STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335678	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELDERWOOD AT LIVERPOOL	4800 BEAR ROAD LIVERPOOL, NY 13088

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 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during the abbreviated survey (NY 364), the facility did not promote and facilitate self-determination and did not ensure residents had the right to make choices about aspects of their lives that are significant to them for 1 of 3 residents reviewed (Resident #1). Specifically, Resident #1 was care planned for no male caregivers and a male certified nurse aide (CNA) assisted with positioning the resident during personal care. Findings include: A policy addressing residents' wishes for no male caregivers was requested and the surveyor was informed the facility did not have a written policy. Resident #1 had [DIAGNOSES REDACTED]. The 6/9/20 Minimum Data Set (MDS) assessment documented the resident's cognition was moderately impaired and extensive assistance was required with most activities of daily living (ADLs). The 1/17/20 comprehensive care plan (CCP) documented the resident had potential for alteration in daily customary routine, had deficits in ADL function, and the potential for alteration in mood due to anxiety and depression. Interventions included limited assistance from one person with rolling side to side in bed, extensive assistance from one person with hygiene, dressing and bathing, two staff members present during care, and no male caregivers. The 8/14/20 facility investigation documented at 11:15 AM, the resident reported to a family member they were sexually assaulted by a male the prior evening (8/13/20). Statements obtained by the facility included: - Certified nurse aide (CNA) #1 (male staff member) denied providing personal care to the resident however, he assisted licensed practical nurse (LPN) #3 (female staff member) with placing the resident in bed. - CNA #2 toileted the resident a few times and with the help of LPN #3, transferred the resident out of bed into the wheelchair. - LPN #3 reported the resident was agitated towards staff on 8/13/20 and was yelling loudly. The resident quieted down after being transferred to bed. She and CNA #1 assisted the resident to bed while she provided personal care. - The resident stated in an interview with the social worker that males were not allowed in the room due to the resident not trusting them. The conclusion documented the allegation of sexual assault was unsubstantiated and the facility determined there was a male caregiver in the resident's room on 8/13/20 but he was not alone with the resident at any time, he did not provide any personal care, and only assisted with transfer and positioning. On 8/17/20 at 10:15 AM, the Director of Nursing (DON) stated in an interview, the resident was not to have male caregivers for personal care. When a male CNA was assigned to care for the resident, they were to have a female CNA do all personal care. On 8/17/20 at 1:17 PM, CNA #2 stated in a telephone interview, the resident did not want male caregivers. She stated personal care was provided to the resident several times on 8/13/20 and she did not recall CNA #1 going into the resident's room that evening. She stated she was not sure if male staff could transfer or position a resident if their wishes were for no male caregivers. On 8/17/20 at 1:35 PM, CNA #1 stated in a telephone interview, he was occasionally assigned as the resident's primary CNA even though her wishes were for no male caregivers. He stated when he was assigned to the resident, he needed to find a female CNA to provide personal care and he was not sure if he could transfer or reposition the resident. He stated on 8/13/20, he was assigned as the resident's primary CNA. When the resident needed to use the bathroom, he asked CNA #2 to assist the resident. Later on during the shift, the resident was agitated, kept trying to get out of the chair, and LPN #3 asked for his assistance with the resident. He brought linens and towels to the resident's room and prepared a basin in the resident's room while waiting for LPN #3. When LPN #3 came into the room, they transferred the resident to the bed from the chair. He remained in the room while LPN #3 provided personal care to the resident which included undressing the resident, providing peri care and putting pajamas on the resident. He stated the resident did not say anything about him being in the room, he knew the resident did not want male caregivers, and believed it went against the resident's wishes when he remained in the room during personal care. On 8/17/20 at 2:05 PM, LPN #3 stated in a telephone interview, when male CNAs were assigned to residents that wanted no male caregivers, it was up to the male CNA to find a female CNA to switch residents with. LPN #3 stated CNA #1 switched residents with CNA #2 that evening but CNA #2 was busy when the resident needed assistance, so she asked CNA #1 to help. She and CNA #1 assisted the resident to bed and CNA #1 got washcloths and a basin. She pulled the resident's pants down and began peri care while CNA #1 assisted by holding the resident in position. She then put the resident's incontinence briefs and pajamas on while CNA #1 remained in the room. She stated she forgot the resident did not want male caregivers and CNA #1 never said anything to her. On 8/17/20 at 3:45 PM, the DON was re-interviewed and stated the resident was care planned for no male caregivers and also required 2 staff to be present during care. When a resident was care planned for no male caregivers, the facility's practice was male staff would not provide personal care but could assist with transferring and positioning. On 8/14/20, when the resident made the allegation, she called CNA #1 and had him walk her through his shift from the day before. CNA #1 told her CNA #2 provided personal care to the resident during the shift and that he did assist with repositioning and transferring. She stated she was not aware CNA #1 remained in the room with LPN #3 during the resident's personal care, he should not have remained in the room, and should have at least closed the privacy curtain. She stated when residents' care plans documented no male caregivers, it was open for interpretation and not clear what the instruction was. The facility needed to clarify instructions, needed to meet the residents' preferences, and needed to keep residents safe. 10NYCRR 415.5(b)(1-3)

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