STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335201	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETH ABRAHAM CENTER FOR REHABILITATION AND NURSING	**612 ALLERTON AVENUE BRONX, NY 10467**

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 0564 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview conducted during the Infection Control Focus and Abbreviated Survey (NY 418), the facility did not ensure that the resident's representative were informed, where appropriate, of their visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights were honored. Specifically, the facility did not allow the resident's representatives to visit a resident who was categorized under the exception of end of life status . This was evident for 1 of the 3 resident reviewed for Resident Rights. (Resident # 1) The finding is: The Centers for Medicare & Medicaid Services (CMS) notice dated 3/13/20 # Ref: QSO-20-14-NH, documented the following: In order to protect the most vulnerable in our society, the Centers for Medicare & Medicaid Services (CMS) has announced new measures designed to keep nursing home residents safe from COVID-19. On March 13, 2020, CMS published a revised Memorandum offering guidance for the control and prevention of the spread of Coronavirus in nursing homes. Pursuant to the revised Memorandum, facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain [MEDICATION NAME] care situations, such as an end-of-life situation. The facility policy titled Clinical Operations dated 3/11/20 documented the following: the facility has established policies to attempt to prevent and control the spread of COVID-19, this include but is not limited to visitation. Facility shall restrict visitation, except for the following (resident on end of life) visitor should be limited to a specific room and the visitors are required to go through screening process prior to entry. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Annual MDS dated [DATE] documented the resident's cognitive status as impaired, and the resident required total assistance with Activities of Daily Living. The MDS also documented that the resident received Hospice care. Physician order [REDACTED]. On 8/14/20 at 10:10 AM, the resident was observed in the room, alert and awake. The resident was lying on the GeriChair, appeared confused. The resident did not respond to verbal communication when the resident's name was called. On 8/14/20 at 12:23 PM, an interview was conducted with the Resident's Designated Representative (DR) (daughter). The DR stated the family made several efforts to visit their mom who is receiving Hospice care at the nursing home but the facility informed them that no one was allowed to visit at that time. The DR also stated that she spoke with the social worker and the administrator about it. On 8/14/20 at 1:34 PM, the Administrator was interviewed. The Administrator stated that the facility is not open for visitation yet. Administrator also stated that the facility is adhering to the NYSDOH regulation about visitation. The Administrator further stated that they were not sure if the resident fell under the end of life status despite receiving Hospice care because the resident had been on hospice care for a long time. The Administrator further stated the family member was never told they cannot visit, just that we haven't made determination yet if they are eligible for visitation. On 8/14/20 at 3:11 PM, an interview was conducted with the Medical Director (MD). The MD stated with a life expectancy of 6 months the resident meets the criteria for Hospice care and family members are contacted. The need for Hospice care is re-evaluated every 6 months. The MD stated that end of life, especially during COVID-19 period is when the resident is near imminent death, like within days or weeks. The MD further stated that the resident's medical condition improve after self toe-amputated, and so the resident would no longer be considered end of life and could probably be removed from Hospice care. On 08/14/18 at 3:36 PM, an interview was conducted with the Director of Social Work (DSW). The DSW stated they would order Hospice for a resident who has a life expectancy of 6 months. The Interdisciplinary Team would meet with the family to discuss and if the family is in agreement we can make a referral to to MJHS. The DSW also stated that the resident is stable on Hospice care and would not be considered a resident in need of Hospice services at this time. This change in status would need to be discussed with the physician and Hospice agency. The DSW further stated that she could not recall any discussions with the family regarding visitation. 415.3 (d)(2)(iv)(g)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview conducted during the Infection Control Focus and Abbreviated Survey (NY 418), the facility did not ensure that a resident's representative was immediately notified after a change in the resident's clinical condition. Specifically, the facility did not notify the resident representative after the resident's right # 1 toe self-amputated during wound care. This was evident for 1 of the 3-residents reviewed for Notification of Change. (Resident # 1) The findings are: According to the CMS Guidance 483.10(g)(14) Notification of Changes, the facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS further documented that the resident's cognitive status as impaired, and the resident required total assistance with Activities of Daily Living. On 8/14/20 at 10:10 AM, the resident was observed in her room, alert and awake. The resident was lying on the Geri-Chair and was not verbally responsive when greeted. Dry dressings were also observed to the resident right foot. The Registered Nurse (RN#1) stated that the wound dressing was changed earlier in the morning. A review of weekly wound notes dated from 03/06/20 to 04/18/20 documented the following: Right dorsal foot, noted with no drainage, periwound is intact, tissue is black eschar. Wound consult dated 4/23/20 documented the following: right # 1 toe fell off during removal of dressing immediately before evaluation. The wound consult further documented that the wound presented with 50% of eschar (dark tissue) and 50% of scant yellow moisture and moderate exudate. Dakin's two times a day and as needed. There was no documented evidence in the medical record that the resident's representative had been informed about the right great toe self-amputation that was observed during wound care rounds on 4/23/20. On 8/14/20 at approximately 9:30 AM, an interview was conducted with the Resident's Designated Representative (DR){daughter}. The DR stated that she met the resident at the Vascular Clinic in late May 2020 and was shocked to see that the resident had lost the right great toe. The DR also stated that she was informed by the Vascular doctor the resident's great toe had been amputated. The DR further stated that the Hospice nurse informed her about the resident's toe and she had tried unsuccessfully to contact the facility for additional information as no one from the facility had contacted her. The DR stated that the wound nurse spoke with her about 2 months later after the incident and after she had left multiple voice messages. On 8/14/20 at 1:15 PM, an interview was conducted with the Wound Care Nurse who stated that it is the responsibility of the Charge Nurse to contact family members to report

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) changes in a resident's medical condition. The Wound Care Nurse also stated she was present at the time when the toe fell off during wound care but did not notify the family member. The wound nurse stated that about 2 months later she discussed the concerns about the toe amputation with the resident's representative. On 8/14/20 at 3:11 PM, an interview was conducted with the Medical Director (MD). The MD stated that the wound doctor is a consultant and both the primary care provider (PCP) and the wound consultant communicate with each other. The PCP is no longer employed at the facility. The MD also stated that the Wound Care Nurse should have called the family member since she was present at the time when the toe self-amputated. The MD further stated that there are instances where the physician needs to contact the family member for a significant change or to discuss some other medical issues with the family. In this particular case, the Wound Care Nurse should have been the one to contact the family member and notify them of what had occurred. 415.3(e)(2)(ii)(b)