STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335103	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER VIEW REHABILITATION AND NURSING CARE CENTER	510 FIFTH AVENUE OWEGO, NY 13827

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview, and record review during the recertification survey, the facility did not ensure each resident had the right to a dignified existence for 2 of 2 nursing units reviewed (First and Second Floors) for dignity. Specifically, staff were observed having personal conversations at a lunch meal and not engaging or including the residents. Additionally, staff were observed discussing resident private information in a loud manner at the nursing station where others could overhear. Findings include: The 2/2013 HIPAA (Health Insurance Portability and Accountability Act) documents residents' health information may not be used and/or disclosed contrary to privacy rules managed by the federal registrar. The facility is required to ensure that health information that identifies the resident is kept private. The undated facility HIPAA Privacy Rule policy documents the privacy rule affects everyone in the facility and at any location on the property. All healthcare facilities are required to protect resident privacy and confidentiality in any form-oral, written or electronic. The 4/2019 revised Quality of Life-Dignity facility policy documents each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. - Resident shall be treated with dignity and respect at all times - Staff shall maintain an environment in which confidential clinical information is protected and verbal staff-to-staff communication (e.g. change of shift reports) shall be conducted outside the hearing range of residents and the public. There was no documentation regarding staff having personal conversations in front of residents. 1) Dining Observation On 3/3/20 from 12:38 PM to 1:01 PM, lunch in the second-floor dining room was observed. Certified nurse aide (CNA) #2 and three other unidentified CNAs were assisting five unidentified residents. The CNAs were talking amongst themselves and not to the residents they were assisting. CNA #2 was overheard discussing an upcoming work party with food and which items she was going to bring. She was also heard discussing personal plans for the upcoming weekend. The staff did not include or engage any of the five residents in the conversation. During an interview on 3/3/20 at 1:45 PM, CNA #2 stated that staff were to talk with the residents and not amongst themselves while feeding residents. She stated that sometimes the conversations crossed over, but she should not have been talking about an upcoming work party or going out over the weekend. She stated it was not intentional. During an interview on 3/3/20 at 3:42 PM, registered nurse (RN) Unit Manager #4 stated staff should be talking with the residents while assisting them with feeding and should not be talking amongst themselves. The staff should not have been talking about their social lives or an upcoming work party. It was a dignity issue and it was unacceptable. During an interview on 3/4/20 at 8:50 AM, the Director of Nursing (DON) stated she expected staff to interact with the resident they were feeding and not to have discussions with each other. Staff should not talk about personal issues and it was not appropriate. 2) First Floor Nursing Station On 3/3/20 at 3:51 PM, the Minimum Data Set (MDS) Coordinator and the Assistant Director of Nursing (ADON) were overheard at the nursing station discussing a new admission in which the resident's name was used. The conversation was in the presence of staff, residents, and visitors. The MDS Coordinator discussed personal details about the resident and the resident's family including mentation. During an interview on 3/3/20 at 4:00 PM, the ADON stated that she was working as the overnight supervisor. She stated the conversation she had was probably not a good conversation to have in a public area and anyone near the desk could overhear their discussion. During an interview on 3/4/20 at 8:35 AM, the MDS coordinator stated that resident information should not be discussed at the nurse's station and she should not have had that conversation with the someone from the State present. During an interview on 3/4/20 at 8:50 AM, the Director of Nursing (DON) stated resident information should be relevant to the resident's condition and report should not include the resident's personal issues or inappropriate comments regarding the resident's mentation. Resident information should be pertinent to the staff receiving report and not be shared with everyone. Shift report or resident report should have been conducted at a low volume level or in a private place such as the Nursing Supervisor's office or the medication rooms; the conversation should not have been conducted at the nursing station and they should not have discussed the resident's mentation. 10NYCRR 415.3(a)
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **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 each resident was provided a clean, comfortable, and homelike environment for 1 of 1 resident (Resident #14) reviewed for homelike environment. Specifically, Resident #14 had a basin containing emesis (vomit) resting on top of the garbage can for 3 days of survey. Findings include: The facility did not have a policy for homelike environment. Resident #14 had [DIAGNOSES REDACTED]. The 12/9/19 Minimum Data Set (MDS) assessment documented the resident was cognitively intact, independent with most activities of daily living (ADLs) and required [MEDICAL TREATMENT]. The 1/12/18 comprehensive care plan (CCP) documented the resident was at increased nutritional risk related to end stage [MEDICAL CONDITION]. The CCP did not address the resident's nausea or related interventions. The 9/6/19 physician order [REDACTED]. The 1/2020 to 2/2020 nursing progress notes documented the resident had nausea, vomiting, or received [MEDICATION NAME] four times. On 3/1/20 at 11:56 AM, the resident was observed sleeping in bed. The resident shared a room with two other roommates who were also in their beds; one watching television and one resting in bed. A gray basin was observed resting on top of the resident's garbage can. The basin contained pieces of undigested beans and clear thin liquid emesis. The basin was observed in the same position and contained the same undigested food pieces on 3/2/20 at 9:22 AM, 3/2/20 at 3:24 PM, and on 3/3/20 at 8:37 AM. The clear fluid had dried onto the edges of the basin and the pieces of undigested food had dried up. When interviewed on 3/3/20 at 1:34 PM, housekeeper #8 stated she was trained that housekeepers were not allowed to touch stool, vomit, or blood. If there were body fluids in the resident rooms, the certified nurse aides (CNAs) would wipe it up and then the housekeepers went around behind them and deep cleaned. She stated she was not aware of Resident #14 throwing up and when she cleaned the resident's room there was no basin resting on their garbage can. If she had noticed one, she would have the CNA remove it so she could take care of the garbage. When interviewed on 3/3/20 at 1:45 PM, CNA #9 stated she was assigned to Resident #14 on 3/1/20 and on 3/3/20. She stated the resident kept a basin at the bedside because the resident sometimes threw up after [MEDICAL TREATMENT]. This did not happen all the time but happened often. The resident was independent and usually emptied the basin themselves. She had thrown a basin away that morning because it was unclean.

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) She stated she threw basins away a lot. She stated if the resident was not taking care of the basin, someone should have been. She stated three days was a long time for a bucket of vomit to be in a room. She did not remember it being there on 3/1/20. She thought people were just used to the resident emptying the basin. It would not be very homelike for the resident's roommates. When interviewed on 3/4/20 at 10:11 AM, licensed practical nurse (LPN) Unit Manager #10 stated room cleanliness contributed to a homelike environment. LPN #10 stated the resident had emesis on occasion. He stated the resident preferred to keep the basin at the bedside because when the resident got sick, it came quickly. The resident was given a new basin every month and emptied it on their own, or the staff emptied it. He had asked the resident to ring the call bell so the basin could be emptied. If the resident did not clean the basin, he expected staff to clean it up. He stated it was no different than leaving a urinal full of urine at the bedside and agreed that the basin with the emesis in it did not contribute to a homelike environment. The resident had roommates that would have to look at it, it contained body fluids, and it was right where staff could easily see it was dirty. 10NYCRR 415.5(h)(1)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **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 develop and implement a comprehensive person-centered care plan for each resident to include services that are to be furnished to maintain the resident's highest practicable physical, mental and psychosocial well-being for 1 of 2 residents (Resident #12) reviewed for communication. Specifically, Resident #12 did not have hearing aids placed for 2 days of survey and hearing aid use was not documented on the resident's comprehensive care plan (CCP). Findings include: The 3/2015 revised Hearing Aids facility policy documented the resident's care plan was to be reviewed for any special needs of the resident. When storing the hearing aid, an order was to be entered into the electronic medical record to remove the hearing aid at bedtime and replace in the morning. The resident's ability to use the hearing aid was to be assessed and any complaints were to be reported to the supervisor. A care plan for the hearing aid was to be initiated on admission and re-admission. Resident #12 was admitted to the facility with [DIAGNOSES REDACTED]. The 12/6/19 Minimum Data Set (MDS) assessment documented the resident did not use a hearing aid and had adequate hearing, was cognitively intact, and was independent for most activities of daily living. The 1/22/18 Audiology Consult documented the resident had moderate-severe hearing loss bilaterally (on both sides). The hearing loss impacted communication. Based on the test results and communication struggles, the resident was recommended for a hearing aid in the left ear and was scheduled for a fitting on 2/13/18. The 2/21/18 nursing progress note documented the resident's hearing aids were placed in the medication cart. The comprehensive care plan (CCP) active on 3/2/20 did not document the resident had hearing aids or a hearing impairment. The 2/2020 and 3/2020 Medication Administration Record [REDACTED]. On 3/2/20 at 11:00 AM, the resident arrived for a resident council meeting. The resident was having a hard time hearing and staff asked if the resident wanted their hearing aid. The hearing aid was brought to the resident at 11:05 AM by the Activity Director. The resident stated to the Activity Director that the resident was unable to put in the hearing aid on their own, and it was given to registered nurse (RN) Unit Manager #4 to put in. On 3/3/20 at 11:33 AM, the resident was lying in bed without the hearing aid. The resident stated that only one nurse offered assistance with the hearing aid on a regular basis and the resident had to ask the other nurses for it. The resident stated it would be easier if assistance with the hearing aid was offered instead of having to remember to ask. During an interview on 3/3/20 at 1:51 PM, licensed practical nurse (LPN) #3 stated that she knew one resident who had a hearing aid and they did not have any orders to have it placed. She was unsure if the facility put physician orders [REDACTED].#4 stated she was responsible for updating the CCP and she was unsure if hearing aids would be documented on the CCP. At 3:34 PM, the ADON joined the interview and stated hearing aids or assistive devices would be documented on the CCP. She said a physician order [REDACTED]. The ADON thought Resident #12 cared for their own hearing aids and was unaware that the resident was unable to put the hearing aid in by themself. She had noticed the resident's hearing aids in the medication cart the previous week and thought it was an unusual occurrence for the resident, and she did not have a chance to follow up on it. RN Unit Manager #4 reviewed the CCP and stated that the hearing aids were not documented on the CCP. The ADON and RN Unit Manager #4 stated the resident needed to have an order entered to assist the resident with the hearing aids on the MAR indicated [REDACTED]. 10NYCCR 483.12(c)(2)-(4)
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.** **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 each resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent decrease in range of motion for 1 of 6 residents (Resident #21) reviewed for position and mobility. Specifically, Resident #21 was observed without a palm guard (a device used between fingers and the palm to prevent injury to the palm from severe finger flexion contracture) in place as care planned. Findings include: The revised 2/2019 Rehabilitation Contracture Management policy documented a contracture was treated with techniques, modalities, or devices deemed appropriate by evaluating and treating clinicians. The care plan will be updated with the therapist's recommendations and a progress note will be entered in the resident's record. There was no documentation regarding the placement of contracture devices. Resident #21 was admitted to the facility with [DIAGNOSES REDACTED]. The 12/14/19 Minimum Data Set (MDS) assessment documented the resident had severely impaired cognition, required extensive or total assistance with activities of daily living (ADLs), and had impairments of both arms and legs. The resident profile (care instructions) initiated 3/22/19 documented the palm guard should be on at all times. Please complete hand hygiene (wash, dry, check nails and skin) prior to each application. The 12/20/19 revised comprehensive care plan (CCP) documented the resident had a contracture of the left hand; interventions included to have a palm guard in place at all times. During an observation on 3/1/20 at 11:40 AM, the resident was sitting in a Geri (positioning) and the resident's left hand was contracted into a fist without a splint or washcloth in the palm. During observations on 3/1/20 at 12:59 PM and 3:00 PM, the resident had no splint or washcloth in either hand. The resident's left hand remained contracted in the same position. During observations on 3/2/20 at 8:44 AM and 10:00 AM, the resident was sitting in a Geri chair in the resident's room, the left hand was contracted into a fist and the hand was bent at the wrist and towards the forearm. The resident had no splint or washcloth in either hand During an observation on 3/2/20 at 2:20 PM, there was a palm guard in a pink wash basin in the resident's nightstand cabinet. The resident was in bed lying on the left side facing the wall. The resident's left hand remained contracted into a fist with nothing in the palm. When interviewed on 3/2/20 at 3:22 PM, certified nurse aide (CNA) #1 stated she cared for the resident every time she worked. Resident specific care was documented on each resident's care plan and care instructions. The resident was to have a palm guard in the left hand at all times. When interviewed on 3/3/20 at 9:34 AM, CNA #2 stated she may have gotten the resident up on the morning of 3/1/20 and was not sure as they were short staffed. Resident specialized care was written in each resident's care plan. She thought the resident used to have a splint but was not sure if the resident was using it anymore. The CNA looked up the care plan and stated the resident was to have a left palm guard at all times except during care. She stated the morning of 3/1/20, there were only 2 CNAs on the unit, and they forgot to put it in the resident's hand. The purpose of the palm grip was to prevent contractures, and the resident was unable to open the left hand or put the palm guard on without assistance. When interviewed on 3/3/20 at 9:44 AM, licensed practical nurse (LPN) #3 stated the nurse on duty was responsible for ensuring the CNAs used the resident equipment. Palm guards were used to prevent further contractures and prevent skin breakdown. She stated she usually checked to ensure the resident had it on when doing treatments on the unit. She stated the resident was supposed to have a palm grip in the left hand at all times, except for care. She stated she was on duty 3/2/20 and was off 3/1/20. She was not sure if the resident was wearing the left palm guard on 3/2/20. She expected the CNAs to place the palm guard in the resident's hand if it was on the care plan and notify her if the resident refused. When interviewed on 3/3/20 at 9:56 AM, registered nurse (RN) Unit Manager #4 stated she expected care planned resident equipment to be utilized. The nurses on the unit were to check to ensure the equipment was used as ordered. If the resident refused, the CNA was to tell the LPN, who then was to tell the RN. She expected the LPN to document any refusals and if it occurred frequently, they would request a therapy

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) screen. The palm guard was used to prevent skin breakdown and prevent the contractures from getting worse. The resident had left hand contractures and could not open the left hand without assistance. When interviewed on 3/3/20 at 11:49 AM, the Director of Therapy stated occupational therapy (OT) was usually responsible for the evaluation and recommendation of palm guards. The purpose of a palm guard was to prevent skin breakdown in the palm and to prevent a contracture from worsening. The resident had a left palm grip to be worn at all times except during care. She expected it to be worn as ordered and the palm guard was evaluated quarterly. She stated the CNAs were responsible to ensure the use of the palm guard if it was in the care plan. The nurse was responsible for ensuring it's use if there was a physician order [REDACTED].
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview, and record review during the recertification survey, the facility did not ensure each resident received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 3 of 4 meals (breakfast, lunch, dinner) tested for palatability and temperature. Specifically, items on breakfast, lunch, and dinner trays were served at unpalatable and unsafe temperatures. Findings include: The 10/2018 Food Preparation and Service policy documented the danger zone for food temperatures is between 41 degrees Fahrenheit (F) and 135 degrees F. The longer foods remain within the danger zone, the greater the risk for the rapid growth of microorganisms that can cause foodborne illness. On 3/1/20 at 11:16 AM, Resident #3 stated the food was often cold. On 3/1/20 at 2:52 PM, Resident #46 stated the temperature of the food was lukewarm. On 3/2/20 between 11:09 AM to 11:47 AM, a resident council meeting was conducted, and anonymous residents stated that the hot foods were not always hot, and the cold foods were not cold. Residents had specific complaints regarding cold soup and cold breakfast. On 3/2/20 at 5:15 PM, Resident #3's dinner tray was tested . The temperature of the mechanically ground pork was 122 degrees Fahrenheit (F), the gravy was 110 degrees F, and the applesauce was 66 degrees F. The resident received a replacement meal. On 3/2/20 at 12:10 PM, Resident #16's lunch tray was tested . The temperature of the soup was 110 degrees F, the roast beef was 129 degrees F, the milk was 47 degrees F, the rice was 131 degrees F, and the cauliflower was 132 degrees F. The resident received a replacement meal. On 3/4/20 at 7:44 AM, Resident #63's breakfast tray was tested . The temperature of the toast was 111 degrees F, the milk was 46 degrees F, and the juice was 49 degrees F. The resident received a replacement meal. During an interview on 3/3/20 at 8:05 AM, the Food Service Director stated that food temperatures should be greater than 140 degrees F and less than 40 degrees F when served. She stated that the gravy, mechanically ground pork, beef, soup, rice and cauliflower should have been a little warmer. The applesauce, juice, and milk should be served at a colder temperature. Foods should be served in the acceptable range to prevent residents from getting sick from food poisoning, and for palatability. 10NYCRR 415.14
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **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 maintain an infection and prevention control program designed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of communicable diseases for 4 of 9 residents (Residents #20, 21, 38, and 46) observed during medication administration observations. Specifically, two licensed practical nurses (LPNs) were observed not performing hand hygiene during medication administrations. Findings include: The 1/2017 Handwashing/Hand Hygiene facility policy documented staff were to use an alcohol based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations: before and after direct contact with residents; before preparing or handling medications, after contact with a resident's intact skin, and after contact with objects in the immediate vicinity of the resident, among others. Resident #21 had [DIAGNOSES REDACTED]. The 12/14/19 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment and took an antianxiety medication daily. The 4/4/19 physician order [REDACTED].); give 30 ml. three times a day at 8:00 AM, 2:00 PM, and 8:00 PM for chronic pai[DIAGNOSES REDACTED]. Resident #46 had [DIAGNOSES REDACTED]. The 2/14/20 Minimum Data Set (MDS) assessment documented the resident was severely impaired cognitively and took antianxiety medication daily. The [DATE] provider order documented [MEDICATION NAME] 1mg three times a day at 9:00 AM, 3:00 PM, and 9:00 PM for dementia with behavioral disturbance. During a medication administration observation on 3/3/20 at 2:27 PM, LPN #11 prepared [MEDICATION NAME] and [MEDICATION NAME] for Resident #21. She crushed the [MEDICATION NAME] pill and thickened the liquid [MEDICATION NAME] medication. She assisted sitting the resident up and touched the resident's blanket and chair. She gave the resident the medications with thickened juice, then returned to the medication cart. She did not perform hand hygiene. LPN #11 then withdrew an [MEDICATION NAME] pill from the locked narcotic box on the medication cart for Resident #46. She crushed the pill and mixed it with pudding. She touched the resident's wheelchair, pushed the resident back to their room and administered the medication. She returned to the medication cart, touched the cart, the cart keys, and the narcotics count sheets. She did not perform hand hygiene. When interviewed on 3/3/20 at 2:47 PM, LPN #11 stated she did not think she needed to perform hand hygiene more often than every three residents. She stated she had participated in a mock survey and that was what she was told. When interviewed on 3/3/20 at 2:53 PM, registered nurse (RN) Unit Manager #4 stated she expected the LPNs to clean their hands between residents when passing medications. Resident #20 had [DIAGNOSES REDACTED]. The 12/14/19 MDS assessment documented the resident had mild cognitive impairment. Resident #38 had [DIAGNOSES REDACTED]. The 1/7/20 MDS assessment documented the resident was moderate cognitive impairment. The 10/13/16 physician order [REDACTED]. The [DATE] physician order [REDACTED]. During a medication administration observation on 3/3/20 at 3:20 PM, LPN #12 prepared a [MEDICATION NAME] tablet for Resident #20. She touched the medication cart, the computer, and the medication container. She gave the resident the medication and touched the resident's arm. She returned to the medication cart and did not perform hand hygiene. LPN #12 then touched the cart, computer, and placed a [MEDICATION NAME] pill in a cup for Resident #38. She gave Resident #38 the medication and returned to the medication cart. She did not perform hand hygiene. When interviewed concurrently, LPN #12 stated it was her first night passing medications independently. She had received training in orientation regarding when to clean her hands. She stated she was nervous and must have forgotten. She stated not washing her hands was an infection control issue. When interviewed on 3/4/20 at 10:36 AM, the Assistant Director of Nursing (ADON)/Infection Control RN #7 stated employees were trained regarding hand washing and hand hygiene during orientation and they tried to go over it yearly after that. She stated they were taught to wash their hands before doing treatments, before and after wearing protective gloves, and when going from dirty to clean procedures. She stated during medication passes they should be using hand sanitizer after every resident, and then washing their hands with soap and water after every three to four residents. 10NYCRR 415.19(4)