION] equipment should be documented because if not properly cleaned it could cause respiratory infections. During an interview on 3/5/20 at 3:00 PM with Infection Control Nurse (ICN) #12, she stated her expectation was the [MEDICAL CONDITION] should be cleaned daily per facility policy. She could not recall the exact policy but thought the machine should be cleaned daily, and the tubing and mask weekly. There should be a physician order [REDACTED]. 10NYCRR 415.12(K)(6)