STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335473	A. BUILDING _____ B. WING _____	06/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIGHTON MANOR	989 BLOSSOM ROAD ROCHESTER, NY 14610

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Post Survey Revisit, it was determined that for three of three residents reviewed, the facility did not ensure the services provided or arranged by the facility as outlined in the Comprehensive Care Plan met professional standards of quality. Specifically, the medication or treatment records had missing documentation that prescribed medications or treatments were administered as ordered on multiple occasions for Residents #5, #7, and #10. This is evidenced by the following: The undated facility policy, Administration of Medications, included that medication administration must be documented in the Electronic Health Record (EHR) immediately before moving on the next resident. 1. Resident #5 had [DIAGNOSES REDACTED]. The Minimum Data Assessment (MDS) Assessment, dated 2/20/20, revealed the resident was cognitively intact. When interviewed on 7/29/20 at 12:45 p.m., Resident #5 stated that they receive their medications late in the morning. Resident #5 said the facility was short staffed the previous evening, and they did not receive any of their scheduled medications, which included a medication for high blood pressure. Review of the Administration Documentation History Detail Report for Medications in the EHR, from 7/25/20 to 7/29/20, revealed there was no documentation that prescribed medications or supplements were administered as ordered for 21 of 69 opportunities. The progress notes for the same timeframe did not include any documentation related to the administration of medications or supplements. 2. Resident #10 had [DIAGNOSES REDACTED]. The MDS Assessment, dated 7/22/20, revealed the resident was cognitively intact. When observed on 7/29/20 at 11:52 a.m., the skin under Resident #10's left breast was darker in color, shiny, with no open areas or weeping noted. When interviewed at that time, Resident #10 stated they were supposed to have medicated creams applied under their breasts and to their groin, arms, and knees daily, but the creams had only been applied twice in the last four weeks. Resident #10 stated that the nurses had not taken their blood pressure in a long time. Review of the Administration Documentation History Detail Report for Treatments in the EHR, from 7/25/20 to 7/29/20, revealed there was no documentation that prescribed treatments were administered as ordered for 26 of 64 opportunities, and the resident's blood pressure was not monitored as ordered for 6 of 14 opportunities. Review of the Administration Documentation History Detail Report for Medications, from 7/25/20 to 7/29/20, revealed there was no documentation that prescribed medications were administered for 10 of 53 opportunities. Review of the progress notes during that same timeframe did not include any documentation related to the administration of treatments, medications, or blood pressure monitoring. 3. Resident #7 had [DIAGNOSES REDACTED]. The MDS Assessment, dated 5/20/20, revealed that the resident understands others, was understood by others, and was independent in decision making that was reasonable and consistent. In an interview on 7/29/20 at 12:57 p.m., Resident #7 stated that the facility was still short of help and that they are still not getting their prescribed medications. Review of the Administration Documentation History Detail Report for Medications in the EHR, from 7/25/20 to 7/29/20 at 9:00 a.m.) revealed 39 entries for 13 different medications were Not Documented as administered and the user (nurse) was blank. The medications were for [MEDICAL CONDITION], heart failure, diabetes, [MEDICAL CONDITION], depression, and multiple eye drops for ocular hypertension (high pressure in the eyes). Review of progress notes during that same timeframe did not include any documentation related to the administration of medications. Review of the staffing sheets revealed several different nurses were assigned to the shifts that had the missing documentation. When interviewed on 7/29/20 at 3:13 p.m., the Licensed Practical Nurse (LPN) stated that she worked on some of the shifts with missing documentation. The LPN said she was sure she had administered all medications for Residents #5 and #7 but forgot to sign that they were administered. The LPN said she sometimes forgets to sign that she administered medications but will usually catch it later when she reviews the Medication Administration Records at the end of her shift or from home. The LPN said she was supposed to sign the medications when they are administered. The LPN said if a medication was not documented, then it was not done. When interviewed on 7/29/20 at 3:15 p.m., the LPN Nurse Manager stated that if a medication was not documented, then it was not done. She said that she expects the nurses to document in a progress note and notify the provider if a medication was not given. (10 NYCRR 415.11(c)(3)(i))
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the COVID-19 Focused Infection Control Survey (#NY 869) and complaint investigations (#NY 450, #NY 577, #NY 694 and #NY 170) completed on 6/8/20, it was determined that for two of two units (second floor and third floor) the facility did not have sufficient nursing staff on a 24 hour basis to care for residents' needs. Specifically, staffing ratios were not adequate. Residents were not receiving medications and treatments in a timely manner. Observations revealed multiple residents were not assisted out of bed or dressed the entire shift. Residents were not getting personal care per their choice or being fed timely due to insufficient staffing. This is evidenced by the following: Review of the current facility policy, Human Resources Emergency Policy, revealed the policy was to be utilized in an extreme shortage of direct care staff due to an illness outbreak. The policy included use of outside agencies and non-licensed staff in an emergency and included staffing ratios for a 40 bed unit. The CNA ratio should be 1:10 on days, 1:12 on evenings, and 1:25 on nights. The nurse ratio was 1:27 on days and evenings, and one nurse on nights. Review of staffing schedules and billing records for two of two residential units (second floor unit and third floor), dated 5/18/20 through 6/7/20, included the following: a. The CNA to resident ratio exceeded 1:14 and up to 1:22 on day or evening shifts on at least 20 shifts on one or both units. b. The night shift on 5/23/20 had one LPN and no CNAs on the third floor for a census of 36. c. The night shift on 5/24/20 had no CNAs in the house. Two LPNs worked, one on each unit for a census of 15 on the second floor and 35 on the third floor. d. The night shift on 5/27/20 had no LPNs and one CNA for 13 residents on the second floor and one LPN and one CNA on the third floor for 33 residents. The Director of Nursing (DON) was on call via phone as the supervisor. e. The evening shift on 6/1/20 had one LPN on unit two and no CNAs for 22 residents. Unit 3 had one LPN and one CNA for 22 residents. There were four residents that were positive for COVID-19 on the second floor and 15 on the third floor at that time. f. The evening shift on 6/6/20 revealed one LPN and one CNA (till 8:00 p.m.) on the second floor for 22 residents, and the third floor had one LPN and one Occupational Therapist (OT) until 8:00 p.m. and a nourishment aide (who did not provide direct care) for 21 residents. g. The day shift on 6/7/20 revealed one LPN and one CNA on the second floor for 22 residents, and one LPN alone on the third floor for 21 residents until the OT was called into work and arrived at 10:30 a.m. Observations conducted on the second floor on 6/1/20 (day shift) starting at 9:00 a.m., revealed a census of 22 residents. There was one LPN and one CNA caring for all residents the entire shift. At 10:00 a.m., there were 17 residents in bed wearing hospital gowns, and at 2:00 p.m., 10 residents remained in bed, ungroomed and wearing hospital gowns. Eight of the residents required extensive assist of staff for some or all of their Activities of Daily Living per their most recent Minimum Data Set (MDS) Assessments. At 4:00 p.m.,

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) there was one LPN and no CNAs. LPN #5 stated at that time she was the only staff currently on the unit (staying over from the day shift) and she did not have any CNAs on the units. In an interview on 6/1/20 at 4:40 p.m., the Administrator stated he was aware there was no CNA on the second floor for the evening shift and said he requested a staff member to stay and do a double. Observations conducted on the second floor on 6/2/20 at 2:35 p.m., revealed a census of 22 residents and there was one LPN and one CNA. Fifteen residents remained in bed and were dressed in hospital gowns. A strong odor of bowel incontinence permeated one side of the unit. Observations conducted on 6/7/20 at 12:45 p.m., revealed one LPN and one CNA caring for 21 residents on the second floor. The third floor had one LPN, no CNAs, and one Occupational Therapist. The Electronic Health Records were reviewed for six residents (Residents #1, #2, #3, #5, #6 and #7) and included the following: 1. Resident #5 resides on the third floo and has [DIAGNOSES REDACTED]. The MDS Assessment, dated 2/20/20, revealed the resident was cognitively intact. Review of the Medication Administration Record [REDACTED]. On 15 occasions a medication was not documented as administered at all. Medications included, but were not limited to, anti-hypertensive, blood thinners, anti-depressive, and diuretics (water pill). When interviewed on 6/1/20 at 10:46 a.m., Resident #5 stated they waited one hour for a nurse to get them off the bedpan, but she never came back, so the resident transferred themselves. Resident #5 said they needed help to get cleaned up and no one ever came until the next shift. Resident #5 said they had not had a bath in several weeks and thinks they should be getting a full bed bath at least once a week. 2. Resident #3 resides on the second floor and has [DIAGNOSES REDACTED]. The MDS Assessment, dated 4/29/20, revealed the resident was cognitively intact. Physician orders, dated 4/6/20, included a left lower extremity stump sock to be worn at all times and to check for placement every shift. When observed on 6/1/20 at 2:10 p.m., Resident #3 did not have a stump sock on their left lower extremity and there was no dressing or heel bootie to the right lower extremity. The May 2020 Treatment Administration Record Report revealed it was not documented as completed on 38 shifts. 3. Resident #7 resides on the third floor and has [DIAGNOSES REDACTED]. The MDS Assessment, dated 2/24/20, revealed that the resident had moderately impaired cognition. The current CNA Care Plan provided by the facility revealed that the resident required one-person physical assist for personal hygiene and directed to provide care in the bathroom. The CNA Documentation History Detail, from 6/1/20 to 6/7/20, revealed no documentation for any type of care (bathing, bed mobility, behaviors, eating, dressing, locomotion, nutrition, oral care, range of motion, personal hygiene, toilet use, skin checks, and ambulation). Current physician orders, dated 5/10/20, included to monitor vital signs every shift. The Clinical Monitoring Detail Report from 6/1/20 to 6/7/20 (day shift) revealed that the resident's vital signs were not documented 10/21 opportunities (no vital signs were documented 6/4/20 thorough 6/7/20 days) and no vital signs were documented in the progress notes from 6/4/20 through 6/7/20. In an observation and interview on 6/7/20 at 1:35 p.m., Resident #7 was in bed in a hospital gown and stated that there was only one nurse working on the third floor and no CNAs. Resident #7 said that the last time they were assisted with personal care was the previous day. Resident #7 stated that breakfast was delivered at 10:45 a.m. but he did not eat it because the food was cold from sitting in the food cart for two or more hours. When interviewed on 6/7/20 at 3:15 p.m., LPN #1 said that vital signs should be taken every shift on the COVID-19 units and documented. She said if it was not documented it was not done. She said the residents on the third floor require more assistance with cares. In an interview on 6/2/20 at 2:50 p.m., LPN #4 stated that having one CNA on the unit was a problem. She said residents do not get toileted enough, maybe once or twice a shift. She said showers are not being done, residents are not getting out of bed, and incontinence care was not done timely. In an interview on 6/3/20 at 12:45 p.m., the Administrator stated that he was aware of the shortage of staff and was very concerned. He stated that he gave the owner the names of two more agencies to attempt to get contracts drawn a month and a half ago but was refused until last week and feels his hands are tied if the owner refuses to hire more staff. He said that the two additional agency contracts have not gone through yet. In a telephone interview on 6/4/20 at 11:48 a.m., the Administrator stated he was still waiting for approval from the owner for the contracts for more agency help. He said the current Director of Nursing was interim and works Monday through Friday on the evening shift but does not work on the units. When interviewed on 6/7/20 at 12:45 p.m., LPN #2 said they were the only person on the third floor until about 10:30 a.m. when the Occupational Therapist arrived. LPN #2 said that call bells were not being answered, care was not being provided timely, residents were requesting assistance, and breakfast trays were not delivered until between 10:45 a.m. and 11:00 a.m. He said the breakfast food was cold and had been sitting for hours. LPN #2 said that they made medications and treatments their priority. They said it was impossible to complete vital signs for 21 residents. In an interview on 6/7/20 at 2:10 p.m., and again on 6/8/20 by telephone at 9:05 a.m., CNA #1 stated that she was the only aide on the unit on 6/6/20 day shift and that she completed morning care for all 21 residents by 2:40 p.m. She said that she did not have time to check and change anyone once their morning care was completed. She said care should be documented in the computer but it can not be done due to short staffing. When interviewed on 6/7/20 at 2:00 p.m., 5:20 p.m., and 6:25 p.m., the interim Administrator said that for the day shift on 6/7/20, there was one nurse on each unit and eventually one person on each unit providing direct care. She said that no one reported that breakfast was not served or served late. She said the breakfast trays arrive on the third floor about 8:10 a.m., and she expects the trays to be served within 20 minutes. She said that she would not expect one nurse to pass medications, pass breakfast trays, provide care, answers call lights, and complete vital signs as that was impossible. She said the CNAs should be documenting cares every shift, but it has not been done due to short staffing. (10 NYCRR 415.13(a)(1)(i-iii))
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Post Survey Revisit, it was determined that for one of three residents reviewed, the facility did not ensure that each resident was free from significant medications errors. Specifically, Resident #7 did not receive an ordered medication for an extended period of time. This is evidenced by the following: Resident #7 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 5/20/20, revealed that the resident understands others, was understood by others, and was independent in decision making that was reasonable and consistent. The current Comprehensive Care Plan (CCP) included that the resident had [MEDICAL CONDITION] requiring supplements and interventions, to administer medications per orders, and monitor lab values. The CCP also revealed that the resident has a history of refusing care and medications at times. In an interview on 7/29/20 at 12:57 p.m. and again on 7/30/20 at 1:30 p.m., Resident #7 stated that they were not getting their [MEDICAL CONDITION] medication and they did not know why. Resident #7 said that they had their [MEDICAL CONDITION] taken out and they were supposed to be receiving a [MEDICAL CONDITION] medication. Resident #7 stated that sometimes they refuse medications or blood work but mostly because staff do not tell them what the medications or lab work is for. Resident #7 said if they knew, they would not refuse. Review of the Electronic Medical Record (EMR) revealed the following: a. Physician orders, dated 6/12/20, 7/5/20 and 7/28/20, revealed orders for [MEDICATION NAME] 50 micrograms (mcg) by oral route once daily for 14 days. Take along with 200 mcg daily dose for a total dose of 250 mcg. b. The most recent medical progress notes, dated 6/9/20 by the physician and again on 7/23/20 by the Nurse Practitioner (NP), revealed the resident was on [MEDICATION NAME] daily, was being monitored, and that the most recent [MEDICAL CONDITION] level (blood test) was therapeutic. c. Review of the June 2020 and July 2020 Medication Administration Records (MARs) in the EMR revealed no documented evidence that the resident received the [MEDICATION NAME] since 5/21/20. When interviewed on 7/30/20 at 1:15 p.m., the Licensed Practical Nurse (LPN) stated that she thought the resident was on [MEDICATION NAME]. After review of the MARs and the medication drawer, the LPN said the resident has not been getting the [MEDICATION NAME]. In an interview on 7/30/20 at 2:00 p.m., the Interim Director of Nursing (DON) stated, after review of the EHR, that it appeared the order did not to make it to the MARs. She said if the provider enters the order in the computer accurately, they have to push a second button for it to show up on the MARs. She said the unit managers are expected to reconcile the orders with the MARs but somehow it got missed. When interviewed on 7/30/20 at 2:50 p.m., the pharmacist stated that he did not realize that the [MEDICATION NAME] was dropped from the system when he completed his monthly review. He said it was not unusual for the physician to hold the medication for a short period of time (which occurred in May). He said he felt the resident should be on the medication long term. When interviewed on 8/3/20 at 10:40 a.m. and again at 2:12 p.m., the Interim DON said that after discussion with the physician (following surveyor intervention), the physician said the resident was supposed to be on the medication and thought possibly the resident had been refusing. She said another [MEDICAL CONDITION] blood level was ordered which was drawn on 7/31/20 and revealed a value of 144 (normal range is 0.27-4.20). When asked how the order got missed for so long, the Interim DON stated that she was not sure how it fell through the cracks. She said the pharmacy reported they did not fill the order and requested clarification of such a high dose. She said the pharmacy reported they never received a call back and it was not followed up on. In an interview with the NP on 8/3/20 at 2:30 p.m., she stated that a side effect of the

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) elevated [MEDICAL CONDITION] level would be [MEDICAL CONDITION] (severe [MEDICAL CONDITION] resulting in severe swelling of the body, especially the face, tongue, and lower legs and in advanced cases coma). She said she did a full assessment and the resident appeared to be stable at that time other than some lethargy. The NP said she ordered STAT (immediate) blood work to check the resident's kidney function, respiratory function, hemoglobin, and added oxygen therapy as a precaution. The NP said she was also ordering consults with renal, cardiac, and the endocrinologist. (10 NYCRR 415.12(m)(2))
F 0836 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during the COVID-19 Focused Infection Control and Complaint Investigations (#NY 694, #NY 170, #NY 577, and #NY 869) Survey completed on 6/8/20, the facility did not ensure that it was in compliance with all applicable Federal, State, and Local Laws, Regulations, and Codes. Specifically, the facility did not comply with New York State Executive Order (EO) 202.18 and ensure that resident's family and/or their next of kin were notified of either a single confirmed infection of COVID-19 or COVID-19 death within 24 hours from the date of occurrence for one (Resident #6) of three residents reviewed. This is evidenced by the following: The Executive Order #202.18, dated April 16, 2020, documented the following: Any skilled nursing facility, nursing home, or adult care facility licensed and regulated by the Commissioner of Health shall notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death. 10 NYCRR 415.3(f)(2)(ii)(b) further provides that the facility shall, except in a medical emergency, consult with the resident immediately if the resident is competent, and notify the resident's physician and designated representative within 24 hours when there is . a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and services(.) Review of the facility's COVID-19 Isolation Forms revealed that there were 20 resident confirmed cases of COVID-19 between 4/28/20 and 5/22/20. Review of the Admission, Discharge, Transfer (ADT) Activity Detail Report included three resident deaths on 5/4/20, 5/6/20, and 5/17/20. The facility's Robocall system notified families of confirmed positive resident COVID-19 cases as well as deaths related to COVID-19 in the facility. Additionally, the facility's Robocall system communicated to families on 5/27/20 that there was of one additional resident death in the last 24 hours. Resident #6 has [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 1/13/20, revealed the resident was cognitively intact. There was no documented evidence Resident #6's Health Care Proxy (HCP) or any other family members had been contacted regarding the resident's [DIAGNOSES REDACTED]. During an interview on 6/1/20 at 4:05 p.m., Licensed Practical Nurse (LPN) stated Social Work notifies the residents and their families about new cases of COVID-19 at the facility. During an interview on 6/1/20 at 5:07 p.m., Resident #6's HCP stated that no one has given her any information about Resident #6's condition or notified her of any new cases of COVID-19 or related deaths at the facility. The HCP stated she contacted the facility several times and provided her contact information but has not heard back so she has filed a formal complaint. During interviews on 6/1/20 at 3:50 p.m. and 6/2/20 at 3:47 p.m., the Social Worker stated that there was no documentation in the medical record related to when Resident #6's sister was identified as the HCP. The Social Worker said she had not personally spoken to the HCP and could not find documentation that nursing had talked to her either. She said the facility did not have a Social Worker when the resident was transferred from another facility, and no one followed up to get a copy of the Health Care Proxy. She said that she sends out the Robocall regarding COVID-19 information in an email to all family members every day. (10 NYCRR 400.2)