STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335658	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROTON COMMUNITY HEALTH CARE CTR RES CARE FAC	120 SYKES STREET GROTON, NY 13073

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 0582 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**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 record review and interview during the recertification survey, the facility did not ensure residents and/or their designated representative were fully informed of potential financial liability for rehabilitative services during a non-covered stay for 2 of 3 residents (Residents #44 and 75) reviewed. Specifically, Residents #44 and 75 who remained in the facility were not provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), form CMS , when services were no longer covered under Medicare Part A benefits. Findings include: 1) Resident #44 was admitted with [DIAGNOSES REDACTED]. The 4/2/20 Minimum Data Set (MDS) assessment documented the resident started Medicare services on 3/16/20 and the end date of the most recent Medicare stay was 4/1/20. The Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form documented the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The resident's skilled services episode started on 3/16/20 and the last covered day was 4/1/20. There was no documentation that a SNF Advance Beneficiary Notice of Non-Coverage (ABN) was completed and reviewed with the resident and/or the representative upon discharge from Medicare Part A services. 2) Resident #75 had [DIAGNOSES REDACTED]. The 8/15/19 Minimum Data Set (MDS) assessment documented the resident's start date of the most recent Medicare stay was 8/8/19 and was documented as ongoing. The Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form documented the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The resident's Medicare Part A skilled services episode start date was 8/8/19 and the last covered day of Part A service was 9/30/19. There was no documentation that a SNF Advance Beneficiary Notice of Non-Coverage (ABN) was completed and reviewed with the resident and/or the representative prior to discontinuing rehabilitation therapy services. During an interview with billing coordinator #18 on 9/25/20 at 9:11 AM, she stated that Residents #44 and 75 were residents that stayed at the facility for long term care after services ended. She did not know what a SNF ABN was, why it was needed, and had never provided one. 10NYCRR 415.3(g)(2)(iii)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review during the recertification and abbreviated surveys (NY 336), the facility did not ensure the resident environment remained free of accident hazards for 1 of 4 residents (Resident #59) reviewed. Specifically, Resident #59 sustained a fall when the bed lock was broken and the bed moved during a transfer. The resident's current bed was observed with a missing wheel lock. Findings include: The maintenance policy for PCREE (Patient Care Related Electrical Equipment) and non-PCREE equipment dated 11/3/17, documented if no manufacturer maintenance recommendations can be obtained this will be noted in the book and an inspection will be done monthly. The 2/19 facility policy Preventative Maintenance and Inspection documented that in order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program had been implemented to keep equipment in a state of good repair and condition. Routine inspections promote safety throughout the facility and aid in keeping equipment in good working order and operating in accordance with the manufacturer's guidelines. Resident #59 had [DIAGNOSES REDACTED]. The 7/27/20 Minimum Data Set (MDS) assessment documented the resident was cognitively impaired and independent with transfers. The 2/3/20 incident report documented at 11:55 AM, a housekeeper found Resident #59 on the floor in the resident's room. The investigation documented the resident attempted to sit on the bed, the brakes on the bed were not working, and the resident fell . The resident landed on the left knee and hit the left shoulder on the bed resulting in a bruise on the left shoulder. The resident landed on their buttocks on the floor. A maintenance request was made for the bed to be fixed and it was fixed that day. The certified nurse aide (CNA) care instructions active in 9/2020 documented the resident was independent with bed mobility and transfers. During an interview with CNA #15 on 9/23/20 at 11:49 AM, she stated the resident's bed wheels should always be locked prior to transfers. During the interview, the surveyor observed the resident's bed with the CNA. The wheel brakes were locked on 3 wheels and one wheel lock was missing. The bed shifted when pushed. The CNA stated she did not know the lock was missing. If she was aware, she would have notified the Unit Manager. During an interview with licensed practical nurse (LPN) Assistant Unit Manager #23 on 9/23/20 at 12:45 PM, she stated she had not been informed of any issues with the resident's bed wheel locks. The last time the resident had a fall, it was related to brakes not working on the bed and the resident was moved to a new room. The resident's bed was to be locked at all times. During an interview with registered nurse (RN) Unit Manager #24 on 9/23/20 at 12:50 PM, she observed the resident's bed and stated there was a wheel lock missing at the head of the bed. She stated the brakes were to be locked at all times on the bed. During interview on 9/24/20, between 2:05 PM and 2:45 PM, the Maintenance Director stated he was not aware that routine PCREE electric bed maintenance was not being documented. 10NYCRR 415.(h)(1)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional standards, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication rooms (Unit 1) observed. Specifically, the Unit 1 medication room contained expired floor stock multi-vitamins and laxatives. Additionally, the refrigerator contained medications and batteries that were frozen into a sheet of ice. Findings include: The undated facility policy General Rules Concerning Medications did not address disposal of expired medications or refrigerator care and monitoring. During an observation of the Unit 1 medication room on 9/23/20 at 8:32 AM with licensed practical nurse (LPN) #5, the following floor stock medications were observed: -3 bottles of multi-vitamins all with a manufacturer expiration date of 08/2020; and -3 bottles of 5 mg [MEDICATION NAME] laxative capsules all with a manufacturer expiration date of 07/2020. During the observation on 9/23/20 at 8:32 AM, the refrigerator and floor stock shelving was a combined large stainless-steel wall unit. The refrigerator was observed to contain a large sheet of ice that had formed along 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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) back wall and onto the second and third shelves. The second shelf contained several boxes of foiled wrapped [MEDICATION NAME] suppositories and a small tub of [MEDICATION NAME] suppositories that were frozen into the ice and not able to be removed. The third shelf contained multiple boxes of batteries, frozen in the ice, that could not be removed. The battery and suppository boxes were soggy and falling apart. The temperature was observed to be 44 degrees Fahrenheit. There was no temperature log present for 9/2020; the 8/2020 temperature log for days 1-15 had 4 entries only. When interviewed during the observation on 9/23/20 at 8:32 AM, LPN #5 stated nurses were to check for expired medications when they reordered them. He said they probably got missed because the facility did not use those brands anymore. He stated he did not know the policy but would let maintenance know about the ice in the refrigerator. He stated the temperature was to be checked twice daily and overnight staff were to check the temperatures. He stated the temperature log for September would normally be hanging on the bulletin board with the others. During an interview on 9/23/20 at 3:25 PM, registered nurse (RN) Unit Manager #8 stated maintenance was responsible for maintaining the refrigerator and he did not know their process for defrosting. He was unsure if there was a scheduled process, but nursing was supposed to check for expired medications on the night shift. He put the expiration dates on the bottles in black marker so they could be seen easier, and when more were obtained the newer medications were to be placed behind the older ones to rotate the stock. He expected the staff to check the dates every day, so the residents were not given expired medications. 10NYCRR 415.18(e)(1)(4)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review during the recertification survey, the facility did not store food in accordance with professional standards for food service safety for 1 of 1 walk-in cooler (main kitchen walk-in cooler). Specifically, the main kitchen walk-in cooler had a coolant unit compressor that was spitting/leaking water onto food containers. Findings included: During an observation on 9/22/20 at 3:00 PM, the main kitchen walk-in cooler had a metal pan that was full of water on the top shelf located under the coolant unit compressor. The coolant unit compressor was spitting/leaking water into the metal pan, and on top of various jars of food. Three paper boxes for individual yogurts on the shelf beneath the metal pan were water damaged/wet. There was a bin of 7 individually wrapped sandwiches and a container of wrapped lettuce (approximately 1/2 pound) with a water puddle on top of it. These items were immediately voluntarily discarded. During an observation on 9/24/20 at 3:00 PM, the main kitchen walk-in cooler had a metal pan on the top shelf located under the coolant unit compressor. The coolant unit compressor was defrosted, and there was a small piece of glass in place to redirect the splash of water toward the pan. Water was dripping out of the metal pan onto empty shelves. During an interview on 9/22/20 at 3:00 PM, the Food Service Director stated he was not aware the metal pan was being used to collect leaking compressor water. He stated no one notified him that the coolant unit compressor was leaking and there were no work orders for the leaking compressor. 10NYCRR 415.14(h)
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the recertification and abbreviated (NY 230) surveys, the facility did not provide a safe, functional, sanitary, and comfortable environment for residents on 2 of 2 nursing units (Units 1and 2). Specifically, the ice machines, nourishment room countertops and shower rooms were not maintained. Findings include: 1) Ice Machine Maintenance: The ice machine user's manual for the ice machine used on both Units 1 and 2 documented ice machine maintenance and cleaning should be scheduled at a minimum of twice a year. Sanitizing of the ice storage bin should be scheduled for a minimum of four times a year. During an observation on 9/22/20 at 11:20 AM, the Unit 1 nourishment room ice machine tray was discolored with calcium deposits and a black substance. A black substance was also observed around the water spray nozzle on the ice machine. Additionally, the Unit 1 nourishment room counter tops had multiple areas with delamination. During an observation on 9/22/20 at 12:20 PM, the Unit 2 nourishment room ice machine tray was discolored with calcium deposits. During an interview on 9/24/20 at 2:30 PM, the Maintenance Director stated during the month that he had been the Maintenance Director, he had not checked on the maintenance of the ice machines located within the Unit 1 and Unit 2 nourishment rooms. He stated no staff had mentioned to him that the Unit 2 nourishment room countertops were in disrepair. He stated he would expect staff to submit a work order if they had seen any deficient issues. 2) Shower Room Maintenance: During an observation on 9/22/20 at 11:45 AM, the shower room opposite room [ROOM NUMBER] had water accumulated/puddled near the access door to the room. The base of the door frame had exposed rust. The water retention installation on the floor, used to keep the water within the shower section of the room, was damaged/torn. During an observation on 9/22/20 at 12:33 PM, the shower room opposite room [ROOM NUMBER] had water accumulated/puddled around the toilet. There were water stain marks which indicated water would run along the shower water retention installation and then run along the back wall toward the toilet area. During an interview on 9/24/20 at 2:30 PM, the Maintenance Director stated during the month he has been the Maintenance Director, no staff members have ever brought the shower room issues to his attention. He would expect staff to submit a work order if they had seen any deficient issues. 10NYCRR 415.29