STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335554	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE BRIGHTONIAN, INC	1919 ELMWOOD AVENUE ROCHESTER, NY 14620

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 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during the Recertification Survey, it was determined that for two of three residents reviewed for residents' rights, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries to notify them of their appeal rights under the regulation. Specifically, Resident #299 did not receive a Notice of Medicare Non-Coverage letter or an Advanced Beneficiary Notice notifying the resident of their appeal rights and liability notice, and Resident #300 did not receive a Notice of Medicare Non-Coverage letter prior to being discharged from the facility. This is evidenced by the following: 1. Resident #299 was admitted to the facility on [DATE] and was discharged to the community on 12/16/19. The resident's Medicare A benefits were terminated on 12/13/19. There was no evidence that a Notice of Medicare Non-Coverage letter was provided to the resident prior to being terminated from Medicare A benefits and no Advanced Beneficiary Notice letter was given to the resident regarding their liability. 2. Resident #300 was admitted to the facility on [DATE] and was discharged home on[DATE]. There was no evidence that a Notice of Medicare Provider Non-Coverage letter was provided prior to discharge to notify the resident of their appeal rights. When interviewed on 3/3/20 at 1:05 p.m., the Business Office Manager stated that Resident #299 did not get the Advanced Beneficiary Notice and they should have because they stayed an extra two days which was private pay. She said she was not aware or informed that Resident #299 was being discharged . She said that Resident #300 agreed with the discharge and left before she could give them the Notice of Medicare Non-Coverage letter. She said no one told her the resident was going to be discharged . The Business Office Manager said she did not send Resident #300 a Notice of Medicare Non-Coverage letter via mail when she was notified. She said that she was given an in-service regarding the non-coverage letters. She said that she missed these two residents because she was not informed of the discharges. (10 [ST]CRR 415.3(g)(2)(i))
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews conducted during the Recertification Survey and complaint investigation (#NY 044), it was determined for one (Resident #34) of one resident reviewed for accidents, the facility did not report allegations of possible abuse, neglect, or mistreatment, including injuries of unknown source, to the New York State Department of Health timely. This is evidenced by the following: Resident #34 has [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 10/31/19, revealed the resident had moderately impaired cognition and required the extensive assistance of two staff members for bed mobility, transfers, and toileting. The facility policy, Abuse, Neglect, and Exploitation Prohibition, Training, Investigation, and Reporting Policy, dated December 2016, revealed that an injury is classified as an injury of unknown source when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent or location of the injury. Federal and New York State regulations require the reporting of alleged violations of abuse, neglect, or mistreatment, including injuries of unknown source, immediately to the Department of Health. Alleged violations, including injuries of unknown source, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. In a progress note, dated 12/4/19 at 9:26 a.m., a Registered Nurse (RN) documented that she was notified by a Certified Nursing Assistant that the resident had a bruise on their left ankle. The bruise measured 15 centimeters (cm) x 8 cm, the ankle appeared swollen, and the resident complained of pain when the area was touched. The RN documented that she placed the resident on 24-hour report and the Nurse Practitioner (NP) was notified via the medical team's communication book. An acute medical visit note, dated 12/4/19 at 1:52 p.m., revealed the resident was seen for a bruised and swollen left ankle. The physical exam included that the left ankle was externally rotated (pointing outward), extremely swollen, and appeared to be fractured. Medical was unable to do any type of Range of Motion secondary to severe pain. The provider noted that the resident was a poor historian related to advanced dementia, the cause of injury was undetermined at that time, and there was no reported accident or incident. An X-Ray report, dated 12/4/19 at 2:05 p.m., revealed that the resident had a bi-malleolar (ankle) fracture. Review of the medical record revealed that the resident was hosptalized on [DATE] and had surgery on their left ankle (ORIF- open reduction internal fixation- type of surgery used to stabilize and heal a broken bone) on 12/5/19. An Investigation Summary, dated 12/4/19, revealed that the resident was lying in bed on 12/4/19 at 5:30 a.m., when they were found to have an injury of unknown source to her left ankle. The Director of Nursing (DON) started the investigation on 12/4/19 at 2:00 p.m. In a report to the New York State Department of Health, the alleged event occurred 12/3/19 and was reported by the facility on 12/5/19 at 2:17 p.m. When interviewed on 3/5/20 at 12:54 p.m., the DON stated an incident report should have been started at the time the resident's injury was identified but that did not happen. During interviews on 3/5/20 at 2:42 p.m. and 4:25 p.m., the Administrator stated that she could not say why the incident was not reported immediately to the Department of Health. She said that she did not think it needed to be reported within two hours if the facility was not sure that there was abuse. She said that the facility would have needed to investigate the incident to know if there was abuse. (10 NYCRR 415.4(b)(2))
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, conducted during the Recertification Survey, it was determined for one (Resident #24) of four residents reviewed for Activities of Daily Living (ADLs), the facility did not ensure each resident's care plan was revised to reflect the resident's current condition. Specifically, Resident #24 had grooming needs that were not being met due to non-compliance and refusal of care, and the care plan had not been revised to include measurable goals and approaches to address the resident's care needs. This is evidenced by the following: Resident #24 has [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 1/15/20, revealed the resident had moderately impaired cognition, behavioral symptoms not directed toward others that significantly interfered with resident care, and rejected care on one to three days during the look-back period. The Comprehensive Care Plan (CCP), last revised 3/3/20, included that the resident had behavioral symptoms as evidenced by continuous yelling, non-compliant with care, accusatory of staff, disruptive to peers and visitors, manipulative, and refuses to have nails cut. The goal was that the resident will have

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

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) fewer behavioral episodes. Approaches included to remove resident from group activities if having inappropriate behaviors and that the resident does not attend group activities per choice. Under ADL's approaches included, but were not limited to, to provide assistance per therapy and under behavior plan: no was written. The CCP did not include person-centered, measurable goals or approaches to address the resident's non-compliance and refusals of care. Additional review of the medical record did not include documented evidence that the resident or the resident's representative had input in the development of care plan goals and approaches. A Psychiatry Initial Evaluation Note, dated 1/16/20, includes that the exam was limited due to the resident being uncooperative, easily frustrated, agitated, and not allowing testing or assessment. The exam included that the resident showed an element of paranoia. The Assessment and Plan for mood disorder and dementia with behavioral disturbances, revealed that it was unclear if the resident's behaviors were lifelong or more prone to cognitive changes. The Psychiatrist recommended that Social Work may be able to help by getting some information from the family about the resident's past behaviors. Review of interdisciplinary progress notes included the following: a. On 1/29/20, the note included the resident's daughter was in and requested staff try to get the the resident to the hairdresser. b. On 2/5/20 and [DATE], the Activities Director documented that nail care was offered and the resident refused. c. On 2/14/20, the nurse documented that the resident's thigh was scratched, red and excoriated. The resident stated that they had done it on accident. d. On 2/19/20, the note included the resident was on an antibiotic for [MEDICAL CONDITION] (a bacterial skin infection) of the thigh. e. On 3/3/20, the Nurse Practitioner documented the resident had been evaluated several times over the past 60 days for behaviors of yelling out. She said the resident was not a harm to themselves or others but had anxiety and needed reassurance and non-pharmacological interventions to help the resident be more comfortable. In observations conducted on [DATE] at 2:19 p.m., 3/2/20 at 3:21 p.m., and 3/3/20 at 8:22 a.m., the resident was noted to have hair that was uncombed and matted and fingernails that were untrimmed with a large amount of dark colored debris underneath all nails. When interviewed on 3/3/20 at 2:48 p.m., Certified Nursing Assistant (CNA) #1 and CNA #2 stated the resident will sometimes refuse care but was more compliant with two people in the room. They said the resident allowed them to give a bed bath but always refuses to let anyone touch their hair or nails. CNA #2 stated that the resident's nails were dirty and that she did not think the resident would let anyone touch them. She said the resident's hair needed to be shaved off as it is was all matted. Both CNAs stated that they notify the nurse when the resident refuses care. When interviewed on 3/3/20 at 3:01 p.m., the Licensed Practical Nurse (LPN) stated the resident can be resistant to care at times. She said sometimes the CNAs will request help in convincing the resident to receive care. She said the resident's nails are dirty and that the resident refuses to have their hair and nails done despite trying countless times. The LPN said that the resident's daughter was in agreement with trying to get the resident to the salon if possible, but it was difficult. In an interview on 3/5/20 at 1:10 p.m. and again at 4:10 p.m., the Director of Nursing (DON) stated that the resident's hair and nails looked better then it did when the resident first came. She said the staff have asked the resident and their spouse permission to cut the resident's hair but neither will give permission. She said activities and nursing have tried to do the resident's nails, but the resident will only keep them in the water for few seconds and then will throw the bucket of water. The DON stated the family informed them that this was the resident's behavior and thought it was documented in the record. She said she knew of things that have been tried for the resident but it was not documented. The DON said that the resident's CCP was very generic. The DON said she has been updating resident care plans as she gets to them. She said that often she was the only Registered Nurse in the facility. (10 [ST]CRR 415.11(c)(2)(iii))
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 observations, interviews, and record review conducted during the Recertification Survey, it was determined that for two of four residents reviewed for activities of daily living, the facility did not provide the necessary care and services to maintain personal hygiene. Specifically, Residents #33 and #38 did not receive timely nail care. This is evidenced by the following: 1. Resident #33 has [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated 1/24/20, revealed that the resident required limited assistance of one staff member with personal hygiene. The Comprehensive Care Plan (CCP), dated 12/31/19 revealed that the resident required limited assistance with hygiene. Review of the progress notes for the last 30 days revealed that the resident was cooperative with care. In an observation on [DATE] at 2:25 p.m., the resident's fingernails on both hands were long and jagged with brown debris under the thumb and first finger on the left hand. On 3/3/20 at 12:00 p.m., the resident's nails were jagged, and debris was noted under all of the fingernails on the right hand. When interviewed at that time, the resident said their fingernails could use a little cleaning. During a joint observation with the surveyor and the Licensed Practical Nurse (LPN) Manager on 3/4/20 at 4:15 p.m., the resident's fingernails were jagged with brown debris under the nails on the right hand. When interviewed at that time, the LPN Manager said the resident's fingernails are a little jagged and need to be cleaned. 2. Resident #38 has [DIAGNOSES REDACTED]. The MDS Assessment, dated [DATE], revealed that the resident had severely impaired cognition. The CCP, dated [DATE], included to make sure the resident's nails are trimmed as they scratch themselves. In an observation on [DATE] at 1:53 p.m., the resident's fingernails were jagged. The resident was rubbing their nose and caused a scratch on the left side. On 3/3/20, there was brown debris under all of the resident's fingernails. In a joint observation with the surveyor and the LPN Manager on 3/4/20 at 4:15 p.m., the resident had dark debris under all of the fingernails on their right hand. When interviewed at that time, the LPN Manager said the resident fingernails need cleaning. (10 [ST]CRR 415.12(a)(3))
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #38) of one resident reviewed for activities, the facility did not provide an ongoing activity program based on the comprehensive assessment and care plan to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Specifically, a cognitively impaired resident was not consistently provided with activities per plan of care. This is evidenced by the following: Resident #38 has [DIAGNOSES REDACTED]. The Minimum Data Set assessment dated , [DATE], revealed that the resident had severely impaired cognition, and the activity preferences completed by staff included listening to music, pet visits, doing things with groups of people, and participating in religious activities. The Comprehensive Care Plan for activities, dated 1/14/20, included that the resident would benefit from encouragement and assistance to participate in activities. Approaches included to assist the resident with transportation to all appropriate activities, encourage group activities that will be beneficial to the resident such as music and special events, and provide individual visits for activities as able. The Resident Profile (Certified Nursing Assistant Care Plan), dated 2/16/20, revealed that the resident's activity preferences are coffee and donuts, social hour, music, pets, some television and family. The facility was able to provide the activity history for the resident for the last month (February 2020) which revealed that the resident attended one music activity each week and had a 1:1 visit on [DATE]. Observations revealed that on [DATE] at 1:49 p.m., the resident was sitting in a Geri chair in the hall talking to themselves. On 3/3/20 at 9:52 a.m., the resident was sleeping in a Geri chair in the hallway by the entrance of their room. On 3/4/20 at 1:49 p.m., the resident was asleep in the hallway by the entrance of their room. When interviewed on 3/4/20 at 1:51 p.m., the Activity Assistant said that the resident goes to a music program once a week. He said the resident cannot sit in the common area by the TV because a male resident in the lounge will approach female residents. He said that he did not know what specific activities were meaningful for the resident. He said the Activity Director would have more information but was on vacation. The Activity Assistant said that the Nurse Manager develops the Care Plan. In an interview on 3/4/20 at 2:44 p.m., the Licensed Practical Nurse Manger said the resident goes to activities like bowling . When asked if that was a meaningful activity for the resident, she said, yes, the resident can watch. During an interview on 3/4/20 at 4:18 p.m., the Licensed Practical Nurse said that staff occasionally take the resident to activities. She said she thinks the staff take the resident to the music programs. (10 [ST]CRR 415.5(f)(1))
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 observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #24) of one resident reviewed for respiratory care, the facility did not provide care consistent with professional standards of practice. Specifically, there was no documentation in the resident's medical record of the reason

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) for the use of the as needed [MED]gen, and staff did not report to medical that the resident was using [MED]gen continuously. There was no documentation the [MED]gen tubing was being changed or that a Comprehensive Care Plan for [MED]gen use was developed. This is evidenced by the following: Resident #24 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 1/15/20, revealed the resident had moderately impaired cognition and received [MED]gen therapy during the 14-day look-back period, both while not a resident and while a resident in the facility. The facility policy, Oxygen Administration, dated October 2010, included the purpose of the procedure is to provide guidelines for safe [MED]gen administration. Preparation guidelines include to verify that there is a physician's order and review the resident's care plan to assess for any special needs of the resident. After completing the [MED]gen set-up, documentation in the resident's medical record should include, but is not limited to, the date and time the procedure was performed and the reason for the as needed administration. Physician orders, dated 1/8/20, included [MED]gen per nasal cannula at 2 liters for shortness of breath every shift as needed. In a medical visit note, dated 3/3/20 at 11:27 a.m., the Nurse Practitioner documented the resident's lungs were clear with easy respirations. The Assessment and Plan for hypercapnic [MEDICAL CONDITION] in the setting of [MEDICAL CONDITION] includes that the resident has been stable from a [MEDICAL CONDITION] standpoint. The resident has not had any signs or symptoms of [MEDICAL CONDITION]. The resident was breathing comfortably and had not been requiring [MED]gen. The current Comprehensive Care Plan, last reviewed 1/29/20, does not include the use of [MED]gen. Review of the Treatment Administration Records for January 2020, February 2020, and March 2020 revealed that the as needed [MED]gen was not signed off as administered for three months. During observations on [DATE] at 2:19 p.m., 3/2/20 at 3:21 p.m., and 3/3/20 at 8:22 a.m., the resident was receiving [MED]gen at 2 liters via nasal cannula from a portable [MED]gen concentrator. The nasal cannula tubing was labeled, 2/13/20, 11-7 A. The resident did not have obvious signs or symptoms of respiratory distress. When interviewed on 3/3/20 at 3:01 p.m., Licensed Practical Nurse (LPN) #1 stated that the resident's [MED]gen was ordered as needed for shortness of breath. She said the staff keep the [MED]gen on the resident most of the time due to their anxiety and yelling out that they cannot breathe. LPN #1 said the [MED]gen tubing should be changed weekly on the night shift. After reviewing the date on the nasal cannula tubing, LPN #1 said the tubing should have been changed. In an interview on 3/5/20 at 1:10 p.m., the Director of Nursing stated that the resident's Comprehensive Care Plan should include the use of [MED]gen. She said the resident should have orders to use the [MED]gen continuously, and the Treatment Administration Record should have instructions to change the [MED]gen tubing weekly. She said she would expect that the [MED]gen tubing to be changed weekly, and if the resident was wearing the [MED]gen at all times, the provider should have been notified. She said the resident was having respiratory distress that morning, the provider was notified, and the resident was sent to the hospital. (10 [ST]CRR 415.12(k)(6))
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interviews and record review conducted during the Recertification Survey, it was determined that the facility did not use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This is evidenced by the following: Review of the daily staffing sheets, which includes the actual names of staff who worked from 12/1/19 to 3/4/20 revealed that on 23 of the 27 weekend days (Saturday and Sunday), there was an RN listed as on-call. There was no RN coverage scheduled in the facility. When interviewed on 3/4/20 at 8:19 a.m., Licensed Practical Nurse (LPN) #1 stated that she works every other weekend. She said an RN was not always in the building on weekend shifts, but there was an RN on-call. She said there are some weekends when an RN passes medication. In an interview on 3/5/20 at 3:40 p.m., the Director of Nursing stated that the on-call weekend RN does not always report to the facility. She said there was not always an RN available. When interviewed on 3/5/20 at 3:40 p.m., the Administrator stated that it has been hard to hire RNs. (10 [ST]CRR 415.13(b))
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that the facility did not post the required daily staffing information. Specifically, the facility did not post the resident census, or the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care daily. The daily staffing was not posted in a prominent place readily accessible to residents and visitors, and the facility did not retain daily staffing for a minimum of 18 months. This is evidenced by the following: During observations on [DATE] and 3/2/20, the survey team was unable to locate the daily staffing information. When interviewed on 3/3/20 at 8:30 a.m., the Administrative Assistant/Front Desk Receptionist stated that the daily staffing was posted on the Center Unit at the nurses station. When observed on 3/3/20 and 3/4/20, the daily staffing was posted behind the nurses station on the Center Unit. The daily staffing sheet did not include the resident census, the actual hours worked for licensed and unlicensed nursing staff was pre-printed, the staffing totals for Licensed Practical Nurses and Certified Nursing Assistants had been completed for day, evening, and night shifts, and there were no staffing totals for the Registered Nurse. The daily staffing was observed on 3/5/20 on a table adjacent to the Front Desk Reception in a 5-inch by 7-inch frame. The staffing sheet had been shrunk in size to fit into the frame. Review of facility records revealed that the facility had not retained daily nurse staffing data for a minimum of 18 months to include, but not limited to, no daily staffing for 1/1/20 to 1/15/20 and no daily staffing for December 2019 or November 2019. When interviewed on 3/3/20 at 8:37 a.m. and 3/5/20 at 3:45 p.m., the Assistant Business Office Manager stated that he was responsible for completing and posting the daily staffing. He said that he was not sure if residents and visitors knew where to find the daily staffing information, but they were welcome to view the posting on the Center Unit. He said that he does not necessarily direct residents or visitors to the posted staffing, but he was sure that if they wanted to view it, the Nurse Managers would direct them where to find it. The Assistant Business Office Manager stated the staffing form includes the time the staff are supposed to work not their actual hours worked. He said that was how he was taught to complete the form. He stated the facility started posting the daily staffing in the lobby on 3/4/20. In an interview on 3/5/20 at 3:40 p.m., the Administrator stated the daily staffing form should be updated with the actual staff hours worked.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #22) of six residents reviewed for medication administration, the facility did not ensure that it was free from a medication administration error rate of 5 percent or greater. Specifically, the facility had a medication error rate of 6.9 percent. This is evidenced by the following: Resident #22 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated [DATE], revealed that the resident was cognitively intact and denied pain. Current physician orders [REDACTED]. During an observation of medication administration on 3/3/20 at 8:37 a.m., the Licensed Practical Nurse (LPN) poured multiple medications including the [MEDICATION NAME] into a medi-cup and then into a plastic bag and crushed all the medications, mixed them with applesauce and administered the mixture to Resident #22. The LPN then applied the Salonpas patch to the resident's left shoulder and proceeded to remove a patch that was adhered to the resident's upper arm, dated 3/2/20, and a second patch from the resident's shoulder blade, dated [DATE]. The patch, dated [DATE], had a foul odor when removed. When interviewed at that time, the LPN stated the patches are supposed to be removed at bedtime and agreed that the one had a foul odor. When interviewed on 3/3/20 at 9:06 a.m., along with LPN Nurse Manager, the LPN stated that the resident had trouble swallowing so he had been crushing the medication. The LPN Nurse Manager stated that delayed release capsules should not be crushed, and she expects staff to notify medical if a resident has trouble swallowing medications. The LPN Nurse Manager said that the Salonpas patches should be removed at bedtime each day. The LPN Nurse Manager reviewed the electronic medical record, and then said the order for the Salonpas patches was entered incorrectly when ordered on [DATE]; therefore, the evening shift was not getting the directive to remove the patch. The LPN said that he removed the patch each morning when he was working on that unit. In an interview on 3/5/20 at 10:39 a.m., the Nurse Practitioner (NP) stated that the [MEDICATION NAME] should not be crushed. She said if she had been informed that the resident was having trouble swallowing it, she would have ordered something different. The NP said that the Salonpas pain patches should not be left on the resident for an extended period as it can cause skin irritation. (10 [ST]CRR 415.12 (m)(1))
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.**

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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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) Based on interviews and record reviews conducted during the Recertification Survey, it was determined that the facility did not establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Specifically, the facility did not consistently document employee's influenza vaccination status or declination, and staff were observed in resident care areas without wearing a mask. This is evidenced by, but not limited to the following: Review of the Infection Control program on 3/4/20 at 4:51 p.m. with the Registered Nurse responsible for infection control revealed that the facility had an outbreak of influenza(flu) in February 2020. The Employee Declination Influenza Vaccination and Declination List updated 9/[DATE]9 revealed that 16 of 74 employees had no documentation of their influenza vaccination status and 12 of 74 employees had declined the vaccination. The [ST] State Department of Health Commissioner declared influenza was prevalent in [ST] on 12/5/19. The Regulation for Prevention of Influenza Transmission requires unvaccinated health care workers in certain healthcare facilities regulated by the [ST] State Department of Health to wear surgical or procedure masks during those times when the Commissioner declares that influenza is prevalent in [ST] State In an observation on [DATE] at 8:40 a.m., the maintenance worker was observed on the East unit without a mask. Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1 were observed in resident care areas during survey without wearing a mask. Observation and interviews conducted on 3/5/20 included the following: a. At 9:34 a.m., LPN #1 was observed entering resident room West 12 without wearing a mask. When interviewed at that time, LPN #1 said she just entered the resident's room to hang up their phone. LPN #1 said at 9:34 a.m., that she had worked during that week and did not wear a mask. LPN #1 said that she did not have a flu vaccine. b. At 9:37 a.m., CNA #1 was observed without a mask walking down the west hall and stopped at a doorway to talk to a resident. When interviewed at that time, CNA #1 said that he knew he should be wearing a mask. CNA #1 said that he worked during the week and did not wear a mask. CNA#1 said that he did not have a flu vaccine. c. At 9:34 a.m., the LPN Nurse Manager said staff that did not receive the influenza vaccine should be wearing masks. She said that she did not have a list of employees who should be wearing a mask and did not know who should be wearing one. d. At 9:42 a.m. and 10:57 a.m., the Registered Nurse responsible for infection control said staff that did not receive an influenza vaccine should be wearing a mask. She said she was unable to provide the current influenza mask guidelines. (10 [ST]CRR 415.19(a)(4))