STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335280	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TROY CENTER FOR REHABILITATION AND NURSING	49 MARVIN AVENUE TROY, NY 12180

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (Case #NY 874), the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 3 residents reviewed. Specifically, the facility did not ensure Resident #1, received medications as ordered by the physician, when Resident #1 had no bowel movement (BM) for more than 48 hours. Additionally, there was no evidence the medication was given when there was no BM in more than 72 hours. This is evidenced by: The Policy and Procedure (P&P) titled Bowel Management last revised on 5/2019, documented the goal of the facility was to assure residents would have interventions to optimize/maintain bowel health. The Nursing Assistant was to document the resident's bowel movement status every shift in the electronic medical record. The documentation was to include number, size, and consistency of bowel movements. If a resident had no BM in 3 days (72 hours), the licensed nurse was to initiate the bowel regimen, which was approved by the Medical Director, and was to document the administration on the Medication Administration Record [REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 1/21/2020, documented the resident was cognitively intact. The Comprehensive Care plan (CCP) did not include a nursing care plan for the care and management of small bowel obstruction (SBO). The Comprehensive Nutritional Care Plan last updated 12/18/2019, documented Resident #1 had a potential for alteration in nutritional status related to SBO. Physician order [REDACTED].#1 was to receive the following bowel medications: [REDACTED]. The Resident CNA (Certified Nurse Aide) Documentation History Detail Report dated 12/1/2019 through 2/27/2020, documented the resident had a BM on 12/21/19 at 1:29 PM. The next documented BM was 12/26/19 at 4:36 PM. Review of the MAR indicated [REDACTED]. The Medication Administration Record [REDACTED]. There were no documented administrations on the MAR from 12/17/2019 through 12/31/2019. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 12/17/2019 through 12/31/2019. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 12/17/2019 through 12/31/2019. The MAR indicated [REDACTED]. There was no documentation the physician was notified from 12/17/2019 through 12/31/2019. The Resident CNA (Certified Nurse Aide) Documentation History Detail Report dated 12/1/2019 through 2/27/2020, documented the following BMs in January 2020: 1/8/2020 at 11:05 AM. The next documented BM was 1/13/2020 at 12:38 AM. 1/13/2020 at 3:11 PM. The next documented BM was 1/18/2020 at 4:39 PM. 1/26/2020 at 11:27 PM. The next documented BM was 1/31/2020 at 11:53 AM. Review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 1/1/2020 through 1/31/2020. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 1/1/2020 through 1/31/2020. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 1/1/2020 through 1/31/2020. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 1/1/2020 through 1/31/2020. The Resident CNA (Certified Nurse Aide) Documentation History Detail Report dated 12/1/2019 through 2/27/2020, documented the following BMs in February 2020: 2/4/2020 at 12:41 AM. The next documented BM was 2/8/2020 at 1:20 PM. 2/10/2020 at 6:31 AM. The next documented BM was 2/13/2020 at 11:03 AM. 2/14/2020 at 11:46 AM. The next documented BM was 2/18/2020 at 10:33 AM. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 2/1/2020 through 2/21/2020. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 2/1/2020 through 2/21/2020. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 2/1/2020 through 2/21/2020. The MAR indicated [REDACTED]. There were no documented administrations on the MAR from 2/1/2020 through 2/21/2020. During an interview on 2/26/2020 at 3:39 PM, Licensed Practical Nurse (LPN #1) stated the CNAs documented when Resident #1 had a BM. She said she prints a report that shows all residents who have not had a BM in the past 48 hours, and the bowel protocol was initated for all residents on the list. MOM was typically given on the 3 PM -11 PM shift. If there was no BM a suppository would be given on the 11 PM - 7 AM shift. And, if still no BM, a Fleet enema would be given on the 7 AM - 3 PM shift. LPN #1 stated if there was still no BM, she would call the physician (MD). During an interview on 2/26/20 at 3:53 PM, Director of Nursing (DON) stated, the facility's BM protocol was to be started if no BM in 72 hours. She said the nurses could run the No BM report for 48 hours and it might be better for the resident, but the protocol was 72 hours. The DON also stated the physician order [REDACTED].#1 to receive MOM if no BM in 48 hours, but the facility protocol was that it was to be given if there was no BM after 72 hours. During an interview on 3/6/20 at 11:39 AM, MD #1 stated, prior to coming to the facility, they were trying to determine whether Resident #1 had small bowel obstruction (SBO) versus dysmotility. He said the facility should be following the bowel protocol for all residents and said they were the ones who came up with the protocol. 10 NYCRR 415.12
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (Case #NY 874), the facility did not ensure medications were administered per prescriber's order for 2 (Resident #s 1 and 2) of 3 residents reviewed for medication administration. Specifically, the facility did not ensure Resident #1 received prescribed medication for low blood pressure within the parameters ordered. Additionally, for Resident #2, the facility did not ensure the resident received prescribed antianxiety medication for muscle spasm as ordered. This is evidenced by: The Long-Term Care Facility's Pharmacy Service, Policy and Procedures (P&P) Manual documented the following P&Ps revised on 2/1/2018: P&P titled Medication Administration Guidelines documented medication was to be administered as ordered by the physician according to facility policy, and specific medication administration instruction may be included on the pharmacy label. The P&P titled Contacting the Pharmacy documented that, to prevent a delay, facility staff were to contact the prescriber to determine if a drug in the facility's interim/stat/emergency drug supply could be used/substituted until the next scheduled delivery from the pharmacy. If the drug was considered essential and could not be substituted or delayed, facility staff were to contact the pharmacy and request a STAT delivery. Resident #1: Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 1/21/20, documented the resident was cognitively intact. The Comprehensive Care Plan (CCP) for Potential for Alteration in Cardiac Status related to [MEDICAL CONDITION] and hypertension last updated 12/18/19, documented the resident would be free from signs and symptoms of cardiac distress through the next review, but did not include goals and interventions for [MEDICAL CONDITION]. The Physician order [REDACTED].#1 was to receive [MEDICATION NAME] (treats low blood pressure) 2.5 mg, 3 times per day. The medication was to be held if the systolic blood pressure (SBP; the first number) was greater than 120. The Medication Administration Record [REDACTED]. 12/21/19 at 12:00 PM, BP was 152/94; medication was given. 12/22/19 at 5:00 PM, BP was 124/71; medication was given. 12/23/19 at 5:00 PM, BP was 128/76; medication was given. 12/24/19 at 5:00 PM, BP was 130/88; medication was given. 12/26/19 at 12:00 PM, BP was 58/38; medication was not given for below normal parameters 12/29/19 at 8:00 AM, BP was 122/72; medication was given.

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 12/29/19 at 12:00 PM, BP was 123/72; medication was given. The Medical Progress Note dated 1/24/20 at 9:43 PM by the physician (MD #1), documented the resident was on a vasopressor (medication that raises blood pressure) for [MEDICAL CONDITION] three times a day with parameters to hold for SBP greater than 120. The MAR indicated [REDACTED]. 1/4/20 at 8:00 AM, BP was 128/83; medication was given. 1/5/20 at 12:00 PM, BP was 130/76; medication was given. 1/5/20 at 5:00 PM, BP was 124/70; medication was given. 1/6/20 at 8:00 AM, BP was 123/69; medication was given. 1/6/20 at 5:00 PM, BP was 104/66; medication was not given for clinical monitoring 1/7/20 at 5:00 PM, BP was 140/80; medication was given. 1/9/20 at 8:00 AM, BP was 95/65; medication was not given for below normal parameters 1/9/20 at 12:00 PM, BP was 99/86; medication was not given for below normal parameters 1/10/20 at 8:00 AM, BP was 98/58; medication was not given for below normal parameters 1/10/20 at 5:00 PM, BP was 102/67; medication was not given for below normal parameters 1/14/20 at 5:00 PM, BP was 124/76; medication was given. 1/16/20 at 5:00 PM, BP was 122/89; medication was given. 1/18/20 at 5:00 PM, BP was 124/67; medication was given. 1/20/20 at 5:00 PM, BP was 121/62; medication was given. Resident #2: Resident #2 was admitted to the facility with [DIAGNOSES REDACTED]. The MDS dated [DATE], documented the resident had moderate cognitive impairment. The CCP for [MEDICAL CONDITION] Drugs last updated 1/21/20, documented antianxiety medication was being used twice daily for muscle spasm. The Physician order [REDACTED]. The Physician order [REDACTED]. The MAR indicated [REDACTED]. MD aware 2/12/20 at 8:00 PM: Other: awaiting from pharm 2/13/20 at 8:00 AM: Other: pending 2/13/20 at 8:00 PM: Other: n/a 2/14/20 at 8:00 AM: Other: pending 2/14/20 at 8:00 PM: Other: na 2/15/20 at 8:00 AM: Other: waiting in rx 2/15/20 at 8:00 PM: Other: awaiting pharmacy 2/16/20 at 8:00 AM: Refused 2/16/20 at 8:00 PM: Other: awaiting 2/17/20 at 8:00 AM: Other: awaiting from pharm. MD aware 2/17/20 at 8:00 PM: Other: n/a 2/18/20 at 8:00 AM: Other: awaiting from pharm 2/18/20 at 8:00 PM: Other: n/a 2/19/20 at 8:00 AM: Other: awaiting from pharm 2/19/20 at 8:00 PM: Other: n/a 2/20/20 at 8:00 AM: Other: awaiting from pharm 2/20/20 at 8:00 PM: Other: not available 2/21/20 at 8:00 AM: Other: awaiting from pharm During an interview on 2/28/20 at 10:39 AM, Assistant Director of Nursing (ADON) stated, if the nurses had questions about the [MEDICATION NAME] order for Resident #1, they should have contacted the physician, and if nursing administration noticed a trend on the MAR, they could have done staff education. Review of the MAR indicated [REDACTED]. The ADON also stated the protocol for medications that were unavailable at the time of administration was for the nurse to notify the physician to see if there was something else that he wanted to use in lieu of that medication. [MEDICATION NAME] was not in the emergency kit, and she was not made aware that the medication was unavailable for Resident #2. The MD should have been notified and a prescription sent to the pharmacy. During an interview on 3/6/20 at 11:39 AM, MD #1 stated he put the parameter on Resident #1's [MEDICATION NAME] order to hold the medication if the SBP was greater than 120 because the resident had low blood pressure and the purpose of the medication was to keep the blood pressure at a higher level. The nurses should have followed the parameters on the orders, and if the parameters had no meaning, he would not write them on the orders. MD #1 also stated that waiting 10 days for the antianxiety medication to come from the pharmacy was too long to wait. He was able to order medications electronically and did not have to be in the facility to enter orders. Staff should have called him because he could have changed the medication to something else if it was not available from the pharmacy. 10 NYCRR 415.12(m)(2)