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Emerald North: Profile of a WNY Nursing Home

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Purpose and Overview of the Report

There are 59[1] nursing homes in four counties (Cattaraugus, Chautauqua, Erie, and Niagara) of WNY. Of these, 17 are Centers for Medicare & Medicaid Services (CMS) Nursing Home Compare (NHC) rated one-star facilities. (28.8%).When two-star rated facilities are incorporated the number increases to 24 (40.7%.)[2] Upon review of 2016 data from CMS Nursing Home Compare, the number of one-star facilities has remained relatively constant, ranging from 16 to 19.

Every nursing home resident, regardless whether the purpose of care is short-term (rehabilitative services) or long-term, deserves to receive quality care. CMS NHC data demonstrates there is no major difference in occupancy rates between the lower rated facilities (1 and 2 star) and the high rated facilities (4 and 5 star). Our goal is to improve the quality of nursing home care in WNY by providing profiles on area nursing homes so that the community gains a better understanding of what goes on in a nursing home and how residents and the community can advocate to effectuate positive change in care.

We are beginning our profiles with current CMS NHC one-star facilities. Factors that will trigger a profile on a one-star nursing home will depend on the New York State Department of Health (DOH) annual survey results and whether cited deficiencies have been identified as Immediate Jeopardy, or Actual Harm that is not Immediate Jeopardy, or when a repeat deficiency is cited.

Emerald North is the first nursing home being profiled as it is CMS one star rated nursing home and the DOH Survey team identified deficiencies that were Immediate Jeopardy while they were at the nursing home.

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[1] ECMC Transitional Unit and TLC Health Network are not included

[2] CMS Nursing Home Compare, dataset. *See, ProviderInfo_Download @ https://data.medicare.gov/data/nursing-home-compare (Processed Jan. 1, 2017)*

Our profiles will provide an overall picture of the nursing home and each nursing home profile will be structured as follows:

- Overview of the ownership/operator history;
- Summary of recent DOH annual survey and comparison to prior annual surveys;
- Summary of CMS staffing data;
- Summary of CMS quality measure data;
- Summary of NY DOH Nursing Home Quality Initiative;
- Summary of report and recommendations for residents and supporters.

Ownership Background through Today

Starting in 1980, the not-for-profit Presbyterian Senior Care of Western New York (Presbyterian), owned and operated the 95-bed Harbour Health Multicare Center (Harbour Health), formerly known as St. Andrew's Presbyterian Manor (Harbour Health is now known as Emerald North). Financial losses convinced them to sell the nursing home. Presbyterian located a downstate nursing home operator as a buyer and entered into an asset-purchase agreement on March 6, 2012.[3] Presbyterian requested the DOH place Harbour Health into voluntary receivership which would operate Harbour Health during the period of DOH approval of the sale. The receivership was approved by the NYS DOH in August 2012.[4]

In order to operate a nursing home, the prospective operator must be approved by the DOH through the Certificate of Need (CON) application process. The prospective operator filed the CON application with DOH to become the new operator of Harbor Health, now known as Emerald North.[5] The financial plan, as outlined in the CON, and approved by the DOH, focused on cutting costs and increasing revenues. The plan included measures to cut operating costs by "decreasing excess staff" and enhancing revenues by continuing and expanding the facility's policy of admitting difficult to "discharge from the hospital" patients.[6]

The receiver operated the facility from mid-2012 until mid-2014. After DOH Certificate of Need (CON) approval, the prospective operator became the operator of the nursing home.

Overview of CMS Health Inspection Survey Rating System[7]

The CMS NHC website is meant to provide a way for residents and their families to understand assessment of nursing home quality and "make meaningful distinctions between high and low performing nursing homes." The CMS rating system provides for an overall quality rating that is based on nursing home performance in three types of measures: (1) Health Inspections; (2) Staffing; and (3) Quality Measures. The measures are based on a five 'star' rating scale: one-star is the lowest, five-star is the highest.

The health inspection measure is based on state health inspection reports. Congress set minimum health and fire safety standards for nursing homes that choose to be part of the Medicare and Medicaid programs. In agreeing to

[3] State Public Health and Health Planning Council CON Project #131125 E Exhibit Page 6
[4] State Public Health and Health Planning Council CON Project #131125 E Exhibit Page 1
[5] State Public Health and Health Planning Council CON Project #131125 E Exhibit Page 7
[6] State Public Health and Health Planning Council CON Project #131125 E Exhibit Page 9
[7] Information for this section is taken from CMS Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide (January 2017) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf

accept Medicare and Medicaid payment, nursing homes agree to follow these minimum health and fire safety standards and cooperate with an on-site survey process that is conducted about once a year. CMS has contracted with the DOH to do annual health and fire safety inspections and also investigate complaints about nursing home care. The fire safety inspections are not accounted for in the CMS health inspection measure.

CMS calculates a weighted score for each survey health inspection based on points assigned to deficiencies that have been identified by the health inspection in each nursing home's three most recent recertification health inspections along with deficiency findings from the three most recent years of complaint inspections. Points are assigned to individual health deficiencies according to their scope and severity: more serious, widespread deficiencies receive more points, with additional points assigned for substandard quality of care. If the DOH has to conduct repeat visits to confirm that deficiencies have been corrected, points are added. The below tables from the CMS Designed for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide show how the points are assigned:

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.
Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices, 42 CFR 483.15 quality of life, 42 CFR 483.25 quality of care.
* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a "G-level" deficiency (i.e., 20 points) are assigned.
Source: Centers for Medicare & Medicaid Services

Table 2
Weights for Repeat Revisits

Revisit Number	Noncompliance Points
First	0
Second	50 percent of health inspection score
Third	70 percent of health inspection score
Fourth	85 percent of health inspection score

Note: The health inspection score includes points from deficiencies cited on the standard health inspection and complaint inspections during a given survey cycle.

In calculating the total weighted score, more recent surveys are weighted more heavily than early periods. Cycle 1 (recent survey) 1/2 weighted; Cycle 2 1/3 weighted; Cycle 3 1/6. The weighted scores are then added to create the total score for the nursing home. Complaint inspections are weighted in the same manor based on 12 month time periods.

CMS then ranks the performance of nursing homes within a state. This means nursing homes in New York are compared to each other and not other states. The ranking is curved so that a certain percentage of nursing homes are ranked under each star. The cut points for star ratings for NY as of January 2017 are as follows[8]:

# NH	1 star (20%)	2 star (23.33%)		3 star (23.33%)		4 star (23.33%)		5 star (10%)
		Upper	Lower	Upper	Lower	Upper	Lower	
623	>52.000	≤52.000	>26.000	≤26.000	>13.333	≤13.333	>4.0	≤4.000

15 nursing homes in Erie County have a health inspection rating of 1. Of the 37 nursing homes in Erie County, this means 40.5% of Erie County nursing homes have a 1 star health inspection rating. The average weighted score for Cycle 1 (the most recent survey-2016) in Erie County is 80.8. Emerald North has a 1-star ranking for health survey and for Cycle 1 (2016) has a weighted score of 104. The average number of total health deficiencies (including complaint surveys) in a nursing home in Erie County was 10 for 2016. Average for Erie County standard surveys in 2016 was 9.[9]

February 7, 2017 NYS DOH Survey[10]and Comparison to Prior Results

The written Statement of Deficiencies was issued were issued February 7, 2017. The DOH survey team issued 22 health deficiencies and during the period of survey, 3 were ranked Immediate Jeopardy (IJ); the highest level of severity that may be issued by the DOH survey team for failure to properly document the Advance Directive status of its residents. The scope of the 3 IJs were found to be a "pattern".[11] This means the citation affected more than a very limited number of residents and/or involved more than a very limited number of staff. ("K" on the deficiency chart.)[12]

An IJ deficiency is when the deficiency resulted in noncompliance and immediate action is necessary; an event has caused or is likely to cause serious injury, harm, impairment or death to the residents. The DOH survey team documented 3 IJs, one citing to an incident that occurred on September 6, 2016, and required Emerald North take corrective measures to the survey team prior to exit from the facility. As a result of the corrective measures, the DOH survey team removed the IJ status.

[8] CMS Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide- State Level Health Inspection Cut Point Table. January 2017. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/cutpointstable.pdf

[9] CMS Nursing Home Compare, dataset. *See, ProviderInfo_Download @ https://data.medicare.gov/data/nursing-home-compare (Processed Jan. 1, 2017)*

[10] Copy of the written survey follows this report

[11] *See written survey report*

[12] *See CMS State Operations Manual, Appendix Q-Guidelines for Determining Immediate Jeopardy: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf*

Specific findings of IJ, during the DOH inspection, are as follows:

1. Lack of properly documented Advance Directive status resulted in Immediate Jeopardy with actual harm to Resident #83[13] and the potential for serious harm to resident health and safety.

Resident #83 was admitted to the facility for rehabilitation on 8/15/16 with diagnoses that include Alzheimer's dementia and a history of breast cancer. The physician's History & Physical (H&P) dated 8/19/16 revealed the resident was oriented to person, place, and time. In addition, the H&P documented the resident's judgment was intact, insight was intact, and decisional capacity was present. The Physician's Orders, signed 8/19/16, included a DNR order. The facility's "Resident Admission/Readmission Evaluation" dated 8/15/16, also revealed the following: Advance Directive was checked - DNR. The Minimum Data Set (MDS-a resident assessment tool) dated 8/28/16 revealed the facility did not assess the resident's cognitive status. Review of the entire medical record revealed there were no Social Work Progress Notes and there was no documented evidence that advance directives were addressed with the resident.

An undated "Admission Intermin [sic] Care Plan", had a green FULL CODE (designation that means to start CPR if a patient's heart stops beating or if the patient stops breathing) sticker on the lower right hand corner of page 1.

The morning of 9/6, the resident was slumped in wheelchair, unresponsive with shallow, gasping breathing. Rescue breathing with O2 (oxygen) started after the resident was put back into bed. 911 called. Resident was noted not to have a pulse and CPR was started prior to 911 coming in. 911 arrived and resumed CPR and ACLS (advanced cardiac life support – clinical interventions for the urgent treatment of cardiac arrest). Resident was noted to have electrical activity on monitor but remained unresponsive. She was transported to the hospital by emergency services. The resident expired that day.

2. The survey team found a separate pattern of Immediate Jeopardy as 8 of 29 residents reviewed during the January survey visit had their Advanced Directives improperly documented.

3. The third pattern of Immediate Jeopardy was cited as the facility failed to ensure that the Quality Assessment and Assurance (QAA) committee effectively identified and corrected quality deficiencies with the potential to cause serious harm to residents and did not develop and implement appropriate plans of action. Specifically, the facility QAA failed to ensure complete and accurate documentation of the residents' Advance Directive status was communicated to the interdisciplinary team.

As stated above, the DOH survey team removed the Immediate Jeopardy findings on 1/22/17, prior to the completion of the survey, as Emerald North undertook corrective measures. The scope and severity of these deficiencies was changed to "isolated deficiency" that constitute "actual harm that is not Immediate Jeopardy" ("G" on the deficiency chart from "K") This means that only one or a very limited number of residents were affected by the deficiency and it resulted in a negative outcome that has compromised the residents' ability to reach the highest practicable level of functioning.

[13] The DOH conducts yearly certification surveys every 9 to 15 months at each nursing home. The surveys are unannounced and the survey teams follows pre-established protocols. The survey system will select residents for review based on information collected by the survey team pre-visit and during the initial day(s) of the survey.

The scope and severity of the IJ deficiencies were changed; the DOH required that the facility address the IJ deficiencies while the survey team was present. The DOH survey process is a snapshot in time. Emerald North was still in violation of the federal regulations and the violations were of IJ. The DOH survey team noted that facility policy did not reflect the procedures that staff were following. Resident #83 had a DNR in place, yet the Care Plan had a FULL CODE designation that means staff are to start CPR. In addition, Emerald North was cited on the April 2015 survey for a similar situation. In that case the survey team identified 1 of 17 residents reviewed did not have the Advanced Directives accurately identified on the physician's orders.[14]

The DOH survey team cited Emerald North for 16 other health deficiencies which had the potential for more than minimum harm and includes areas of deficiencies that were cited on prior DOH surveys. These 16 deficiencies found by the survey team include: failure to listen/respond to Resident Council; administration of an antipsychotic medication without prior attempts at have nonpharmacological behavioral interventions; inadequate pest control program. 3 deficiencies were found with no more than minimal harm, bringing the total health deficiencies to 22.

In addition to the above stated areas, Emerald North was cited under F-Tag F315 "Resident Not Catheterized Unless Unavoidable." A federal regulation, specifically,42 CFR 483.25(e) states in part:

> (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
>
> (ii) A resident who enters the facility with an indwelling catheter …is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and
>
> (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

The DOH report states the following:

Resident #67 was re-admitted to the facility on 10/24/16… and has an indwelling Foley catheter. Review of the Minimum Data Set (MDS-a resident assessment tool) dated 12/6/16 revealed the resident has severe cognitive impairment for daily decision-making and has an indwelling Foley catheter.

Review of the Physician's Orders from October 2016 through January 13, 2017 revealed no order for a Foley catheter, a plan for a voiding trail or attempted removal of the catheter.

Review of the Comprehensive Care Plan dated 1/17/17 revealed there was no Care Plan for the use or care of the Foley catheter.

When questioned by the survey team member on 1/17/17 the Licensed Practical Nurse Unit Manager "was unable to provide a reason for the Foley catheter or documented indication for its use."

The day the survey team member raised this issue with the Unit Manager, a Physician entered an order to discontinue the Foley catheter and conduct a voiding trial. The severity and scope of this citation was 'potential for more than minimal harm' and 'isolated'. While the specific citation is for a deficiency in violation of 42 CFR 483.25(e), in cases such as this it usually stems from a lack of communication.

[14] April 24, 2015 survey inspection report, pg 1: https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335640&INSPTYPE=STD&SURVEYDATE=04/24/2015

The below table[15] provides a summary of the 2014, 2015, and 2016 survey results:

Health Inspection Summary

EMERALD NORTH NURSING AND REHABILITATION CENTER

1205 DELAWARE AVENUE
BUFFALO, NY 14209
(716) 885-3838

Deficiency Category	Inspection Date: **03/08/2016** Complaint Reporting Period: 1/1/2016 - 12/31/2016	Inspection Date: **04/24/2015** Complaint Reporting Period: 1/1/2015 - 12/31/2015	Inspection Date: **05/07/2014** Complaint Reporting Period: 1/1/2014 - 12/31/2014
Mistreatment Deficiencies	1	0	1
Quality Care Deficiencies	5	9	4
Resident Assessment Deficiencies	6	2	1
Resident Rights Deficiencies	1	4	1
Nutrition and Dietary Deficiencies	0	0	1
Pharmacy Service Deficiencies	1	0	1
Environmental Deficiencies	2	2	2
Administration Deficiencies	1	0	1

Emerald North's survey results have declined over the past four DOH surveys. As documented from CMS Nursing Home Compare datasets, the decline began in 2013, when the facility was under receivership and continued to decline post-sale. Since 2014, when the new operator officially began operating the facility, the health deficiencies continued to increase. The average weighted score for 2016 in Erie County is 80.8. Emerald North's weighted score for 2016 was 104. (2017 figures are yet to be determined.) Higher weighted survey scores equate to worse survey results.

During the transition, and under the receivership, the facility had an "approximately month ban on admissions at the facility during the late summer of 2013…'[16] The specific reasoning for the ban was not disclosed in the reviewed CON.

[15] CMS Nursing Home Compare Emerald North Profile: accessed February 13, 2016
https://www.medicare.gov/nursinghomecompare/previousInspections.html?ID=335640&Inspn=HEALTH&profTab=1&Distn=4.2&loc=14215&lat=42.9397553&lng=-78.8099472

[16] State Public Health and Health Planning Council CON Project #131125 E Exhibit Page 9

It should also be noted that CMS has updated how it ranks nursing homes on its 5-star scale. As a result, we cannot directly compare the overall current rankings with those prior to 2013 when Emerald North was operated by Presbyterian. However, we can review the survey health deficiency numbers and the weighted score.[17]

DOH Survey date	health deficiencies	Weighted score
January 2017	22	TBD
March 8 2016	17	104
April 24 2015	16	72
May 7 2014	12	68
June 17 2013	15	138
July 12 2012	5	36
July 27 2011	4	20
July 29 2010	10	44

Staffing

According to the CMS Nursing Home Compare[18], Emerald North reports below average staffing compared to other nursing homes in New York State. RN staff per resident is less than half the statewide average. (19 minutes per resident per day as compared to a NYS average of 44 minutes). The LPN staffing is slightly above average, but the total nursing remains below average. CNA staffing is also below average, at less than 75% of the NYS average. (1 hour and 46 minutes per resident per day as compared to the NYS average of 2 hours and 22 minutes.). Emerald North ranks in the bottom 5 of the 37 nursing homes in Erie County in terms of overall staffing per resident. (See below table.)[19]

[17] CMS Nursing Home Compare, dataset. Figures for 2010-2012 were obtained through 2013 Annual Files: ProviderInc_2013 using the health cycle score history.

[18] CMS Nursing Home Compare, Emerald North Profile, Staffing last accessed February 13, 2017 : https://www.medicare.gov/nursinghomecompare/profile.html#profTab=2&ID=335640&Distn=0.5&loc=14209&lat=42.9137921&lng=-78.8637428 *See also* CMS Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide (January 2017) *, see also https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2016-2017-Nursing-Home-Action-Plan.pdf that explains* CMS staffing measures are derived from the CMS Certification and Survey Provider Enhanced Reports (CASPER) system, and are case-mixed adjusted using the Resource Utilization Group (RUG III) categories. CMS opines that the case-mix adjustments allow for fair comparison of staffing across nursing homes with different levels of resident activity. Utilizing this adjustment, the star ratings for staffing is calculated as follows: RN and total staffing are given equal weight and for each of RN staffing and total staffing the star rating is assigned on a percentile-based method. While CMS began collecting quarterly payroll-based staffing data nationwide, it began in July 2016 and the information is not included in current reports

[19] CMS Nursing Home Compare, Emerald North Profile, Staffing accessed February 13, 2017: https://www.medicare.gov/nursinghomecompare/profile.html#profTab=2&ID=335640&Distn=0.5&loc=14209&lat=42.9137921&lng=-78.8637428

	EMERALD NORTH NURSING AND REHABILITATION CENTER	NEW YORK AVERAGE	NATIONAL AVERAGE
Total number of residents	82	167.0	86.1
Total number of licensed nurse staff hours per resident per day	1 hour and 20 minutes	1 hour and 37 minutes	1 hour and 42 minutes
RN hours per resident per day	19 minutes	44 minutes	50 minutes
LPN/LVN hours per resident per day	1 hour and 2 minutes	53 minutes	51 minutes
CNA hours per resident per day	1 hour and 46 minutes	2 hours and 22 minutes	2 hours and 28 minutes
Physical therapy staff hours per resident per day	6 minutes	7 minutes	6 minutes

How to read staffing charts | About staff roles

Federal law requires nursing homes provide enough staff to adequately care for residents in order for residents to attain and maintain their highest practicable physical, emotional and social well-being. While there is no current federal standard for the best nursing home staffing levels, "there is considerable evidence of a relationship between nursing home staffing levels and resident outcomes. The CMS Staffing Study found a clear association between nurse staffing ratios and nursing home quality of care, identifying specific ratios of staff to residents below which residents are at substantially higher risk of quality problems."[20]

New York State does not have minimum nurse staffing levels in nursing homes (or hospitals). There is proposed legislation that will establish minimum nurse staffing levels in both nursing homes and hospitals.[21] Unless legislation is passed at the state or feral level that specifies minimum nurse staffing levels, the standard is there be 'sufficient' staff.

On September 28, 2016, CMS issued updated federal nursing home regulations. The updated rule is being implemented in three phases, the first phase began on November 28, 2016. The second phase begins November 28, 2017 and in that phase nursing homes are required to "have sufficient staff with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at" 42 CFR 483.70.[22] This facility wide assessment also includes behavioral health. While nursing homes should already be taking such self-assessments in order to properly care for residents, it will soon be a requirement starting November 28, 2017.

[20] *See Kramer AM, Fish R. "Relationship Between Nurse Staffing Levels and the Quality of Nursing Home Care." Chapter 2 in Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report. Abt Associates, Inc., Winter 2001.; see also* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf, at p.6

[21] Assembly bill A01532: http://assembly.state.ny.us/leg/?default_fld=&bn=A01532&term=2017&Summary=Y&Actions=Y&Text=Y&Votes=Y

[22] 42 CFR 483.35

Quality Measure

Nursing Home Compare reports on twenty-four Quality Measures, nine for short-term residents and fifteen for long term residents. The measures are a combination of Minimum Data Set (MDS) (facility reported data) and Claims-Based data. The MDS is completed by the nursing home and is a tool for implementing standardized assessment and for facilitating care management. Most of the quality measures are MDS based. For additional details as to which measures are MDS based or Claims-Based, see Table 6 of the Technical Users' Guide for the CMS Five-Star Quality rating system.[23]

Emerald North's rating on Quality Measures is average according to CMS' rating system (3 stars out of 5)[24]. The table below shows the measures where this facility reported results and how they were compared with the New York average, for the most recent reporting periods.[25] As seen below, Emerald North was sometimes above the NYS average and sometimes below the NYS average. Even though Emerald North has a 3-star rating for quality measures, the CMS overall score is 1-star. This is due in part due to the CMS rating system placing greater weight on health surveys and part of the quality measures coming from the MDS vs claims based measures.

Quality Measures reported for the four quarters from July 1 2015 to June 30, 2016	Emerald North	NYS average	ratio
Significantly Worse than State Average for Long-stay residents			
Percentage of long-stay residents experiencing one or more falls with major injury (lower % better)	8.41	2.88	2.92
Percentage of long-stay residents whose need for help with daily activities has increased (lower % better)	24.81	14.10	1.76
Percentage of long-stay residents with a catheter inserted and left in their bladder (lower % better)	3.81	2.28	1.67
Percentage of long-stay residents who have depressive symptoms (lower % better)	16.29	9.80	1.66
Percentage of high risk long-stay residents with pressure ulcers (lower % better)	11.22	7.20	1.56
Percentage of long-stay residents who lose too much weight (lower % better)	9.29	6.36	1.46
Significantly Better than State Average for Long-stay residents			
Percentage of long-stay residents who were physically restrained (lower % better)	0.00	1.09	0.00
Percentage of long-stay residents with a urinary tract infection (lower % better)	0.66	4.10	0.16
Percentage of low risk long-stay residents who lose control of their bowels or bladder (lower % better)	28.44	48.90	0.58
Percentage of long-stay residents who received an antipsychotic medication (lower % better)	9.13	15.21	0.60

[23] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf
[24] CMS Nursing Home Compare, dataset. *See, ProviderInfo_Download @ https://data.medicare.gov/data/nursing-home-compare (Processed Jan. 1, 2017)*
[25] Information from CMS Nursing Home Compare, last accessed February 13, 2017 https://www.medicare.gov/nursinghomecompare/profile.html#profTab=3&ID=335640&Distn=0.5&loc=14209&lat=42.9137921&lng=-78.8637428

Percentage of long-stay residents who self-report moderate to severe pain (lower % better)	3.27	5.15	0.63
Percentage of long-stay residents who received an antianxiety or hypnotic medication (lower % better)	10.60	16.50	0.64
Significantly Worse than State Average for short-stay residents			
Percentage of short-stay residents with pressure ulcers that are new or worsened (lower % better)	2.68	1.13	2.37
Percentage of short-stay residents who newly received an antipsychotic medication (lower % better)	4.65	1.99	2.34
Significantly Better than State Average for short-stay residents			
none			

New York DOH Nursing Home Quality Initiative[26]

The NYS DOH Nursing Home Quality Initiative (NHQI) is an annual quality and performance evaluation project to improve the quality of care for residents in NYS Medicaid-certified nursing homes. The NHQI offers an alternative method of ranking nursing homes to CMS Nursing Home Compare. Current evaluations are based on the previous calendar year's performance and worth 100 points. Nursing homes receive points based on quality and performance measures under Quality, Compliance, and Efficiency categories.

NHQI rankings include 10 quality measures out of the 21 used by CMS Nursing Home Compare. One example is percentage of long stay residents who lose too much weight. The NHQI highly values these quality measures and they account for ½ of the total possible score. CMS Nursing Home Compare puts greater weight on the findings of the last three annual survey reports.

Staffing levels count a maximum of 5 points out of 100 for NHQI. Nursing homes also earn 5 points each for timely submission to the DOH of nursing home cost reports and employee influenza vaccination data. The nursing home gets an additional 5 points if the percent of employees vaccinated for influenza is 85% or greater, and zero points if the rate is less than 85%. Up to 10 points can be earned based on their Potentially Avoidable Hospitalizations rate. Extra points are awarded if the facility's performance on QM improved from the prior year.

Any facility that was cited for an immediate jeopardy deficiency between July 1, 2015 and June 30, 2016 is not eligible to be rated in the 2016 rankings.

The total scores are grouped into five tiers, or quintiles. The facilities in the first quintile are the top approximately 20% of NY nursing homes. Emerald North has been ranked as follows: 2016-3rd quintile, 2015-5th quintile, and 2014 (noted as Harbour Health)-5th quintile.[27]

Because the NHQI places high emphasis on quality measures, Emerald North is in the middle/average. Emerald North is ranked 3 out of 5 stars under the CMS quality measures.

[26] *See NYS DOH site: https://www.health.ny.gov/health_care/medicaid/redesign/nursing_home_quality_initiative.htm*

[27] For 2016 see https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2016/quintile_ranking.htm ; For 2015 see https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2015/quintile_ranking.htm ;for 2014 see https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2014_nhqi_quintile_ranking.htm

Summary and Recommendations for the Consumer/Resident

Emerald North has a CMS overall rating of 1-star even though the facility rates average under the CMS NHC quality measure (3-star) and NYS DOH NHQI (3rd quintile), Emerald North has a 1-star rating in both health inspection and staffing measures.

The DOH imposed a directed plan of correction on Emerald North requiring Emerald North obtain the services of a consultant to develop and implement a plan of correction, and convene its Quality Assurance Committee to address the issues under Advanced Directives, Effective Administration, and effectiveness of the Quality Assurance & Assessment committee.

The DOH annual survey brought to light facility-wide issues, and now it is up to Emerald North to establish and follow plans to prevent the issues from occurring in the future. Patients, residents, and advocates need to be vigilant in speaking up for the rights of the resident to receive quality care and to have a quality life while in a nursing home.

Our office offers the following tips for residents, prospective residents, and their families when looking for a nursing home and residing in a nursing home:

1. Develop a relationship with the hospital discharge planner.
   Hospital discharge planners are under pressure to move patients who no longer need hospital-level care to a lower-levels care facility, such as a nursing home. This is a stressful time for the patient and often the patient is not in a position to make an informed choice. Developing a relationship with the hospital discharge planner and explaining the patient's needs (such as geographic location) will assist in the patient and the family making an informed choice of nursing home. If you do not like the selection of nursing homes made available to you by the discharge planner, reach out to area nursing homes for applications.[28]

2. Do your research.
   While CMS NHC, NYS DOH Nursing Home Profile (which is derived from the CMS NHC information), and NYS DOH NHQI websites offer a wealth of information, these websites are not perfect and each measure has pros and cons. Ask around for people's opinions on a nursing home. Visit the nursing home.[29]

3. Staffing levels.
   Quality is generally better in nursing homes that have more staff who work directly with residents. It's important to ask nursing homes about their staff levels, the qualifications of their staff, and the rate at which staff leave and are replaced. (New York State does not have minimum nurse staffing levels in nursing homes.)

   From the CMS publication, Your Guide to Choosing a Nursing Home or Other LongTerm- Care[30], ask the following questions:

[28] NY Connects,716-858-8526, http://www2.erie.gov/nyconnects/ , is a resource available to help select nursing homes and answer question pertaining to long term care facilities..

[29] Review consumer directed materials such as http://theconsumervoice.org/uploads/files/family-member/A-Consumer-Guide-To-Choosing-A-Nursing-Home.pdf

[30] https://www.medicare.gov/Pubs/pdf/02174.pdf

- Is there enough staff to give me the care I need?
- Will I have the same staff people take care of me day to day or do they change?
- Does the nursing home post information about the number of nursing staff, including Certified Nursing Assistants (CNAs)?
- Are they willing to show me if I ask to see it? (Note: Nursing homes are required to post this information.)
- How many residents is a CNA assigned to work with during each shift (day and night)?

4. Develop a relationship with nursing home staff.
   Ask the nursing home who the 'point person' is at the facility for questions and concerns. Knowing who to speak with regarding a concern is the first step in resolving the concern. Address concerns when they arise; do not let them 'fester' as it will only exacerbate the situation.

   Be tactful on how a concern is raised. Nursing home staff chose to work in the caregiving field and want to do a good job; they do not want to provide poor care. While some concerns may need to be addressed abruptly and with a sharp tone, in general people respond better when the tone is one of respect.

   Get to know the nursing home staff who take care of the resident. This includes staff in housekeeping and maintenance.

5. Be proactive
   Read all of the admission paperwork materials. Know the rights of a nursing home resident. In the initial care plan meeting with the facility, make it known your likes, dislikes and needs. Know what medications the resident is on and why. Get involved with activities and become an active member of the resident council or family council. If there is no family council, start one.

These are only some of the tips available to the community in selecting and residing in a nursing home. There are many resources out there and the Center for Elder Law & Justice is available to answer questions and connect you to the resources:

- NY Connects: https://www.nyconnects.ny.gov/
  - Long term care services and supports directory offered in each county of NY.
- Long Term Care Ombudsman Program: https://ltcombudsman.ny.gov/
  - 1-855-582-6769
  - Resident advocacy program by investigating and resolving complaints made by or on behalf of residents.
  - Also facilitates formation of resident and family councils.
- NYS Dept. of Health Complaints:
  - Is responsible to investigating complaints and incidents which are related to a regulatory violation.
  - https://www.health.ny.gov/facilities/nursing/complaints.htm
  - 1-888-201-4563

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F 155 SS=K	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 155	Continued From page 1 with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during the Standard Survey completed on 1/24/17, it was determined that the facility did not have a consistent system in place to identify residents' wishes regarding Advanced Directives. Specifically, facility policy and procedure specified different indicators of resident's code status that included: the CNA (certified nurse aide) Closet Care Plan; color coded stickers in resident charts; "code status" list kept in the Medication Administration Record (MAR) book, at the facility front desk, and in the therapy department; physician orders; and advanced directives/MOLST (Medical Orders for Life Sustaining Treatment) form. Eight (Residents #30, 63, 64, 73, 80, 83, 99, 102) of 29 residents were identified as having their advance directives improperly documented in these areas; including inconsistencies with the physician's order. Further concern was revealed	F 155		

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with direct care staff interviews that included inconsistent responses when asked how to identify residents' code status; including the failure to verify the Resident #83 Advance Directive orders and/or the physician orders prior to initiating cardiopulmonary resuscitation (CPR-emergency resuscitation measures, including artificial ventilation and chest compressions) when the resident had a physician's order for a DNR (Do Not Resuscitate - allow natural death) in place.

The lack of properly documented Advance Directive status resulted in a pattern of IMMEDIATE JEOPARDY with actual harm to Resident #83 and the potential for serious harm to RESIDENT HEALTH AND SAFETY.

The IMMEDIATE JEOPARDY was removed on 1/22/16, prior to the completion of the survey.

The findings include but are not limited to:

1. Resident #83 was admitted to the facility for rehabilitation on 8/15/16 with diagnoses that include Alzheimer's dementia, hypercholesterolemia (elevated level of cholesterol in the blood), and a history of breast cancer. Review of the Minimum Data Set (MDS-a resident assessment tool) dated 8/28/16 revealed the facility did not assess the resident's cognitive status.

Review of the physician's History & Physical (H&P) dated 8/19/16 revealed the resident was oriented to person, place, and time. In addition, the H&P documented the resident's judgment was intact, insight was intact, and decisional capacity was present.

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F 155	Continued From page 3 Review of a "Resident Admission/Readmission Evaluation" dated 8/15/16 revealed the following Advance Directive was checked - DNR. Review of an undated "Admission Intermin [sic] Care Plan", revealed a green FULL CODE (designation that means to start CPR if a patient's heart stops beating or if the patient stops breathing) sticker on the lower right hand corner of page 1. Review of the Physician's Orders, signed 8/19/16 revealed the resident had a DNR order. Review of the entire medical record revealed there were no Social Work Progress Notes and there was no documented evidence that advance directives were addressed with the resident. Review of a Nurses Progress Notes dated 9/6/16, timed "9:05 - 9:45", written by the Director of Nursing (DON) revealed the following: - "Called to 2nd (second) floor STAT (immediately). Resident was observed slumped in wheelchair, unresponsive with shallow agonal (gasping) breathing. + (positive) RT (right) femoral (femoral artery - situated at, in or near the thigh) pulse. Unable to assess pupil response due to cataracts (clouding of the normally clear lens of the eye) B/L (bilateral). Rescue breathing with O2 (oxygen) started after the resident was put back into bed. 911 called. Rescue breathing and frequent pulse checks. Resident was noted not to have a pulse and CPR was started prior to 911 coming in. 911 arrived and resumed CPR and ACLS (advanced cardiac life support - clinical interventions for the urgent treatment of cardiac	F 155		

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arrest). Resident was noted to have electrical activity on monitor but remained unresponsive. She was transported by emergency services. Family was called but was unable to be reached. Daughter came in at 9:50 AM and a staff member drove her to the hospital."

Review of the MDS Death in facility tracking record revealed the resident expired 9/6/16.

During an interview on 1/18/17 at approximately 1:25 PM, the DON stated, "I remember the incident when I was called to the unit and the resident coded. The resident was slumped in her chair, we got her into the bed, and checked the Closet Care Plan (guide used to provide care). The Closet Care Plan had a Full Code sticker, so CPR was initiated and 911 was called."

Interview with the DON on 1/18/17 further revealed, staff is instructed to look at the Closet Care Plan and/or the Resident face sheet to determine code status when someone is found unresponsive. In addition, the DON stated, "The code status stickers (on the Closet Care Plan and Resident face sheet) should absolutely match the Physician's orders. It's a huge problem if you go against a residents' wishes."

Review of the facility policy and procedure entitled "Emergencies/Safety: Basic Life Support/C.P.R." dated 10/27/16 revealed the following:

- Residents who require basic life support (B.L.S.) (want to be resuscitated) will have a green FULL CODE sticker on the plastic sheet covering the face sheet in the front of the chart. Residents who request not to be resuscitated will have a red DNR sticker on the plastic sheet covering the

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face sheet in the front of the chart.
- A list of all full code residents will be listed in the MAR and will be located at the front desk on the 1st floor. The lists will be updated every shift by the Registered Nurse (RN) Supervisor.
- The Social Worker or Nursing Supervisor will be responsible to identify advanced directives or resuscitation status on admission, readmission or change in status during a continued stay, and will update their resuscitation status in the front of each MAR and at the front desk.

Interview with the Activities Leader on 1/18/17 at approximately 10:51 AM revealed, "There is no list that I'm aware of. I go to care plan meetings, so I do know the residents code status, especially the regulars."

Interview with the Physical Therapy Director on 1/18/17 at approximately 10:54 AM revealed that the therapy department has access to resident Closet Care Plans on an excel spreadsheet. If a resident were to code in therapy the Director would expect a member of the therapy staff to refer to the excel spreadsheet to determine code status. In addition, the interview revealed there is a "code status" list that is kept in the therapy department.

Observation and review of an untitled "code status" list posted on the wall in the Therapy Department (located on the first floor) on 1/18/17 at approximately 10:54 AM revealed the list was dated 1/13/17 and did not accurately reflect the code status of all the residents listed on the document.

Observation and review of an untitled "code status" list located at the front desk on 1/18/17 at

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approximately 11:02 AM revealed the sheet was dated 1/13/17 and did not accurately reflect the code status of all the residents listed on the document.

During an interview on 1/18/17 at approximately 1:12 PM, Licensed Practical Nurse (LPN #6) stated, "When someone codes, I check the face sheet for a sticker, but there's not always a sticker on the face sheet. If there's no sticker, I guess I would check the Closet Care Plan." Interview further revealed, "There is no "code status" list in the MAR's, I don't ever remember a code list in the MAR's."

Observation of the LPN #6's MAR revealed there was no "code status" list in the MAR.

Interview with LPN #5 on 1/18/17 at approximately 1:18 PM revealed, "I would check the face sheet when someone codes, there is no list in my MAR."

Observation of LPN #5's MAR revealed there was no "code status" list in the MAR.

During an interview on 1/18/17 at approximately 3:00 PM, with the Administrator and the Social Worker, The Administrator stated, issues regarding Advance Directives and discrepancies with Advance Directives were brought up in the December 2016 Quality Assurance (QA) meeting. The interview further revealed the Social Worker and the Assistant Director of Nursing (ADON) were in the process of conducting audits and correcting any identified issues and had a few more to correct. The Social Worker then stated that all audits of residents' Advance Directive status had not been completed and corrections to

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the resident's Advance Directive status had not been completed.

During a telephone interview on 1/18/17 at approximately 2:45 PM, the Medical Director stated, "If there is a Physician's order for DNR, that order needs to be honored. Everything regarding a residents' Advance Directives should match the Physician's order. CPR should not be initiated on a resident with a DNR."

2. Resident #63 was admitted to the facility on 1/14/14 with diagnoses that include chronic obstructive lung disease (COPD, disease that blocks airflow and makes it difficult to breathe), chronic kidney disease (CKD), and congestive heart failure (CHF). Review of the MDS dated 11/26/16 revealed the resident is cognitively intact, understands and is understood.

Review of the Physician's Order, signed 1/3/17, revealed "Advance Directive orders dated 3/30/14 for DNR, DNI (do not intubate- do not place tube down throat or connect to breathing machine)."

Review of the medical record revealed a Health Care Proxy (HCP), dated 7/7/13 with no Advance Directives. Further review revealed two "Physician Orders Health Care Proxy Activation" forms signed 2/4/14 and 2/5/14.

Review of the Admission Record face sheet did not identify the resident's Advance Directive status.

Further review of the medical record revealed the most current Social Services Care Plan Progress Note, dated 1/7/15. The Advance Directive section checked: MOLST/DNR and HCP

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activated.

Review of the Closet Care Plan, dated 1/16/17 documented the resident Advance Directive status as "Full Code".

Review of an untitled "code status" list, dated 1/13/17 revealed the resident was listed as a Full Code.

3. Resident #102 was admitted to the facility on 12/23/16 with diagnoses that include dementia with behavior disturbance, metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function), atherosclerotic heart disease (ASHD - thickening and hardening of the walls of the coronary arteries). Review of the MDS dated 12/30/16 revealed the resident has moderate cognitive impairment, understands and is understood.

Review of the Physician Orders, created by the Assistant Director of Nursing (ADON, RN #1), confirmed with the physician on 12/23/16 and signed by the Nurse Practitioner on 12/27/16 documented the resident's Advance Directive status as Full Code.

Further review of the medical record revealed an unsigned Physician Telephone order, written 1/18/17 with instruction that "Per Advance Directive resident code status is DNR."

Review of the physician's History and Physical examination, dated 12/30/16 revealed the residents' judgement and insight is impaired, and the resident lacks decisional capacity.

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Further review of the medical record revealed a Durable Power of Attorney to Communicate Health Care Decisions, a Health Care Proxy and a Health Care Decisions Declaration, all dated 2/24/11 that documented that the resident did not want CPR to be administered.

Review of the Social Services Care Plan Progress Note, dated 12/27/16, revealed in the Advance Directive section that HCP (Health Care Proxy) was checked but did not document that the resident had a Living Will.

Review of an untitled "code status" list, dated 1/13/17 revealed the resident was listed as a Full Code.

During an interview with the Licensed Practical Nurse (LPN #3) Unit Manager on 1/20/17 at 9:37 AM, the Unit Manager stated that when physician orders are created, the HCP and Advance Directive would be checked. The Unit Manager further stated, "I would have confirmed the orders and the ADON (Assistant Director of Nursing) would check them and sign them. If I had reviewed the Advanced Directives at admission, I would have made the resident a DNR."

During an interview with the ADON (RN #1) on 1/23/17 at 11:50 AM, the ADON stated the facility received eight admissions from their sister facility on the day the resident arrived at the facility. The ADON stated she cannot not remember if she saw the resident's Advance Directive on the day of admission. The ADON stated that she was traveling between both facilities, that day, to assist with the move of the eight residents. The ADON stated that paperwork was being faxed from the resident's previous nursing home and

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receipt of the paperwork was very fragmented. The ADON stated that other personnel in the nursing home may have received the resident's paperwork from the fax machine and it would be placed in the wrong staff member's mailbox.

Review of facility policy and procedure entitled "Advanced Directives" revised 5/1/16 revealed that upon admission, Social Work staff will determine whether a resident has advance directive or a designated Health Care Agent. Further review of the policy revealed Social work and/or Nursing are responsible for documenting the existence of all advance directive on the Medical Alert form in the front of the resident's medical record. Social Work will document in the Social Work Progress Notes in the medical record.

4. Resident #73 was admitted on 10/23/15. The resident's diagnoses included atrial fibrillation (irregular heart rhythm), rheumatoid arthritis and COPD. Review of the MDS dated 11/15/16 revealed the resident had was cognitively intact.

Review of the MOLST form dated 10/25/15 revealed the resident completed the form and chose not to be resuscitated.

Review of the Physician's Orders dated 10/19/16 revealed an order for DNR preceded by a date of 3/4/16. Indicating more than a four-month delay in obtaining a Physician's order for a DNR.

During an interview on 1/20/17 at 10:19 AM, the DON stated the 3/4/16 date on the Physician's Orders indicates the origination date of the Physician's Order.

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Review of the Comprehensive Care Plan (CCP) dated 11/3/16 revealed "The resident is a Full Code with no HCP in place at this time."

Review of the resident's face sheet revealed it did not have a sticker indicating the resident's code status.

5. Additional interviews revealed the following:

- 1/18/17 at approximately 2:10 PM - LPN #3 Unit Manager stated she would look at the Closet Care Plan or check the resident's face sheet.

- 1/18/17 at approximately 2:25 PM - LPN #10 stated she wasn't sure what she would do and has only worked at the facility for a few weeks.

-1/18/17 at approximately 2:30 PM - LPN #2 stated she would look at the resident's face sheet. LPN #2 also stated she would not look at Physician's orders.

- 01/18/2017 at approximately 2:35 PM - LPN #1 Unit Manager stated if a resident was unresponsive she would go to the MOLST to determine the resident's status. If there is no MOLST the resident would be considered a full code.

- 1/18/17 at approximately 4:34 PM - LPN # 9 stated that if a resident was unresponsive she would go to the advance directives section of the chart to check the MOLST. If there is no MOLST then the resident is a full code.

- 1/18/17 at approximately 4:37 PM - LPN # 7 stated if a resident is found unresponsive she would check the sticker on the face sheet. If there

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is no sticker she would check the Physician's orders. There is also a list posted on the Unit Manager's door.

- 1/18 /17 at approximately 4:40 PM - LPN #8 stated she would go to the chart, check the face sheet if the resident was a full code she would call "Dr. Fast". If the resident was a DNR, she would call the Supervisor. LPN #8 also stated if she was off the unit she would go to the reception desk and check the "code status" list.

6. Review of a letter to the New York State Department of Health, signed by the Administrator, dated 1/22/17 revealed the following:

- Resident Advance Directives and Basic Life Support policy and procedure (P&P) was reviewed and revised
- All nursing, clinical and medical staff were educated on the revised Resident Advance Directives and Basic Life Support policy
- Advanced Directive audits were performed and deficient practices identified were corrected
- Facility Medical Director met with the Administrator and Corporate Director of Nursing and approved the revised policy and procedure

7. The Immediate Jeopardy was removed on 1/22/17 because of the following:

a). Review of the revised Resident Advance Directive and Basic Life Support P&P, dated 1/22/17 revealed specific steps to obtain or change a residents' Advance Directive status: communicate and document the resident's Advance Directive status; and methods to implement the resident's Advance Directive in an

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emergency response.

b). Review of facility In-service Records dated 1/18/17 through 1/21/17 confirmed all clinical and medical staff received education on the facility's revised Advance Directives and Basic Life Support policy. Training consisted of specific steps to obtain or change a residents' Advance Directive status, communication of code status, and the methods used to identify the resident's wishes in an emergency response. Provisions were made for education and training to continue on an on-going basis.

c). Observations and reviews on 1/22/17 of three resident records on the 2nd floor nursing unit and three resident records on the 3rd floor nursing unit revealed the following: Resident face sheet, Advance Directive; Physician Orders; facility lists in the 24-hour report book and Therapy Department and room door tag all correctly documented the resident's Advance Directive status.

Additional observations and reviews on 1/23/17 of nine residents' records revealed that the resident code status was accurately identified, communicated and documented based on the resident's wishes.

d). Based on interviews with: Director of Nursing, Assistant Director of Nursing, 3-11 Shift RN Supervisor, RN MDS Coordinator, LPN #1 Unit Manager, LPN #3 Unit Manager, LPN #4, LPN #6, LPN #7, LPN #8, LPN #9, LPN #11, and LPN #12, on 1/23/17 between 2:30 PM and 4:30 PM revealed the staff were educated on the facility "Advance Directives and Basic Life Support" policy and procedure. This included specific steps

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F 155	Continued From page 14 to obtain or change a residents' Advanced Directive status, how the residents' wishes are identified, documented, communicated and located. In addition, the methods used to implement the resident's Advanced Directives in an emergency response, including what to do if there were to be a discrepancy with the identifiers. 415.3 (e)(2)(iii)	F 155		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during a Complaint investigation (Complaint #NY00183004) conducted during the Standard survey completed on 1/24/17, the facility did not promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. One (Resident #64) of three residents reviewed for dignity had an issue involving staff suspended the resident's privileges following an altercation with another resident. In addition, resident meals were served on disposable plates, cups, bowls and plastic utensils on two of two nursing unit dining rooms. This involved Resident #75.	F 241		

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The findings are:

1. Resident #64 was admitted to the facility on 1/29/16 with diagnoses including diabetes mellitus, major depressive disorder and anxiety. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 10/20/16 revealed the resident has an intact cognitive status.

Review of the Comprehensive Care Plan (CCP) dated 11/10/16 revealed the resident has the potential to demonstrate physical behaviors, throwing things related to poor impulse control. Interventions include when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and approach later.

Review of an Accident/ Incident (A&I) Report dated 6/8/16 revealed the resident was outside unsupervised during smoking time when she and another resident from a different unit engaged in a verbal altercation. Resident #64 picked up a stone and threw it at the other resident striking his foot. A follow-up/ intervention to prevent recurrence was no further smoking and nicotine patch.

Review of a statement written by the Registered Nurse (RN)Assistant Director of Nursing (ADON) on 6/8/16 revealed smoking privileges were suspended for both residents pending investigation.

Review of a statement by the Business Office Manager dated 6/10/16 revealed that on 6/8/16 she took Resident #64 to her room following the

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altercation with the other resident. She told Resident #64 to remain in her room and if any more things happened she would be going to the hospital or jail.

During an interview on 1/19/17 at 9:29 AM, Resident #64 stated that she felt she was being treated like a child. When asked if she had a behavior contract in place she stated, "No."

During an interview on 1/20/17 at 11:44 AM, the Business Office Manager revealed that telling Resident #64 she would be going to the hospital or jail was not meant as a threat.

During an in interview with the Social Worker (SW) on 1/20/17 at approximately 2:30 PM revealed the residents should not have had their smoking privileges rescinded.

Review of the facility policy dated 12/11/08 entitled Facility Smoking: Employees and Residents revealed residents must be accompanied by staff members during smoking breaks. Family members may also accompany their resident only for a smoke break.

Review of the facility policy entitled Quality of Life-Dignity dated 12/15/16 noted: Residents shall be treated with dignity and respect at all times and treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

2. Resident #75 has diagnoses which include diabetes mellitus, hypertension, and peripheral vascular disease. Review of the MDS dated 12/1/16 revealed the resident is cognitively intact.

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F 241	Continued From page 17 Observation of the Breakfast Meal on 1/13/17 at 8:45 AM revealed the residents were served on paper plates, beverages were in Styrofoam cups, dry cereal was in disposable plastic bowls and plastic ware was being used. During an in interview with Resident #75 on 1/13/17 at approximately 8:45 AM revealed they are served on paper/ plastic ware 75% of the time. During an in interview with the Dietary Director on 1/20/17 at 8:50 AM revealed the meal was served on paper because the dish machine was not working. During an in interview on 1/13/17 at 3:55 PM, the dish machine service man stated, "Nothing was wrong with the dish machine. It was working fine."	F 241		
F 244 SS=E	415.5(a) 483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 244		

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facility must implement as recommended every request of the resident or family group.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review conducted during an Standard survey completed on 1/24/17, the facility did not ensure prompt efforts to resolve grievances the resident may have. The issue involved ongoing grievances for 12 of 12 months regarding food service delivery that were not consistently resolved and continue to be a problem.

The findings are:

1. Review of Resident's Council Report for the months of 1/2016 through 12/2016 revealed the following complaints regarding the food service department;

-Missing items on trays 1/16, 2/16, 9/16, 11/16, 12/16
-Council does not like coffee being sent all together on top of the meal carts 1/16, 2/16, 4/16, 5/16, 7/16
-Menus not followed 6/16, 9/16, 10/16
-Meals are late 7/16, 8/16, 9/16

Review of the Week 2 menu revealed the planned breakfast meal was cold cereal, wheat toast and scrambled eggs. Observation of the breakfast meal on 1/13/17 revealed the residents were served cold cereal, wheat toast and 1 boiled egg.

During an interview on 1/20/17 at 8:50 AM the Dietary Director stated that the menu was changed on 1/13/17 at breakfast because the Dietary Department was short staffed.

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F 244	Continued From page 19 Observation of resident's meal tickets revealed multiple items missing on the resident's meal trays. Resident A, B, C, D, and E should have received 2 ounces (oz.) of scrambled eggs according to their meal ticket and they received only 1 oz. of a boiled egg. Resident C should have received a 6 oz. mighty shake which was not on the meal tray. Resident D had no cereal, canned fruit, or coffee. Resident E lacked cereal and coffee. Observation of the lunch meal on 1/13/17 at 1:02 PM revealed Resident E's meal ticket had a 4 oz. diet mighty shake listed which was not on the resident's tray. Resident G had 4 oz. of diet ice cream on the meal ticket which was not on the tray. Resident H was to have 8 oz. skim milk per the meal ticket which was not on the tray. In summary, the resident's food grievances still have not been resolved.	F 244		
F 246 SS=D	415.3(c)(1)(ii) 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review during an Standard survey completed on 1/24/17, the facility did not ensure that a resident has the right to reside and receive services in the	F 246		

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facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. One (Resident #50) of three residents observed for positioning did not have the appropriate height table for the resident to feed herself while seated in a wheel chair.

The finding is:

1. Resident #50 was admitted to the facility on 8/26/14 with diagnoses which include hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body) following a cerebral infarct (stroke). Review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/18/16 revealed the resident is severely cognitively impaired, understands and is understood.

Review of the current comprehensive Care Plan with a review date of 11/22/16 revealed the resident has the potential for weight change and altered hydration related to history of CVA and right sided weakness. Interventions include to encourage optimal intake of a well - balanced diet.

Review of the Closet Care Plan (guide used by staff to provide care) dated 1/19/17 revealed the resident is independent with eating after set up.

Observation of the lunch meal was conducted on 1/13/17 from 1:01 PM through 1:45 PM. Resident #50 was observed sitting at a dining table in the Unit 2 Lounge. The resident was seated in her wheel chair and the dining table was level with her nose. The table was too high to

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F 246	Continued From page 21 accommodate the resident. She was seated in smaller wheelchair and was having difficulty reaching the food and keeping the food on her fork. During a second observation of the lunch meal on 1/19/17 approximately 12:45 PM, Resident #50 was observed sitting at a dining table in the Unit 2 Lounge. The resident was seated in her wheel chair and the dining table was level with her nose. The table was too high to accommodate the resident. She was seated in smaller wheelchair and was having difficulty reaching the food and keeping the food on her fork. During an interview on 1/19/17 at 2:00 PM, the Director of Therapy stated the resident should not be seated at the dining table. The table is too high for the resident to reach her meal. Staff should be using a tray table positioned to fit the resident while she eats her meals.	F 246		
F 250 SS=E	415.5 (e)(1) 483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during the Standard survey completed on 1/24/17, the facility did not ensure the provision of medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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Specifically, four (Residents #63, 80, 83 and 99) of 29 residents reviewed for social services had issues involving the lack of social work advocacy to ensure that residents or responsible parties were informed of the health care choices and ramification related to Advance Directives. In additional, the facility did not provide adequate social services related to long term needs of Resident #63.

The findings include but are not limited to:

1. Resident #83 was admitted to the facility for rehabilitation on 8/15/16 with diagnoses that include Alzheimer's dementia, hypercholesterolemia (elevated level of cholesterol in the blood), and a history of breast cancer. Review of the Minimum Data Set (MDS- a resident assessment tool) dated 8/28/16 revealed the facility did not assess the resident's cognitive status.

Review of the physician's History & Physical (H&P) dated 8/19/16 revealed the resident was oriented to person, place, and time. In addition, the H&P documented the resident's judgment was intact, insight was intact, and decisional capacity was present.

Review of a "Resident Admission/Readmission Evaluation" dated 8/15/16 revealed the following Advance Directive was checked - DNR (Do Not Resuscitate - allow natural death).

Review of an undated "Admission Intermin [sic] Care Plan", revealed a green FULL CODE (designation that means to start CPR if a patient's heart stops beating or if the patient stops breathing) sticker on the lower right hand corner

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F 250	Continued From page 23 of page 1. Review of the Physician's Orders, signed 8/19/16 revealed the resident had a DNR order. Review of a Nurses Progress Notes dated 9/6/16, timed "9:05 - 9:45", written by the Director of Nursing (DON) revealed the following: - "Called to 2nd (second) floor STAT (immediately). Resident was observed slumped in wheelchair, unresponsive with shallow agonal (gasping) breathing. + (positive) RT (right) femoral (femoral artery - situated at, in or near the thigh) pulse. Unable to assess pupil response due to cataracts (clouding of the normally clear lens of the eye) B/L (bilateral). Rescue breathing with O2 (oxygen) started after the resident was put back into bed. 911 called. Rescue breathing and frequent pulse checks. Resident was noted not to have a pulse and CPR was started prior to 911 coming in. 911 arrived and resumed CPR and ACLS (advanced cardiac life support - clinical interventions for the urgent treatment of cardiac arrest). Resident was noted to have electrical activity on monitor but remained unresponsive. She was transported by emergency services. Family was called but was unable to be reached. Daughter came in at 9:50 AM and a staff member drove her to the hospital." Review of the MDS Death in facility tracking record revealed the resident expired 9/6/16. During an interview on 1/18/16 at approximately 2:45 PM, the Medical Director stated, "Everything should match, what's on the inside should be on the outside. The resident had a Physician's order for a DNR, that order should be honored. The	F 250		

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stickers should match. I would expect the conversations that the Social Worker has with the residents to be documented in the record."

Review of the entire medical record revealed there were no Social Work Progress Notes and there was no documented evidence that advance directives were addressed with the resident.

Interview with the Social Worker on 1/20/17 at approximately 8:21 AM revealed, "I don't know what happened with this case, I didn't work here then."

Review of the policy and procedure entitled "Advance Directives" dated 5/1/16 included "Upon admission, Social Work staff determine whether a resident has Advance Directives or a designated Health Care Agent. If the resident has Advance Directives in place, Social Work will communicate the existence of a resident's Advance Directives to all appropriate staff, including the Receptionist and Unit Clerks. If the resident does not have Advance Directives, s/he will be informed upon admission of his/ her right to formulate them. This includes informing the resident of the Health Care Proxy (HCP) law. A copy of the Health Care Proxy and commonly asked questions will be included in the admission paperwork. Social Work will document in the Social Work Progress Notes in the Medical Record. Advance Directives will be reviewed and revised at the request of the resident or, at a minimum, quarterly."

2. Resident #80 was readmitted to the facility 9/4/16 with diagnoses which included end stage renal disease (ESRD) on hemodialysis (machine filters wastes, salts and fluid from the blood when kidneys are no longer able to), peripheral

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vascular disease (PVD - poor circulation of the lower extremities), and hyperlipidemia. Review of the MDS dated 12/3/16 revealed the resident has severe cognitive impairment, is understood, and understands.

Review of a physician's note dated 12/23/16 documented that the resident's "Judgement is impaired. Insight is impaired. Decisional capacity: None."

Review of the Physician's Order, signed by the Physician 12/23/16 included the following order, "Advance Directives: Do Not Resuscitate with Comfort Care (conservative, supportive measures to be provided at the end of life)."

Review of a Telephone Order dated 12/29/16, and signed by the physician 12/30/16, revealed the following order, "90 day review. Full Code. No capacity."

Review of a Nursing Progress Note dated 12/30/16, "7 - 3" (7:00 AM to 3:00 PM shift) revealed the following, "MD in Advanced Directives Full code, no capacity." Further review of Nursing Progress Notes revealed no documented evidence the responsible was consulted prior to the change in Advance Directives status.

Review of entire medical record revealed there were no Social Work Progress Notes between 7/1/15 and 1/17/17. Additional review of Social Work Progress Notes revealed no documented evidence the responsible was consulted prior to the change in Advance Directive status.

During a telephone interview on 1/19/17 at

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approximately 10:48 AM, the Physician stated, "The process when addressing/ changing Advance Directive status is, if the resident has the capacity the resident makes the decision to change their Advance Directives. If the resident does not have capacity then the Health Care Proxy (HCP - document that allows an appointed person to make health care decisions for a person not capable of making health care decisions on their own) makes the decision for the resident."

During an interview on 1/20/17 at approximately 8:21 AM, the Social Worker revealed the following, "It is the responsibility of the Social Worker to address Advance Directives upon admission. We (the facility) identified issues with Advance Directives so an audit was started in December (2016). The ADON (Assistant Director of Nursing) and myself started to go through the charts to make sure the supporting documentation was in the chart for the Physician's Orders, if a resident had a Physician's Order for a DNR we checked to make sure the DNR paperwork or a MOLST (Medical Orders for Life Sustaining Treatment - medical order form that tells others the patient's wishes for life sustaining treatment) was in the Medical Record. If there was no supporting documentation for a DNR, telephone orders for Full Code were written for the Physician to sign." Interview further revealed, "The families of the residents were not contacted during this process, if there was no supporting documentation the orders were changed to Full Code status."

Review of facility policy and procedure Emergencies/ Safety: Basic Life Support/C.P.R. (cardiopulmonary resuscitation), Effective Date

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10/27/16, revealed "The Social Worker or Nursing Supervisor will be responsible to identify Advance Directives or resuscitation status on admission, readmission or change in status during a continued stay, and will update their resuscitation status in the front of each Medication Administration Record (MAR) and at the front desk.

3. Resident #63 was admitted to the facility on 1/14/14 with diagnoses that include chronic obstructive lung disease (COPD, disease that blocks airflow and makes it difficult to breathe), chronic kidney disease (CKD), and congestive heart failure (CHF). Review of the MDS dated 11/26/16 revealed the resident is cognitively intact, understands and is understood.

Review of the most current Social Services Care Plan Progress Note, dated 1/7/15 revealed the resident had a MOLST (Medical Orders for Life Sustaining Treament)/ DNR and the resident's HCP was activated. Further review of the Care Plan Progress Note revealed the resident was oriented to person, had impaired short-term and long-term memory, always or usually understands and had no behavioral issues. The Social Worker (SW) did not complete the sections about family involvement or discharge planning.

Review of Social Work Progress Notes revealed the following:
- 1/19/16 SW documented that the resident is able to make needs known and reported missing pants and shirt from his closet.
- 1/26/16 SW documented that the resident is able to make needs known with some confusion. The resident asked the SW about possibility of being discharged home. The SW informed the

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resident that his wife stated that she could not provide the care he needed.
- 4/18/16 SW documented that the resident was notified of a new roommate.

Review of a the Physician's Orders, signed 1/3/17, has an Advance Directive orders dated 3/30/14 for DNR and DNI (do not intubate- do not place tube down throat or connect to breathing machine).

Review of the medical record revealed a Health Care Proxy, dated 7/7/13 with no Advance Directive information and two Physician Orders Health Care Proxy Activation forms signed 2/4/14 and 2/5/14.

Further review of the medical record revealed no further Social Work assessments or notes for the resident; there is no evidence that the Social Worker discussed the resident's wishes of discharge with the resident's family; investigated the possible placement of the resident in a lower level of care and lacked evidence that the Social Worker discussed Advance Directive planning with the family when the Health Care Proxy was activated.

During interview with the Social Worker on 1/23/17 at 11:00 AM, the SW stated that the Social Services Care Plan Progress Note is to be completed annually, quarterly and with a significant change in the resident's status. The SW stated that she began working with the facility at the end of May 2016 and was not initially aware of the schedule to document the SW Assessment. The SW stated that the resident had an Annual Care Plan meeting in November 2016 and the resident and his wife were invited to

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F 250	Continued From page 29 the meeting but chose not to attend. The SW stated that she did not document inviting the resident but a log is maintained for the letters mailed to the resident's family. The SW further stated that the resident will frequently stop to speak with her in her office and she is aware that the resident would like to be discharged and the resident may be more appropriate in a lower level of care. The SW stated that she became aware that the resident lacked Advance Directives when she was conducting an audit of residents' medical record and is currently having a MOLST completed for this resident. Review of facility policy and procedure entitled "Advance Directives", dated 5/1/16 revealed that if the resident lacks capacity as so determined by two physicians, Social Work may then turn to an available surrogate, in the following order, for a decision regarding resuscitation of the resident: 1. A person the resident has selected as Health Care Agency. 415.5(g)(1)(iii-ix)	F 250		
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted during the Standard survey completed on 1/24/17, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Two	F 253		

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of two nursing units had issues including resident care equipment unlabeled and stored in an improper or unsanitary manner, personal care supplies unlabeled, spilled feeding, urine odors and walls and window treatments in need of repair.

The findings are:

1. Observations on 1/13/17 from 8:30 through 2:00 PM revealed the following:

- Resident Room #300 - Unlabeled razor and bottle of peri wash (incontinence cleaner) on the shelf in the shared bathroom.
- Resident Room #301 - 2 open bottles of unlabeled peri wash on the shelf above the sink in the bathroom.
- Resident Room #303 - Unlabeled fracture pan in the bathroom transfer bar and an unlabeled basin on the back of the toilet. Unlabeled shaving cream, deodorant and 3 bottles of skin wash were on the shelf above the sink in the shared bathroom.
- Resident Room #304 - 2 bottles of peri wash on the bathroom shelf and 1 bottle of soap unlabeled.
- Resident Room #305 - 2 bottles of unlabeled soap, one open unlabeled bottle of mouthwash in shared bathroom.
- Resident Room #306 - Unlabeled liquid soap on the back of the shared bathroom sink.
- Resident Room #317S - 2 unlabeled wash basins on the floor under the sink in the shared bathroom.
- Resident Room #317- Foot basin, wash basin and fracture pan stored the under sink in bathroom.
- Resident Room #319 - Urinary leg bag on top of

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toilet tank, 2 urinals in the bathroom unlabeled
- Resident Room #320 - Wall behind the bed was patched, not sanded or painted, spilled feed on floor, on extension cord, and power strip.
- Resident Room #321- Wash basin on the floor in the corner of the bathroom.
- Resident Room #324 - Wash basin stored against the wall on the floor of the bathroom.
- Resident Room #323 - Unlabeled wash basin in the corner of the bathroom on the floor and unlabeled personal care items on the shelf above sink in a shared bathroom.

Observations on 1/17/17 from 8:00 AM through 10:00 AM revealed the following:

- Resident Room #200 - Wall behind the bed was scuffed up and in disrepair with plaster showing.
- Resident Room #221 - Odor of urine was detected.
- Resident Room #223 - Odor of urine in the bathroom and a large plastic cover that is not size of toilet covering tank.
- Resident Room #301 - 2 open unlabeled bottles of peri wash on the shelf above the sink in the bathroom and a basin on the back of the toilet with the bed number unreadable.
- Resident Room #302 - 1 bottle of peri wash and 2 body soaps, unlabeled on the shelf above the sink.
- Resident Room #309 - 4 bottles of unlabeled peri wash on the shelf above the sink and an unlabeled wash basin on the floor in the bathroom.
Room #317- Foot basin, wash basin and fracture pan under the sink in the bathroom.
- Resident Room #319 - Unlabeled basin on the floor of the bathroom propped against the wall.
- Resident Room #324 - Basin on the floor under

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F 253	Continued From page 32 the sink containing personal care items. Observations on 1/20/17 from 1:30 PM through 2:00 PM revealed the following: - Resident Room #301 - Unlabeled urinal and urine collection hat on the back of the toilet. - Resident Room #302 - 1 unlabeled bottle of mouth rinse on the shelf above the sink in the bathroom. - Resident Room #305 - 2 unlabeled bottles of soap and 1 bottle of peri wash on the shelf above the sink. - Resident Room #317S - 1 unlabeled bottle of soap on the shelf above the sink. - Resident Room #317- Foot basin and fracture pan on the floor under the sink. - Resident Room #319 - Unlabeled basin on the floor of the bathroom propped against the wall and an unlabeled urine graduate on the toilet tank. Intermittent observations from 1/13/17 through 1/20/17 revealed the following rooms had multiple slats missing from the vertical blinds: - Resident Room #210S - Resident Room #317 - Resident Room #317S - Resident Room #319 - Resident Room #320 - Resident Room #321 - Resident Room #324 had 5 hooks missing from the drapes on the window. During an interview with the Maintenance Director on 1/23/17 at 2:06 PM she stated that the blinds are a work in progress. She orders the blinds as corporate allows and replaces them as needed.	F 253		

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F 253	Continued From page 33 She is looking into other blinds and curtains. The Maintenance Director further stated that the odor in Room #221 was not reported to her. If it was she would have had extra cleaning in place for that room. After being brought to her attention she stated that she had one of the mattresses washed down and would replace it because she found a small tear which could cause retention of odors. 415.5(h)(1) 415.29(h)(3)	F 253		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and	F 309		

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preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review conducted during an Standard survey completed on 1/24/17, the facility did not provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well- being, in accordance with the comprehensive assessment and plan of care. One (Residents #28) of three residents reviewed for quality of care had issues. Specifically, the lack of a Registered Nurse (RN) assessment after the resident was found on the floor.

The finding is:

1. Resident #28 was admitted to the facility on 2/28/15 with diagnoses that included anemia, diabetes mellitus, and hypertension. Review of the Minimum Data Set (MDS- a resident assessment tool) revealed the resident has severe cognitive impairment, is understood, and understands.

Review of a Nursing Progress Note dated 9/8/16 at 1:10 PM, written by a Licensed Practical Nurse (LPN) included the following:
-A noise heard from Resident #28's room, upon entering room Res (resident) noted to be lying on her back, ROM (range of motion) done by DON (Director of Nursing) who was present. Res assisted back to bed, Res denies any disc (discomfort). ROM appear WNL (within normal limits), small reddened area to back of her head, neuro (neurological) checks started and WNL 9within normal limits). Res denies headache. Res fell backwards stated by caregiver/ witness.

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F 309	Continued From page 35 Res states the walker fell up on me. Daughter was called and updated. Review of facility Accident/ Incident (A&I) Report dated 9/8/16 revealed the report was completed by an LPN. Review of Nursing Progress Notes dated 9/8/16 through 9/10/16 revealed no RN assessment after the resident fell on 9/8/16. Review of Nursing Progress Notes dated 10/11/16 at 8:30 AM, written by a LPN included the following: -This writer noted resident ambulating in hallway unassisted. While walking noted resident's feet crossed and she fell. Resident did not hit head. ROM and neuro's within functional limits. No c/o (complaints of) pain/ disc voiced. Review of an A&I Report dated 10/11/16 revealed the report was completed by an LPN. Review of Nursing Progress Notes 10/11/16 through 10/12/16 revealed no RN assessment after the resident fell on 10/11/16. During an interview on 1/19/17 at 10:01 AM, RN #2, Nursing Supervisor stated, "When a resident falls the Supervisor is called to assess the resident. The Supervisor asks how the incident occurred, assesses the resident from head to toe, obtain vital signs, fill out the A&I Report, notify the MD (medical doctor) and family. I don't know why these two falls don't have an RN assessment especially because both these falls were on day shift and there's always an RN in the building on the day shift."	F 309		

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F 309	Continued From page 36 Review of facility policy and procedure entitled, Accident/Incident Reports, effective date 12/10/06, included the RN Supervisor is notified immediately so that he/she may evaluate and assess the person for injury and provide appropriate First Aid.	F 309		
F 315 SS=D	415.12 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 315		

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continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review conducted during the Standard survey completed on 1/24/17, the facility did not ensure that an indwelling catheter (Foley-a tube inserted into the bladder to drain urine) is not used unless there is valid medical justification, an indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted and a resident receives the appropriate care and services to prevent infections to the extent possible. Two (Resident #23, 67) of three residents reviewed for catheter use had issues. Specifically, a resident lacked indication for the use of an indwelling Foley catheter, no attempts were made to discontinue it, there were no Physician's order for the catheter or it's care and the Comprehensive Care Plan was not updated to include the use or care of the catheter (Resident #67); and a resident observed without a dressing on the suprapubic (inserted into the abdomen) catheter site per Physician's order and the suprapubic catheter was changed without a Physician's order (Resident #23) .

The findings are:

1. Resident #67 was re-admitted to the facility on 10/24/16 with diagnoses including chronic kidney disease, diabetes insipidus (the passage of large

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volume of dilute urine) and history of cerebrovascular accident (CVA-stroke).

Review of the Minimum Data Set (MDS- a resident assessment tool) dated 12/6/16 revealed the resident has severe cognitive impairment for daily decision-making and has an indwelling Foley catheter.

Review of the Physician's Orders from October 2016 through January 13, 2017 revealed no order for a Foley catheter, a plan for a voiding trial or attempted removal of the catheter.

Review of the Comprehensive Care Plan dated 1/17/17 revealed there was no Care Plan for the use or care of the Foley catheter.

During an interview on 1/17/17 at 10:39 AM, Licensed Practical Nurse (LPN) #1 Unit Manager (UM) revealed the resident returned from the hospital on 10/24/16 with the Foley catheter in place. LPN #1 was unable to provide a reason for the Foley catheter or documented indication for its use.

Review of a Physician's Order dated 1/17/17 revealed an order to discontinue the Foley catheter and voiding trial. If no voiding in 8 hours reinsert 16 Fr (French) 30cc (cubic centimeters) bulb. Update provider.

Review of Nursing Notes dated 11/17/17 revealed the Foley catheter was discontinued at 4:00 PM and the resident was incontinent of a large amount of urine x 2 on the 3:00 PM to 11:00 PM shift. At 11:00 PM the resident voided x 3.

Review of Nursing Notes dated 1/18/17 on the

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7:00 AM to 3:00 PM shift revealed the resident voided a large quantity of urine x 2. No signs or symptoms of retention. On the 3:00 PM to 11:00 PM shift the resident voided a large amount of urine x 2.

Review of a Nursing Note dated 1/19/16 revealed the resident was incontinent of urine x 2.

2. Resident #23 was re-admitted to the facility on 9/15/16 with diagnoses that include cerebral infarction (stroke), benign prostatic hyperplasia (enlarged prostate) and dementia. Review of the MDS dated 11/23/16 revealed the resident has severe cognitive impairment, an indwelling Foley catheter, and is totally dependent on two persons for toilet use.

During an observation of morning care on 1/19/17 at 7:22 AM the Certified Nurse Aide (CNA) #2 washed Resident #23's upper body and abdomen while CNA #1 assisted with care. The resident was observed to have a suprapubic catheter inserted into the left midsection of the abdomen. The catheter was secured to the resident's right leg with a catheter leg strap. The catheter insertion site was open to air with no protective dressing and a small amount of yellow crusted material observed on the abdomen around the catheter insertion site. CNA #2 was observed to remove the catheter leg strap when washing the resident's lower body and buttocks. CNA #1 secured the leg strap to the left leg after care to the lower body and buttocks was completed. The resident was dressed in a pullover shirt and socks and remained in bed without a brief. During continued observation, LPN #5 entered the resident's room at 7:58 AM and completed wound care to the resident's sacral (area above the tail

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bone on right and left buttocks) pressure ulcer while CNA #2 assisted in holding the resident in place. The resident remained in bed, at his request, after the pressure ulcer dressing was changed by the nurse. At that time, CNA #2 stated she was done with the resident's care. CNA #2 did not inform LPN #5 that the resident did not have a dressing in place at the suprapubic catheter insertion site.

Review of Physician's Visit Notes from 11/18/16, 12/9/16 and 1/6/17 revealed the Physician documented in the examination of each visit that the resident has an intact gastrostomy site and the urethral meatus (external opening of the urinary tract) has a Foley catheter in place.

Review of Physician's Orders, signed 1/6/17, revealed orders to cleanse suprapubic catheter site with normal saline (NS), apply dry clean dressing (DCD) daily by the 11:00 PM to 7:00 AM shift. Further review of the Physician's Orders revealed instructions to flush the suprapubic catheter with Renacidin (medication to dissolve kidney stones) with 30 ml (milliliters) daily and an order to change suprapubic catheter monthly on the 16th at the MD (medical doctor) office.

Review of the Comprehensive Care Plan, dated 12/8/16 revealed the resident has an indwelling suprapubic catheter. The interventions did not include instructions for the MD to change the suprapubic catheter monthly, the need to flush the catheter with Renacidin daily and instructions to cleanse the catheter insertion site with NS and apply a DCD daily.

Review of the CNA Closet Care Plan (used to provide care), dated 1/19/17, did not include

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instruction that the resident is to have a dressing on the suprapubic catheter insertion site and to inform the nurse if the dressing is not present.

Review of the Treatment Administration Record (TAR) for January 2017 revealed instructions to cleanse the suprapubic catheter site with NS and apply DCD daily by 11:00 PM to 7:00 AM shift. The box to initial for completion of this treatment was not initialed on 1/18/17 and 1/19/17.

Review of Nursing Notes revealed that on 1/17/17 at 7:00 PM the Registered Nurse (RN) re-inserted the 20 Fr suprapubic Foley catheter as the catheter was found lying in the resident's bed. There is no documentation that the Physician was informed that the suprapubic catheter was not in place or orders received for the RN to re-insert the resident's catheter.

Review of Physician Telephone Orders revealed no evidence of an order for the nurse to re-insert the resident suprapubic catheter at any time.

During an interview on 1/23/17 at 10:08 AM, CNA #1 stated that when the resident's suprapubic catheter does not have a dressing on it when providing care, the CNA should inform the nurse.

During an interview on 1/23/17 at 10:11 AM, LPN #1 Unit Manager (UM), stated that the resident's suprapubic catheter should have a dressing on it at all times, and the CNA should let the nurse know if the dressing is not there. LPN #1 UM stated that there is an order for doctor to change the suprapubic catheter and the catheter was changed by the nurse on 1/17/17 without a Physician's Order.

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F 315	Continued From page 42 During an interview with the Director of Nursing (DON) on 1/23/17 at approximately 11:00 AM revealed the resident's suprapubic catheter should have a dressing in place at all times and the catheter should not be changed by the nurse without a Physician's Order. Review of the facility policy entitled Resident Care Planning Process, dated 1/2012 revealed the Closet Care Plan is the plan of care for the resident. The Closet Care Plan documents resident's level of assist, what is to be provided and any specifics to that resident. Each staff member who provides care to a resident is responsible to immediately report any changes in the resident's physical, functional or mental behavior that differs from the plan of care. 415.12(d)(2)	F 315		
F 325 SS=E	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a	F 325		

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nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review conducted during an Standard survey completed on 1/24/16, the facility did not ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. One (Resident #20) of five residents reviewed for nutrition had an issue with not receiving the appropriate amount of supplements as planned.

The finding is:

1. Resident #20 was admitted to the facility on 11/28/16 with diagnoses which include diabetes mellitus, cerebral vascular disease, and dementia. Review of the Minimum Data Set (MDS- a resident assessment tool) dated 12/5/16 revealed the resident was severely cognitively impaired.

Review of a Dietary Initial Assessment dated 11/29/16 revealed the resident's Albumin (protein level in the blood)/ Prealbumin (a blood test that can indicate severe nutritional deficiency) levels were low.

Review of laboratory (Lab) results dated 11/29/16 revealed an albumin level of 1.7 with normal levels of 3.1 to 4.6 and a Prealbumin of 5.0 with normal levels of 17 to 34. The plan was to provide 6 ounces (oz.) diet mighty shakes three times a day (TID) for an additional 900 calories and 33 grams protein.

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Review of a Nutrition Progress Note dated 12/30/16 revealed the resident developed an open area to the tip of the right foot. The plan was to continue 6 oz. of diet mighty shake TID and add 8 oz. of high protein juice for an additional 12 grams of protein to aid in healing.

Observation of the breakfast meal on 1/13/17 revealed the resident received 1 boiled egg while his meal ticket indicated he should have received 2 oz. of scrambled eggs.

Observation of the lunch meal on 1/13/17 at 1:05 PM and 1/19/17 at 1:15 PM revealed the resident received 4 oz of mighty shake at lunch while his meal ticket stated 6 oz.

Review of a Nutrition Progress Note dated 1/17/17 revealed the resident had multiple nutrition issues which included a 27# (pound) weight loss in 30 days which they attributed some of that loss related to lower extremity edema (swelling caused by excess fluid accumulation). Remeron was ordered as an appetite stimulant to assist in improved intake. The resident developed a Stage 2 pressure sore on the right medial foot. The plan remained to provide 6 oz. mighty shake TID and the 8 oz. protein juice at breakfast.

Interview with the Dietary Director on 1/20/17 at 8:50 AM revealed the menu for breakfast was changed from 2 oz. scrambled egg to 1 oz. boiled egg because the dietary department was short staffed that morning.

Interview with the Diet Technician (DT) on 1/23/16 at 10:35 AM revealed she did not know the Dietary Director was ordering 4 oz diet mighty

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F 325	Continued From page 45 shake over 6 oz. mighty shakes. The DT stated he needed to get the order approved from their corporate office. Therefore, the resident hasnot been receiving the 6 oz. diet mighty shakes TID as planned until it was brought to the attention of the DT and Registered Dietitian by the surveyor on 1/19/17 at 1:35 PM.	F 325		
F 329 SS=D	415.12(i)(1) 483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard survey completed on 1/24/17, the facility did not ensure that each resident's drug regimen was free from	F 329		

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unnecessary drugs. Two (Residents #13, 85) of five residents reviewed for unnecessary medications did not have nonpharmacological behavioral interventions prior to the administration of an antipsychotic medication and were placed and remained on antipsychotic medication after a single episode of Paranoia (Resident #85) and after two episodes of striking out at a health care provider (Resident #13).

The findings are:

1. Resident #13 was admitted to the facility on 3/13/09 and has diagnoses that include vascular dementia, major depressive disorder and cerebral vascular disease (CVA-stroke). Review of the Minimum Data Set (MDS- a resident assessment tool) dated 11/13/16 revealed the resident has severe cognitive impairment, sometimes understands and is sometimes understood. The resident has little interest in doing things, feels down, depressed or hopeless and had a poor appetite for 2 to 6 days over the look back period. No episodes of psychosis or behavioral symptoms were documented.

Review of May 2016 Physician's Orders, signed 5/13/16, revealed orders for Risperidone (antipsychotic medication) 0.5 mg (milligram) in AM and Risperidone 1 mg po (by mouth) at HS (hours of sleep).

Further review of the Medical Record revealed Physician's Telephone Orders as follows:
-9/8/16 Remeron 7.5 mg po q (every) HS x 7 days then 15 mg po q HS.
-9/27/16 Change Risperidone to 1 mg po BID (twice a day).
-9/29/16 Increase Remeron 22.5 mg po q HS

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F 329	Continued From page 47 (mood). -10/4/16 Discontinue patient weight re: progressive dementia. -1/2/17 Decrease Remeron to 15 mg po q HS. Review of Psychiatry In-house Consultation Reports revealed the following: -4/19/16 The staff note she is throwing her diaper away, not sleeping at night, increased depressed. She says "I want to go home." Positive paranoia ideation, positive agitation, judgement and insight impaired. Psychiatric diagnosis: Vascular Dementia. Increase Risperidone 0.5 mg in AM, 1 mg po q HS (agitated paranoia ideation). -9/29/16 The patient denies any complaints, compliant with meds. No death wishes. She notes she wants to go to bed now. No psychosis. Discouraged, memory impaired. No auditory/ visual hallucination. Sleeps at night. Even mood. Psychiatric diagnosis: Vascular Dementia, no paranoid ideation, increase Remeron 22.5 mg po q HS (mood). -1/2/17 She lives to watch television, no suicidal/ homicidal ideation, denies pain, compliant with meds, no delusions now, no auditory/ visual hallucination. Psychiatric diagnosis: Vascular Dementia. Continue Risperidone 1 mg po BID, decrease Remeron 15 mg po HS. Review of Physician Interval Visits revealed the following: -9/20/16 "patient sitting in common dining area, blanket over her head, head on table. Does not talk with provider; did attempt hitting provider once without success. Awake, alert appearing. No acute distress. Fairly cooperative for physical examination Neuro: alert, mood is normal."	F 329		

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F 329	Continued From page 48 -9/27/17 Sitting in wheelchair in common dining area. Multiple attempts to strike at provider during auscultation assessment. Vascular dementia with behavioral disturbance. Medication discontinued Risperidone 0.5 mg po q AM and 1 mg q HS. Medication new- Risperidone 1 mg BID for schizophrenia. Review of the Comprehensive Care Plan (CCP), dated 12/22/16 revealed the CCP does not document the use of Remeron, including changes in dosage and did not address the increased dosage of Risperidone. The CCP does not include nonpharmacological interventions to address possible episodes of increased agitation, depression or other behavioral concern. Review of Nursing Notes from 8/15/16 through 9/8/16 revealed the resident was eating 50% (percent) or less of meals and was frequently refusing to take medication. No episodes of agitation or other behavioral concerns were documented. Review of Nursing Notes from 9/9/16 through 9/29/16 revealed the resident was eating 50% or greater of meals. Nursing staff documented the resident was calm, compliant with care and medication administration. There was no documentation by nursing staff of episodes of agitation or adverse resident behaviors. Further review of Nursing Notes from 9/29/16 through 1/17/17 revealed on 9/30/16, during the 7:00 AM to 3:00 PM shift, the nurse documented that the resident was very lethargic. On 10/6/16 during the 7:00 AM to 3:00 PM shift, the nurse documented the resident refused to get out of	F 329		

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F 329	Continued From page 49 bed and was napping most of shift. On 10/23/16, no time listed, the nurse documented the resident was referred to therapy due to decrease ability to self-feed, questionable visual impairment, cognitive decline, need for increase direction. There was one episode of an adverse behavior documented by the nurse on 1/3/17 during the 3:00 PM to 11:00 PM shift, that the resident smeared feces on the wheelchair, table and floor. Review of Social Work (SW) Progress Notes from 6/13/16 through 1/20/17 revealed no evidence of adverse resident behaviors. Review of the Consultant Pharmacist Medication Regimen Review revealed on 9/17/16 the Pharmacist documented, "Resident is receiving Risperidone for paranoia. Dose was increased on 4/10/16. No recent notes listed in the Medical Record describing the effectiveness of the medication." The Physician's response, dated 9/22/16 was "will see." Request for 2016 BMARC (Behavior Modification Assessment Record Committee) Recommendation revealed the committee reviewed the resident on 9/9/16 and 11/15/16. Review of minutes of each BMARC meeting revealed the resident had a history of poor eating, loss of appetite and behaviors. The committee documented at each meeting that the resident was stable and recommendations were to continue on current medication. No additional recommendation was documented. During an interview on 1/19/17 at 11:47 AM, the Licensed Practical Nurse (LPN) #1 Unit Manager	F 329		

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(UM) stated that the facility does not have a behavioral tracking form and staff are to write a progress note for any resident behaviors. LPN #1 UM stated she could not remember discussing the resident in any recent BMARC meetings. LPN #1 UM stated that the Psychiatrist sees residents in the facility in the evening so she does not have an opportunity to discuss the changes made with the resident's medications.

Interview with the SW on 1/23/17 at 11:11 AM revealed that nursing is to notify the SW of any resident behaviors to trigger a possible psychiatric evaluation. The residents are reviewed in BMARC. The resident would be placed on 24-hour report and staff are to monitor and document on that resident. When presented with the above finding for Resident #13 including the lack of nonpharmacological intervention prior to the use of an antipsychotic medication and remaining on medication without evidence of behaviors, the SW agreed with the findings and stated "I see what you mean."

During an interview with the Director of Nursing (DON) on 1/23/17 on 11:37 AM, the DON stated that a resident with behaviors is place on the 24-hour report, nursing staff are to document in the Nurse's Notes and the resident would be discussed in morning report. When presented with the above finding for Resident #13 including the lack of nonpharmacological intervention prior to the use of an antipsychotic medication and remaining on medication without evidence of behaviors, the DON stated, "I understood the concern."

Review of a facility policy entitled Psychopharmacologic Medications- Definitions

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and Guidelines for Use, dated 7/9/07, revealed the following:
-Psychopharmacologic medications are ordered by the Physician only when one or more of the following conditions are present and so documented: Specific behaviors quantitatively (number of episodes) and objectively (i.e. biting, kicking, scratching) documented by the facility that cause the resident to:
1. Present a danger to themselves.
2. Present a danger to others (including staff).
3. Actually interfere with staff's ability to provide care.

-Psychopharmacologic should not be used when one or more of the following behaviors are the only indication for use: Anxiety, Insomnia, Poor self-care, Impaired Memory, Depression and Uncooperativeness.

2. Resident #85 was admitted to the facility on 12/17/15 with diagnoses which include Alzheimer's disease, uterine cancer, urine retention, psychotic disorder with delusions due to known psychological conditions, and unspecified dementia. Review of the MDS dated 12/3/16 revealed the resident is severely cognitively impaired.

Review of a Physician's Order signed 10/4/16 revealed the resident receives Lexapro (antidepressant) 10 mg for depression initiated 9/27/16 and Risperidone (antipsychotic) 0.5 mg initiated 9/29/16 for paranoid ideations.

Review of a Psychological Services; Diagnostic Interview dated 9/12/16 revealed the resident is significantly depressed and has symptoms of auditory and visual hallucinations and would

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benefit from a psychological consult.

Review of a Geriatric Consultation Service dated 9/29/16 revealed the reason for the consult was because the resident was having increased delusions and restlessness per the nurse the resident has severe dementia and roams a lot. She has had low grade depression since admission. Has weeping spells and is grouchy in the morning. Started on Lexapro yesterday (9/28/16) as family thinks she is depressed. The second page indicates the resident has no psychiatric history and documents she has a positive history of depression per the daughter. The Psychiatrist diagnosed resident with major depressive disorder (MDD) and dementia and recommended a trial of Risperidone 0.5mg for paranoid ideation.

Review of Nursing Notes dated 9/6/16 through 10/6/16 revealed no documentation regarding paranoid ideations or hallucinations.

Review of 24 hour reports dated 9/1/17 through 9/30/17 revealed no documentation regarding auditory or visual hallucinations.

Review of SW Notes for September 2016 through January 2017 lacked documentation of auditory or visual hallucinations.

Review of an MDS assessment dated 12/13/16 revealed the resident is able to express herself and can make needs known. She is an active participant in activities. Resident has a very bubble spirit and loves to joke around.

Review of BMARC Committee Recommendations dated 12/23/17 revealed the resident remains on

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10 mg Lexapro and 0.5 mg of Risperidone. She has history of sadness and lack of interest in doing things. She is stable on current meds.

Review of a Geriatric Psychiatry Follow-up note dated 1/2/17 revealed the resident did not have any paranoid ideation. Staff Nurse notes depression mostly in the morning. New order to increase Lexapro to 20 mg.

Resident observed on 1/13/17 at 9:15 AM wheeling herself around in wheelchair. The resident responded to a greeting of hello and smiled.

Interview on 1/20/17 at 12:49 PM, LPN #1 UM stated, "The Psychiatrist saw her and that's what he wrote. I haven't seen any paranoia or hallucinations. She is weepy at times and states she is looking for her mother at times but no major events."

Interview with the SW on 1/20/17 at 12:30 PM revealed she was unaware of any paranoid behavior to warrant the use of Risperidone. The Psychological Nurse Practitioner came in and stated she was depressed and ordered the consult with the Psychiatrist. Later on 1/20/17 at approximately 1:30 PM the SW produced a SW Progress Note dated 9/6/16 from her personal files regarding an alleged abuse investigation related to a bruise of unknown origin on the resident's arm which was later determined to be from a blood draw. When asked how she got the bruise, the resident replied, "she did not know, a lady did it." When asked what lady and what color was she, white or black, the resident replied, "over there by the wall, she is black." The SW pointed out that no one was there and there

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F 329	Continued From page 54 was no reply from the resident. Following the interview, a referral was made to a behavioral care consultant and the Psychiatrist. Review of Nursing Notes, SW Notes, and the Physician revealed no attempted nonpharmacological intervention or counseling prior to ordering antipsychotic medications to deal with one incident of a hallucination. Additionally, there was no CCP developed for the use of antipsychotic medication.	F 329		
F 362 SS=E	415.12(l)(1) 483.60(a)(3)(b) SUFFICIENT DIETARY SUPPORT PERSONNEL (a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during an Standard survey completed 1/24/17, the facility did not provide sufficient support personnel to prepare and serve the planned meal, with the appropriate food/ fluid on meal trays per resident's meal tickets. Specifically, the morning shift on 1/13/17 did not have sufficient staff to prepare and serve the scheduled breakfast meal resulting in a changed menu, missing food and fluid items on trays, and the use of paper plates, cups, and bowls and plastic ware.	F 362		

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The finding is:

1. Observation of the Breakfast Meal on the 2nd and 3rd Floors on 1/13/17 at 8:45 AM revealed residents were served on paper plates, beverages were in Styrofoam cups, dry cereal was in disposable plastic bowls and plastic ware was being used.

Review of the Week 2 menu revealed the planned breakfast meal was cold cereal, wheat toast and scrambled eggs.

Observation of the breakfast meal revealed the residents were served 1 boiled egg, 1 wheat toast and cold cereal.

Observation of resident's meal tickets revealed multiple items missing on the resident's meal trays. Resident A, B, C, D, and E should have received 2 ounces (oz.) of scrambled egg according to their meal ticket and they received only 1 oz. of a boiled egg. Resident C should have received a 6 oz. mighty shake which was not on the meal tray. Resident #D had no cereal, canned fruit, or coffee. Resident #E lacked cereal and coffee.

During an interview on 1/20/17 at 8:50 AM, the Dietary Director stated the menu was changed on 1/13/17 at breakfast because the Dietary Department was short staffed.

In a later interview on 1/23 at 3:10 PM, the Dietary Director revealed normal staffing would include one cook, three dietary aides, and a Supervisor in the morning. There were two call-ins that morning so we only had two dietary

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F 362	Continued From page 56 aides and we had no Supervisor. We just hired a dietary Supervisor that started on 1/16/17. 415.14(b)	F 362		
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during an Standard survey completed 1/24/17, the facility did not ensure the resident was provided assistive devices for eating as planned. One (Resident #50) of one resident observed for assistive devices for eating was not provided a scoop dish (assistive device that assists individuals with limited flexibility, neurological disorders eat more independently) as planned. The finsing is: 1. Resident #50 was admitted 8/26/14 with diagnoses which include hemiplegia, hemiparesis following a cerebral infarct. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/18/16 revealed she is severely cognitively impaired, understands and is understood. Review of the Closet Care Plan (guide used by	F 369		

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F 369	Continued From page 57 staff to provide care) dated 1/19/17 revealed the resident is independent with eating after set up; and should have assistive devices for eating which included a scoop dish. Observation of the lunch meal was conducted on 1/13/16 from 1:01 PM through 1:45 PM. The resident was having difficulty reaching food and keeping food on her fork. She was provided a spoon and was still struggling to keep food on the utensil and get it to her mouth. The resident did not have a scoop dish. Observations of lunch meal on 1/16/17 at 12:40 PM and breakfast on 1/18/17 at approximately 8:30 AM revealed a lack of a scoop dish for the resident. Review of the resident's meal ticket revealed the resident should have a scoop dish. During an interview on 1/19/17 at 1:55 PM, the Dietary Director stated they did not have any scoop dishes to give residents. During an interview 1/19/16 at 2:00 PM, the Director of Therapy on stated if the kitchen doesn't have any scoop dishes, they should let us know, so we can order more.	F 369		
F 371 SS=E	415.12(a)(2) 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 371		

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F 371	Continued From page 58 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review during the Standard survey completed on 1/24/17, the facility did not store, prepare, distribute, and serve food under sanitary conditions. Issues included: flies in the kitchen; pots, pans, and pan lids that were ready to use were stacked together and stored wet and with a greasy white and brown colored substances, and various utensils were stored soiled; the floor of the walk-in freezer was greasy and soiled with food, food debris, and various colored substances; the floor of the walk-in cooler was covered with rust, and none of the kitchen sinks were equipped with an indirect drain. This affected one (Main Kitchen) of one Main Kitchen. In addition, one (Second Floor Kitchen/ Nourishment Room) of two Kitchen/ Nourishment rooms had issues that included: unlabeled and undated food and drink items stored in a	F 371		

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refrigerator and a freezer; the freezer and refrigerator were soiled with food splatter; a soiled counter top and shelving and the freezer that did not have a thermometer.

The findings are:

1. Observation on the First Floor in the Main Kitchen on 1/13/17 at approximately 8:35 AM revealed two small flies were observed flying around the coffee station and two small flies were observed flying around the range top .

Observation on the First Floor in the Main Kitchen on 1/13/17 from approximately 1:35 PM through 2:03 PM revealed flies were observed in the follwoing areas:

- eight small flies were observed flying around the bread racks
located in the dietary office
- two small flies were observed flying around the range top
- two small flies were observed flying around the juice machine
- two small flies were observed flying around in the Diet
Technician's office
- two small flies were observed flying around the three bay sinks,
- three small flies were observed flying around in the dry goods storage room and
- six small flies were observed flying around in the dishwashing room

Review of Proof of Service Summary reports dated from 3/21/16 through 12/19/16 from an outside contractor that provided pest control services for the facility revealed the only report

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that documented any fly issues in the building was on 6/20/16 and dealt with the First Floor main kitchen.

Review of the Proof of Service Summary report dated 6/20/16 on 1/19/17 revealed the following: "Standing water and food debris building up under the dishwashing areas along the base of the walls. This is creating a breeding site for small flies. We recommend purchasing a fly light trap for the kitchen to help capture and reduce fly activity. Fruit flies, 11 to 25 under dishwashing area. Foamed all floor drains as well as under food prep and dishwashing areas."

Interview with the Environmental Services Director on 1/20/17 at approximately 10:06 AM revealed she was not aware of any current issues with flies in the building.

2. a). Observation on the Second Floor in the Kitchen / Nourishment room on 1/13/17 at approximately 8:45 AM revealed the following in the refrigerator:

- A paper plate that was covered in tin foil contained a burrito that was unlabeled and undated.
- An egg salad sandwich was unlabeled and undated.
- A plastic bag containing food that was unlabeled and undated.
- The refrigerators's shelves were dirty.

b). Observation on the Second Floor in the Kitchen/ Nourishment Room on 1/13/17 at approximately 8:45 AM revealed the following in the freezer:

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F 371	Continued From page 61 - A plastic bag containing food that was unlabeled and undated. - The freezer's shelves were dirty with food splatter. - Frozen water and colored drinks were unlabeled and undated. - The freezer did not contain a thermometer and there were no logs for the checking of the freezer's temperature located on the exterior of the freezer or within the room. - The counter the micro wave was located on and the shelves underneath it needed to be cleaned. 3. Observation on the First Floor in the Main Kitchen on 1/13/17 at approximately 1:35 PM revealed the following: - Eight pan lids were covered with a greasy white colored substance and were greasy to the touch. The lids were stored in a large pan on the clean pot and pan rack. The interior of one pot on the rack was covered with a greasy white colored substance and was greasy to the touch. - Six pans stacked together on the clean pot and pan rack were wet and water was dripping from them; when they were pulled apart. Six pans were soiled with a greasy white substance and were greasy to the touch. The interior of one of the pans was soiled with a quarter inch thick layer of a slimy brown substance that ranged from one quarter of an inch to one half inch in width and had the consistency of pudding. - Two serving spoons stored in a drawer were soiled with brown and green colored substances and a third spoon was covered with a white greasy substance.	F 371		

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F 371	Continued From page 62 - The interior of the blender had an approximate one half inch of residual (standing) water in it and the interior of the blender was greasy to the touch. Interview with the Dietary Director at the time of the observation revealed the pots, pans, pan lids, stored on the clean pot and pan rack and the utensils stored in the drawer were ready for use and the blender was also ready for use. - An approximate three inch long by three inch wide area of the shelf below the coffee station was covered with an approximate one half inch thick layer of a granular white substance. - The floor of the walk-in freezer was soiled with peas, carrots, french-fries, and tan and brown colored food debris and crumbs. - The entire floor of the walk-in cooler was covered with at least a one quarter inch thick layer of rust. 4. Observation on 1/18/17 at approximately 8:07 AM revealed the kitchen did not a have a sink that was equipped with an indirect drain. Interview with the Dietary Director at the time of the observation revealed one of the three bay sinks would be sanitized and then the lettuce and tomatoes that were used to make salads would be washed in the sink that had been sanitized. 415.14(h) New York State Sanitary Code Subpart 14-1 14-1.43(e) 14-1.44 14-1.110(b)	F 371		

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F 371	Continued From page 63 14-1.110(d) 14-1.110(e) 14-1.116 14-1.140(a) 14-1.141 14-1.160 14-1.170	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be	F 431		

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F 431	Continued From page 64 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during the Standard survey completed on 1/24/16, the facility did not ensure that drugs and biologicals used in the facility are stored in accordance with currently accepted professional principles. One (Unit 2) of two medication rooms was left unlocked and unattended by nursing and a cabinet of stock drugs in that room was unlocked. Medications were stored in the nourishment refrigerator on one (Unit 3) of two units and expired influenza vaccine was observed in one of two medication rooms. The findings are:	F 431		

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F 431	Continued From page 65 1. Observation of the Unit 3 Medication Refrigerator on 1/23/17 at approximately 9:00 AM revealed five open vials of Influenza Vaccine with a manufacturer's expiration date of 5/2016. Interview with the Registered Nurse (RN) Assistant Director of Nursing (ADON) on 1/23/17 at 9:14 AM revealed current stock of Influenza Vaccine is kept in the Supervisor's refrigerator. There is also vaccine on each unit in case a resident is admitted and wants the vaccination. During an interview on 1/23/17 at 10:11 AM, the Director of Nursing (DON) stated that Influenza Vaccine should not be stored in the refrigerators on the units. Review of the facility policy entitled Medication, Storage of Drugs and Biologicals dated 5/5/16 revealed "When medication shelf life is expired and/ or when medications are no longer in use, such medications are disposed of or destroyed in accordance with State and Federal Regulations." 2. During the initial tour of the facility on 1/13/17 at 8:30 AM the door to the medication room on the Unit 2 was found unlocked as was a cupboard containing multiple stock medications. The cupboard contained the following: Geri-jot - 2 bottles Thera tabs multivitamin Aspirin - 2 bottles Zinc sulfate 220 milligrams (mg) -100 tabs - 4 bottles Vitamin D 100 tabs 400 units - 23 bottles b1-50 mg 100 tabs Once daily multivitamin 100 tabs	F 431		

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F 431	Continued From page 66 Vitamin D3-5000 units-100 caps Acid reducer 75 mg - 30 tabs Folic acid 1 mg 100 tabs - 2 bottles Aspirin 325 mg - 2 bottles 100 tabs each Docusate stool softener 100 soft gel 100 mg each Acetaminophen (Tylenol) suppository 650 mg Liquid pain relief bottle 16 fluid ounce (oz.) Vi-daily liquid 16 oz. 17 Vials Heparin 1 milliliters (ml) each Interview with the Licensed Practical Nurse (LPN) #3 Unit Manager (UM) on 1/20/17 at 11:50 AM revealed the medication room door should always be locked, "We generally do not lock the stock medication cupboard." 3. Observation on 1/13/17 at approximately 8:40 AM revealed the Third Floor nourishment room (containing a refrigerator, microwave oven, and sink) door was open and accessible to staff, residents, and visitors. In addition, observation further revealed the nourishment room refrigerator contained one Tylenol (medication used to treat pain and fever) 650 mg suppository, 16 Bisacodyl (laxative used to treat constipation) 10 mg suppositories, and a one ml glass vial, approximately half full, of Tuberculin, Purified Protein Derivative (PPD-a biological solution administered to test for tuberculosis). Interview with the LPN #1 UM on 1/13/17 at approximately 8:51 AM revealed, "Medications should not be stored in the nourishment room refrigerator, residents are free to go in there (nourishment room and refrigerator) and should not have access to medications." Review of an undated facility policy entitled, Medication Use Medication Storage, included the	F 431		

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F 431	Continued From page 67 following: -All medications will be stored in a locked cabinet, cart or medication room and maintains the safety of the residents and is accordance with the Department of Health Guidelines. -All medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel. 415.18(e)(1)	F 431		
F 469 SS=E	483.90(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (h)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review conducted during the Standard survey completed on 1/24/17, the facility did not maintain an effective pest control program so that the facility/ resident environment was free of pests. Issues included small flies flying around in the facility. This affected Three (First, Second, and Third Floors) of three resident use floors and one basement. The findings are: 1. Observation on the First Floor in the Main Kitchen on 1/13/17 at approximately 8:35 AM revealed two small flies were observed flying around the coffee station and two small flies were observed flying around the range top. Observation on the First Floor in the Main Kitchen on 1/13/17 from approximately 1:35 PM through 2:03 PM revealed flies were observed in the	F 469		

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F 469	Continued From page 68 follwoing areas: - eight small flies were observed flying around the bread racks located in the dietary office - two small flies were observed flying around the range top - two small flies were observed flying around the juice machine - two small flies were observed flying around in the Diet Technician's office - two small flies were observed flying around the three bay sinks, - three small flies were observed flying around in the dry goods storage room and - six small flies were observed flying around in the dishwashing room 2. Observation on the Third Floor on 1/17/17 between 8:57 AM and 9:06 AM revealed small flies were flying around the resident and the resident's breakfast tray in Resident Room #310. 3. Observation on the Second Floor on 1/13/17 at approximately 9:05 AM revealed two small flies were flying around the sink in the Clean Utility Room located near Resident Room #212. 4. Observation on the Second Floor on 1/13/17 at approximately 9:27 AM revealed two small flies were flying around the sink in the Janitor's Closet located next to the Nurse's Station. 5. Observation in the basement on 1/17/17 at approximately 8:42 AM revealed one small flies was flying around in the corridor outside of the Clean Laundry/ Folding Room.	F 469		

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6. Observation on the Third Floor on 1/17/17 at approximately 9:34 AM revealed two small flies were flying around in the bathroom of Resident Room #324.

7. Observation on the Third Floor on 1/17/17 at approximately 9:48 AM revealed one small fly was flying around in the corridor outside the dining room.

8. Resident #40 has diagnoses which include depression and a right knee injury. Review of the Minimum Data Set (MDS - a resident assessment tool) dated 10/30/16 revealed the resident is cognitively intact.

Interview with the resident on 1/17/17 at 10:15 AM revealed the facility has a problem with fruit flies and flies. In a later interview on 1/20/17 at 1:40 PM the resident stated the flies were in the main dining room and the lounge on the First Floor.

9. Intermittent observations on the Third Floor on 1/19/17 from 6:30 AM through 2:00 PM revealed a small fly was flying around in the corridor near the Nurse's Station.

Review of Proof of Service Summary reports dated from 3/21/16 through 12/19/16 from an outside contractor that provided pest control services for the facility revealed the only report that documented any fly issues in the building was on 6/20/16 and dealt with the First Floor Main Kitchen.

Review of the Proof of Service Summary report dated 6/20/16 revealed the following: "Standing water and food debris building up under the

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F 469	Continued From page 70 dishwashing areas along the base of the walls. This is creating a breeding site for small flies. We recommend purchasing a fly light trap for the kitchen to help capture and reduce fly activity. Fruit flies, 11 to 25 under dishwashing area. Foamed all floor drains as well as under food prep and dishwashing areas." Interview with the Environmental Services Director on 1/20/17 at approximately 10:06 AM revealed she was not aware of any current issues with flies in the building. 415.29(j)(5) New York State Sanitary Code Subpart 14-1 14-1.160	F 469		
F 490 SS=K	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during the Standard Survey completed on 1/24/17, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain, or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility administration failed to ensure that the facility had an effective system in place to identify residents' wishes regarding Advanced Directives. The Administrator did not	F 490		

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follow up with the Social Worker once problems were identified with system failures to establish mechanisms for accurately documenting and communicating each resident's advance directive choices to the interdisciplinary team.

The lack of properly documented Advance Directive status resulted in a pattern of IMMEDIATE JEOPARDY WITH ACTUAL HARM TO RESIDENT HEALTH AND SAFETY.

The IMMEDIATE JEOPARDY was removed on 1/22/16, prior to the completion of the survey.

In addition, the Plan of Correction (POC) for the Life Safety Code (LSC) survey completed on 3/8/16 identified the Administrator as the individual responsible for the correction of two repeat Life Safety Code deficiencies cited during the LSC survey completed 3/8/16. The Administrator did not ensure corrective actions identified in the POC were completed as evidenced by two (K161 and K918) deficiencies identified during the LSC survey completed 1/24/17.

The findings are:

REFER TO:

F 155 - Right to Refuse: Formulate Advance Directive -scope/severity = K

F 250 - Provision of Medically Related Social Service- scope/severity = E

K 161 - LSC- Building Construction - (formerly K12) - scope/severity = E

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F 490	Continued From page 72 K 918 - LSC- Electrical Systems Maintenance and Testing- (formerly K 144)- scope/severity = E 1. Specifically, eight (Residents #30, 63, 64, 73, 80, 83, 99, 102) of 29 residents were identified as having their Advanced Directives improperly documented in the CNA (Certified Nurse Aide) Closet Care Plan; color coded stickers in resident charts; code status list kept in the Medication Administration Record (MAR) book, at the facility front desk, and in Therapy Department; Physician's Orders; and Advance Directives/ MOLST (Medical Orders for Life Sustaining Treatment) form. During an interview with the Administrator and Social Worker (SW) on 1/18/17 at 3:00 PM, the Administrator stated that residents' Advance Directive status was recently discussed at the facility's Quality Assurance (QA) meeting. The Administrator stated that the Social Worker completed an audit after finding some errors at the end of December 2016. The Administrator stated that the Social Worker was correcting the residents' Advance Directive status and had a few more to correct. The Social Worker then stated that all audits of residents' Advance Directive status had not been completed and corrections to the resident's Advance Directive status had not been completed. During further interview with the Administrator on 1/24/17 at 8:25 AM, the Administrator stated that the Social Worker had made her aware of problems with residents' DNR status on 12/20/16 at the facility QA meeting. The Administrator stated that she did not have follow up meetings with the Social Worker to determine if the Social Worker had corrected problems identified with	F 490		

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residents' Advance Directives. The Administrator stated "I thought she had taken care of it."

2. Review of the approved POC, submitted by the facility following the LSC Survey completed on 3/8/16, revealed the facility identified a correction date of 5/16/16 for LSC deficiency K 12 (now K 161) and a correction date of 4/20/16 for LSC deficiency K 144 (now K 918). Based on observations, interviews and record reviews conducted from 1/13/17 through 1/20/17, the deficiencies cited under K 12 (now K161) and K 144 (now K 918) were not corrected. Furthermore, the Administrator was identified as the person responsible for the correction of these deficiencies. Additional review of the approved POC revealed the following:

a). K 12 (now K 161) - The Outside Contractor administering the Fire Safety Evaluation System (FSES) was to be contacted to complete the inspection and pass the certification once the sprinkler system fire pump was hooked up to the new emergency generator. Once the Outside Contractor approved and certified the FSES, a copy of the document was to be sent to the Department of Health (DOH). A weekly maintenance audit was to be added and conducted by the Environmental Services Director to ensure that maintenance issues were corrected in a timely manner. Results of audits were to be reported to the administrator. The Administrator was to in-service maintenance and management staff about the FSES and how it ensures Fire Safety for the building and residents.

Interview with the Administrator on 1/18/17 at approximately 1:31 PM revealed that no changes were made to the unprotected steel web trusses,

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unprotected steel beams, and non-fire rated lay-in style ceiling assemblies located on the First, Second, and Third floors pertaining to K 12 (now K 161). Further interview with the Administrator at this time revealed a Fire Safety Evaluation System (FSES) was not completed for the building.

Continued interview with the Administrator on 1/18/17 at approximately 1:31 PM revealed that she had left a message for the Outside Contractor approximately two weeks ago, in an attempt to schedule an appointment to have an FSES conducted on the building and the Outside Contractor had not called her back.

Additional review of the POC revealed the facility previously requested a Time Limited Waiver with a completion date of 12/1/14 for the purpose of conducting, completing, and passing an FSES for this deficiency. As of 1/24/17, a passing FSES for the building was not completed or submitted to the survey team or the New York State (NYS) DOH.

b). K 144 (now K 918) - The POC documented that the required emergency testing of the generator was to resume. The weekly generator inspection/exercise was to be completed and documented by the Environmental Services Director or designee and the monthly full load test was to be conducted and documented by Environmental Services Director or designee. A new generator log was to be established for proper documentation and this log was to be audited by the Administrator monthly.

Review of generator logs revealed the facility did not have documentation for weekly inspections of

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F 490	Continued From page 75 the emergency generator from 5/22/16 through 7/31/16 and from 12/4/16 and 12/31/16. Further review of the logs revealed the facility did not have documentation for monthly load tests for the emergency generator for March, April, May, June, July August, September, and November of 2016. Interview with the Environmental Services Director on 1/18/17 at approximately 9:10 AM revealed she has worked at the facility since March of 2016 and that the facility's previous Maintenance Supervisor was in charge of the emergency generator.	F 490		
F 514 SS=D	415.26 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		

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F 514	Continued From page 76 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review conducted during a Complaint Investigation (Complaint #NY00179827) during an Standard survey completed on 1/24/17, it was determined the facility did not maintain clinical records for each resident in accordance with accepted professional standards and practices that are complete, accurate and readily accessible and systematically organized. Two (Resident #23, 96) of 44 medical records reviewed had an issue involving the lack of documentation of resident intake of supplements during meals (Resident #23). In addition, Resident #96's medical record was not complete or readily accessible. The findings are: 1. Resident #96 was admitted to the facility on the following dates 2/3/12, 2/22/12 and 3/19/12. The resident had diagnoses that included diabetes mellitus, right above the knee amputation, and peripheral vascular disease.	F 514		

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On 1/13/17 at approximately 9:35 AM, the surveyor requested from the Assistant Director of Nursing (ADON) Resident #96's entire medical record.

On 1/13/17 at approximately 11:30 AM a medical record for Resident #96 was provided. Review of the medical record revealed the medical record was from a sister facility. The resident was admitted to the sister facility on 1/25/12 and was transferred to a local hospital on 1/27/12. Additional review of the medical record revealed an attached death certificate dated 4/9/12. The death certificate documented that the resident expired at this facility (not the sister facility).

During an interview on 1/13/17 at approximately 12:02 PM, the MDS (Minimum Data Set) Nurse stated he was unable to tell surveyor when Resident #96 was admitted and discharged from the facility.

During an interview on 1/13/17 at approximately 12:07 PM, the Administrator stated that someone in the past had requested Resident #96's medical record but "it was before my time." "I came back to the facility in November of 2015, and no one has contacted me or requested the medical record."

During further interview on 1/13/17 at 2:22 PM, the MDS Nurse stated he was still trying to figure out the dates of admission for Resident #96.

During a telephone interview on 1/13/17 at approximately 2:24 PM, the complainant stated that she requested the medical record in January of 2015, that is when the initial contact was made. Several letters have been sent requesting the

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medical record but we keep getting bounced around. The complaint stated the medical records that they have requested are for the following stays at the facility: 2/3/12 through 2/14/12, 2/22/12 through 3/15/12 and from 3/19/12 through 4/9/12. The complaint also stated they have received the medical records from the sister facility.

During an interview on 1/13/17 at approximately 2:48 PM, the Medical Records Clerk stated that she is responsible for medical record keeping. We keep medical records for seven years then the records can be destroyed. Residents' medical records are stored in this facility and over in our sister facility. We have searched in both storage areas, and we cannot locate the medical record. "It must have been misplaced." The Clerk further stated, she believes about a year ago someone else requested the medical record and we could not locate it then either.

During further interview on 1/13/17 at approximately 3:15 PM, the Administrator provided the surveyor with the dates of admission for the resident which co-inside with the dates provided by the complainant. When asked do you have any additional records for these dates other than what was already provided. The Administrator stated she would have someone look in the other building.

During an interview on 1/23/17 at approximately 3:15 PM the Administrator stated that Resident #96's medical record could not be located.

Review of the facility policy and procedure entitled "Documentation: Closing of medical records" dated 1/2009 revealed the purpose of the policy is

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that all closed or discharged resident's medical records are closed and properly organized for future retrieval if necessary.

2. Resident #23 was re-admitted to the facility on 9/15/16 with diagnoses that include cerebral infarction (type of stroke), benign prostatic hyperplasia (enlarged prostate) and dementia. Review of the MDS dated 11/23/16 revealed the resident has severe cognitive impairment and eats with supervision for set up help only. Further review of the MDS revealed the resident does not have any swallowing disorder, has experienced a weight loss of 5 percent (percent) or more in the last month or 10% or more in the last 6 months. Nutritional approaches listed in the MDS were a mechanically altered, therapeutic diet.

Observation of Resident #23 on 1/18/17 at 8:36 AM revealed the resident was eating breakfast in bed. The resident had a puree diet and had a nectar thick juice in cup.

Review of Physician Orders signed 1/6/16 revealed orders for a puree consistency, thick liquids diet.

Review of the Nutrition Progress Notes revealed the following:
- 12/29/16 at 2:30 PM, the diet technician (DT) documented, "diet remain supplemented 8 oz. (ounces) nectar high protein juice QD (every day), magic cup (a nutritionally enriched dessert) QD, 6 oz. of Mighty Shake (fortified shake) Bid (twice daily).
- 1/3/17 no time listed, the Registered Dietician documented, "Current documented intakes = 35% solid. Meal document sheet were blank as far as supplements. However, staff indicates he

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F 514	Continued From page 80 drinks well." Review of the CNA (Certified Nurse Aide) Closet Care Plan (guide used by staff to provide care) dated 1/19/17 revealed the diet listed was LCS (low concentrated sugar) NAS (no added salt), puree consistency and nectar thick liquids. Review of the Intake Flow Sheets from 12/5/16 through 1/8/17 revealed that 4 oz. Magic Cup at lunch and 8 oz. High Pro Juice at breakfast were pre-printed on the Intake Flow Sheets. There is no documentation of the amount of intake of either supplement on any of the Intake Flow Sheets. Interview with the DT on 1/17/16 at approximately 9:00 AM revealed that nursing staff were not consistency documenting the meal supplements on the Intake Flow Sheet. The DT stated that nursing staff were including the volume of liquid supplements in the fluid documentation on the flow sheet and were not documenting the intake of supplements separately. Review of facility policy and procedure entitled "Meal Consumption", dated 2/10 revealed that if a resident is on a nutritional supplement it will be recorded separately on the Meal/ Intake Record by the nursing staff. Any additional fluids consumed may be recorded in "Other fluid" column on the Meal/ Intake Record by nursing staff.	F 514		
F 515 SS=B	415.22 (a)(1-3)(b)(c) 483.70(i)(4)(i)-(iii) RETENTION OF RESIDENT CLINICAL RECORDS	F 515		

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F 515	Continued From page 81 (i) Medical records. (4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review conducted during a Complaint investigation (Complaint #NY00179827) during an Standard survey completed on 1/24/17, the facility did not ensure that medical records were retained for the period of time required by state law; the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that are readily accessible. Specifically, one (Resident #96) of 44 medical records reviewed had an issue that the complete medical record was not retained. The finding is: 1. Resident #96 was admitted to the facility on the following dates 2/3/12, 2/22/12 and 3/19/12. The resident had diagnoses that included diabetes mellitus, right above the knee amputation, and peripheral vascular disease. On 1/13/17 at approximately 9:35 AM, the surveyor requested from the Assistant Director of Nursing (ADON) Resident #96's entire medical record.	F 515		

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On 1/13/17 at approximately 11:30 AM a medical record for Resident #96 was provided. Review of the medical record revealed the medical record was from a sister facility. The resident was admitted to the sister facility on 1/25/12 and was transferred to a local hospital on 1/27/12. Additional review of the medical record revealed an attached death certificate dated 4/9/12. The death certificate documented that the resident expired at this facility (not the sister facility).

During an interview on 1/13/17 at approximately 12:02 PM, the MDS (Minimum Data Set) Nurse stated he was unable to tell surveyor when Resident #96 was admitted and discharged from the facility.

During an interview on 1/13/17 at approximately 12:07 PM, the Administrator stated that someone in the past had requested Resident #96's medical record but "it was before my time." "I came back to the facility in November of 2015, and no one has contacted me or requested the medical record."

During further interview on 1/13/17 at 2:22 PM, the MDS Nurse stated he was still trying to figure out the dates of admission for Resident #96.

During a telephone interview on 1/13/17 at approximately 2:24 PM, the complainant stated that she requested the medical record in January of 2015, that is when the initial contact was made. Several letters have been sent requesting the medical record but we keep getting bounced around. The complaint stated the medical records that they have requested are for the following stays at the facility: 2/3/12 through 2/14/12, 2/22/12 through 3/15/12 and from

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3/19/12 through 4/9/12. The complaint also stated they have received the medical records from the sister facility.

During an interview on 1/13/17 at approximately 2:48 PM, the Medical Records Clerk stated that she is responsible for medical record keeping. We keep medical records for seven years then the records can be destroyed. Residents' medical records are stored in this facility and over in our sister facility. We have searched in both storage areas, and we cannot locate the medical record. "It must have been misplaced." The Clerk further stated, she believes about a year ago someone else requested the medical record and we could not locate it then either.

During further interview on 1/13/17 at approximately 3:15 PM, the Administrator provided the surveyor with the dates of admission for the resident which co-inside with the dates provided by the complainant. When asked do you have any additional records for these dates other than what was already provided. The Administrator stated she would have someone look in the other building.

During an interview on 1/23/17 at approximately 3:15 PM, the Administrator stated that Resident #96's medical record could not be located.

Review of the facility policy and procedure entitled "Documentation: Closing of Medical Records" dated 1/2009 revealed the purpose of the policy is that all closed or discharged resident's medical records are closed and properly organized for future retrieval if necessary.

Review of an additional facility policy and

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F 515	Continued From page 84 procedure entitled "Retention of Medical Records" dated 9/18/06 revealed Medical Records of discharged resident will be retained for a period of seven years.	F 515		
F 520 SS=K	415.22(b) 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the	F 520		

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Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review conducted during the Standard survey completed on 1/24/17, the facility failed to ensure that the Quality Assessment and Assurance (QAA) committee effectively identified and corrected quality deficiencies with the potential to cause serious harm to residents and did not develop and implement appropriate plans of action. Specifically, the facility QAA failed to ensure complete and accurate documentation of the residents' Advance Directive status was communicated to the interdisciplinary team.

The lack of properly documented Advance Directive status resulted in a pattern of IMMEDIATE JEOPARDY WITH ACTUAL HARM TO RESIDENT HEALTH AND SAFETY.

The IMMEDIATE JEOPARDY was removed on 1/22/16, prior to the survey exit.

In addition, the facility did not ensure that the QAA committee effectively identify and correct Life Safety Code (LSC) deficiencies and did not implement the Plan of Correction; to ensure monitoring was conducted, to prevent the continuation of five Life Safety Code deficiencies

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that were identified during the Life Safety Code surveys completed on 3/8/16 and 4/25/15.

The findings are:

REFER TO:

F 155 - Right to Refuse: Formulate Advance Directive -scope/severity = K

F 250 - Provision of Medically Related Social Service- scope/severity = E

K 161- LSC- Building Construction (formerly K 12) - scope/severity = E

K 351 - LSC- Sprinkler System Installation (formerly K 62) -scope/severity = D

K 353 - LSC- Sprinkler System- Maintenance and Testing (formerly K 62) - scope/severity = E

K 363 - LSC- Corridor Doors (formerly K 18) - scope/severity = E

K 918 - LSC- Electrical Systems Maintenance and Testing (formerly K 144) - scope/severity = E

1. Eight (Residents #30, 63, 64, 73, 80, 83, 99, 102) of 29 residents reviewed for Advance Directives were identified as having their Advance Directives improperly documented in the CNA (Certified Nurse Aide) Closet Care Plan; color coded sticker in resident chart; Code Status list kept in the Medication Administration Record (MAR) book, at the facility front desk, and in Therapy Department; Physician's Orders; and Advance Directives/ MOLST (Medical Orders for Life Sustaining Treatment) form. Subsequently,

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the facility failed to provide a consistent process to identify residents' wishes regarding Advance Directives.

During an interview with the Administrator and the Social Worker (SW) on 1/18/17 at approximately 3:00 PM the Administrator stated that residents' Advance Directive status was recently discussed at the facility's December 2016 Quality Assurance (QA) meeting. The Administrator stated that the Social Worker completed an audit after finding some errors at the end of December 2016. The Administrator stated that the SW was correcting the residents' Advance Directive status and had a few more to correct. The SW then stated that all audits of residents' Advance Directive status had not been completed and corrections to the resident's Advance Directive status had not been completed.

Review of the SW Advance Directive audits revealed the audits were dated 12/29/16.

Review of the Facility Survey Report (FSR), signed by the Administrator on 1/18/17, revealed that the facility's QAA committee meets monthly and the most recent meeting was held on 12/20/16. The FSR documented that the Administrator, Director of Nursing (DON) and Social Worker are members of the QAA committee.

During the QAA review meeting with the Administrator and the DON on 1/24/17 at 8:25 AM, the Administrator stated that after the Social Worker identified the inconsistency in Advance Directive information in resident medical records, the Social Worker began to complete audits of all current resident's Medical Records. The

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Administrator stated that the QAA did not meet again to follow up on the inconsistencies in Advance Directives. The DON stated that the SW did not realize the urgency in correcting the inconsistencies of the residents' Advance Directive information. When asked what QA audits of resident medical records had been completed prior to SW identifying the concern with Advance Directives, the DON stated, "We haven't done any recently. We have gotten off track, but we need to start doing audits again."

2. Repeat Life Safety Code deficiencies were identified during Life Safety Code surveys completed on 1/24/17 and 3/28/16, that were initially identified during the 4/25/15 Life Safety Code survey. The four repeat deficiencies were cited in the following areas:

- K 161 (formerly K 12): Structural steel beams and structural steel web trusses, located above the non-fire rated lay-in style ceiling assembly of resident use floors were not protected to meet the minimum fire rating of building construction type II (111) or type II (222).

- K 363 (formerly K 18): Corridor doors were not designed to resist the passage of smoke and/ or were obstructed from closing.

- K 351 and K 353 (formerly K 62): Sprinkler piping was hung from an electrical conduit instead of from the building's structure, various items were stored less than 18" (inches) from sprinkler heads, sprinkler heads were obstructed, and the fire pump was not tested under emergency power.

- K 918 (formerly K 144) : The facility did not have

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documentation that the emergency generator was continuously tested under load for at least 30 minutes per month. In addition, the facility did not have documentation that the emergency generator was continuously inspected on a weekly basis.

Review of the accepted Plan of Correction (POC) for the 3/8/16 Life Safety Code survey revealed the alleged compliance date for the 3/18/16 Life Safety Code survey was 5/16/16. Review of the Plan of Correction (POC) for the 3/8/16 Life Safety Code survey revealed that "Results will be reported to the Quality Assurance(QA) Committee. The FSES (Fire Safety Evaluation System) and any recommendations of the FSES will be reviewed at QA. The QA Committee may modify reporting requirements depending on the success and consistency of these measures." Audits identified in the POC are as follows:

a) K 12 (now K 161) LSC: Weekly maintenance audits, to be conducted by the Environmental Service Manager (ESM) to ensure that maintenance issues are corrected in a timely manner. Results of audits will be reported to the administrator.

b) K 18 (now K 363) LSC: Weekly maintenance audits, to be conducted by Environmental Service Manager (ESM) or designee will include checking for door obstructions, door latching and penetrations in doors.

c) K 62 (now K 351) LSC and K 353 LSC: Environmental Service Manager's 100 % (percent) audit of the building for 18" clearance form sprinkler heads and exit signs, sprinkler pipes to ensure they are hung properly, and that

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all inspections are completed. The fire pump inspection/testing and will be added to the sprinkler inspection sheet. The fire pump churn test will be added to the generator inspection/test sheet. ESM or designee will in-service all staff on the 18" clearance requirement. ESM will in-service maintenance staff on proper inspection reporting. ESM will audit paperwork for compliance and report to the QA committee.

d) K 144 (now K 918) LSC: Weekly generator inspection/exercised. Monthly full load test documentation. New generator log to be audited by the administrator monthly. The ESM in-serviced all maintenance staff on how to properly run the generator load test and how to properly read the generator gauges and document.

Effective 11/1/16, The Centers for Medicare & Medicaid Services adopted both the 2012 Edition of NFPA (National Fire Protection Association) 101 Life Safety Code and the 2012 Edition of NFPA 99 Health Care Facilities. Due to the adoption of these codes, the "K" tag identifying numbers of the Life Safety Code deficiencies were changed.

Review of the Facility Survey Report (FSR) signed by the Administrator on 1/18/17 documents that the facility has monthly QA meetings and the last meeting held was 12/20/16. Further review revealed that the Administrator and the Director of Environmental Services Department are members of the Quality Assessment and Assurance Committee.

An interview with the Administrator on 1/18/17 at approximately 1:31 PM revealed a Fire Safety

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F 520	Continued From page 91 Evaluation System (FSES) had not been conducted on the building. The FSES is a grading system, designed to demonstrate an atlernative method of compliance of LSC regulations, that a facility may use in lieu of making a physical correction. The FSES was initiated by the facility as a result of findings from the LSC survey completed on 4/25/15, and has yet to be completed. 415.27(a-c)	F 520		