Bay Park Center for Nursing and Rehabilitation, LLC

Deficiency Details, Certification Survey, February 16, 2011

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PFI: 1260
Regional Office: MARO--New York City Area

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F323 483.25(h): FACILITY IS FREE OF ACCIDENT HAZARDS

Scope: Isolated
Severity: Actual Harm
Corrected Date: April 15, 2011

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Citation date: February 16, 2011

Based on observations, record review and staff interviews, the facility did not ensure that (1) each resident received adequate supervision and assistance devices to prevent accidents and (2) the resident environment remained free from accident hazards. Specifically, (1) a resident was not provided with adequate supervision and wheelchair leg rests which resulted in the resident sustaining a subdural hematoma; (2) protruding metal screws were observed in handrails provided in resident unit corridors; and (3) sharp edges were observed in radiators lacking proper covers. This was evident for 1 of 30 sampled residents (Resident #6) and 2 of 12 resident units (units 6 and 7).
This resulted in actual harm for resident #6 that is not immediate jeopardy and no actual harm with potential for more minimal harm for residents on units 6 and 7.

This is a repeat deficiency.
The findings are:

1) Resident #6 is an 81-year-old readmitted to the facility on 12/28/10 with diagnoses which include Right Subdural Hematoma, Dementia, Hypertension, and Renal Mass.

The Minimum Data Set 3.0 Assessment (MDS) dated 1/3/11 documented the resident has severe cognitive impairment, and is totally dependent on staff for eating, dressing, transfers, personal hygiene, and bathing.

The nurses note dated 3/10/10 at 3:30pm documented "...verbally responsive s/p (status post) fall. Small hematoma noted to center of forehead and small abrasion to Rt (right) knee. No signs of pain when site is touched. No c/o (complaints of) pain or signs of discomfort noted. Neurochecks in progress. Seen by ...NP (Nurse Practitioner) ...PT/OT (Physical Therapy/Occupational Therapy) evaluation s/p fall; cold compress for forehead hematoma TID (three times per day) x (for) 2 days; Bacitracin to Rt Knee abrasion daily x 3 days; fall precautions, neurochecks x 24 hours, low bed, floor mattress ...bed alert. No low bed or floor mattress available. Request made through housekeeping and PT department. Bed alarm will be applied when in bed".
The Comprehensive Care Plan for Accidents dated 10/19/09 was updated on 3/10/10 with the

interventions of low bed ordered, mattress at bedside, PT/OT evaluation, and bed alarm.
The Accident/Incident Report (A/I) dated 3/10/10 documented a defined parameter mattress among the interventions.
There was no documented evidence that the plan for a defined parameter mattress was implemented.
The Certified Nursing Assistant Resident Care Plan Directives dated August 2010 documented that as of 10/5/10 the resident required the use of a Hoyer lift and 2 persons to transfer from bed to wheelchair. It also documented that the resident had a bed and chair alarm.
The Daily Bed/Chair Alarm Check Sheet dated 11/6/10 did not contain resident's name for having alarms that needed to be checked.
Nursing Notes on 11/7/10 at 6:43 am documented: " Resident observed on floor in room lying on his (R) (right) side on (L) (left) side of bed. [No] visual injuries, denies pain. Able to move ...extremities. Alert, confused ...Monitor closely by staff".
A Nursing Note on 11/7/10 at 7am documented: "Son called back to request side rails".
The Comprehensive Care Plan for Accidents was updated on 11/7/10 with the following new intervention: "Keep bed in lowest position".
The A/I dated 11/7/10 contained a CNA (Certified Nursing Assistant) statement that was blank for all questions regarding alarms use and if they were in place, bed in lowest position, and whether mats were used and in place. The corrective action documented was low bed.
There was no documented evidence that the bed alarm, floor mattress, defined parameter mattress, and low bed recommended on 3/10/10 were implemented.
The Daily Bed/Chair Alarm Check Sheet dated 11/7/10 did not contain resident's name for having alarms that needed to be checked.
Nursing Notes dated 11/8/10 at 2:20am documented: "Resident observed on (L) side of bed on his (L) side. [No] Visible injuries ...denied pain. No distress noted ...to be monitored closely by staff ...Resident tends to lean to (L) side of bed ...Instruct staff to make sure Resident is positioned to middle of bed".
A Nursing Note dated 11/8/10 at 6:30am documented: "Bed alarm functioning and in place on bed".
A Nursing Note dated 11/8/10 at 6:40am documented: "son notified of incident. Wants a mat placed on floor and 1 side rail. Will f/u (follow-up)."
The A/I dated 11/8/10 documented corrective actions of bed alarm and 72 hour side rail assessment. The CNA Statement attached was blank for questions regarding the use of a bed alarm and floor mats.
The CCP for Accidents was updated on 11/8/10 with the intervention of side rail assessment.
There was no documented evidence that the interventions of bed alarm, floor mattress, and defined parameter mattress, recommended on 3/10/10 were implemented.
A Rehabilitation Consult Form containing an OT consult dated 11/8/10 documented: "Asked to see Res (Resident) [secondary to] fall 11/7/10 ...He will benefit from perimeter mattress and bed should be placed in lowest position. Nursing made aware".
Nursing Notes dated 12/21/10 at 11:40am documented: "While in the process of medication pass, writer heard a loud thud coming from the elevator. Upon my investigation writer observed resident lying on the floor in front of wheelchair. Nurse also observed a superficial cut (2cm) to forehead with minimal bleeding... NP...notified ordered to transfer resident to hosp (hospital) ...for CT (CAT Scan) of the head".
The Radiology Report, from the hospital, dated 12/21/10 documented: "CT Head Without Contrast ...Impression: Large mixed right subdural, small left acute posterior and tentorial subdural. Possible trapped left lateral ventricle".
The following statements were attached to the A/I dated 12/21/10:
1) The CNA Statement dated 12/21/10, written by CNA #1, documented: "Resident was sitting in w/c in the hallway. I took resident from the hallway and was wheeling him to the dayroom when he fell forward out of the chair".
2) A Statement Form dated 12/24/10, written by CNA #2, documented that CNA #2 was assigned to the resident on 12/21/10. CNA #2 wrote that she noticed a few days prior that the resident's pant leg got caught in the foot rest of the w/c while he was doing his "foot dance". The statement further documented that the Resident always put his feet on the floor, and she notified the nurse.
3) An addendum to the statement written by CNA #2, dated 12/21/10, was written by the Registered Nurse (RN) Risk Manager and documented: "I removed his leg rest because he was moving his legs around and it banged against the leg rest. His feet was resting on the metal of footrest so I removed them. I saw the therapist on the unit and was going to show him, but [resident] fell before I could do it".
The Nursing Supervisor's Review of Accident/Incident dated 12/24/10 documented: "...Upon investigation, resident has behavior of placing his feet on the ground off the leg rest. Staff removed leg rest upon noticing that resident legs were resting on the metal base of same to avoid injury. Resident was due for evaluation by rehab on same day. Staff was unable to prevent fall. Resident does not keep his feet on the leg rest and would often be seen dancing his legs around ...Corrective Action: Transferred to hospital for evaluation; Rehab evaluation; 72hr (hour) bed mobility evaluation; Stop drop to footrest of wheelchair".
The Nurse Practitioner note dated 12/29/10 documented that the resident was re-admitted from the hospital on 12/28/10.

There was no documented evidence in the medical record that any rehab consult was requested to assess the resident's equipment needs in the wheelchair prior to the incident on 12/21/10.
On 2/8/11 at 12:26pm, CNA #1 was interviewed and stated that she was in the process of wheeling the resident from the hallway to the day room when he fell forward. She further stated that she could not remember how it happened or whether the resident moved in any way. She also stated that she was not assigned to the resident, and the resident did not have any legs rests on his wheelchair at the time.
On 2/8/11 at 12:43pm, the Occupational Therapist (OT) was interviewed and stated that the resident is supposed to have leg rests on the wheelchair, and the leg rests do prevent the resident from falling forward. She further stated that she went to the unit immediately after the fall and found the leg rests in the resident's room. The OT also stated that she was not informed of any problems with the resident's leg rests prior to the incident, and she is on the unit at least four times per week. In addition, she stated that she had never seen the resident have problems with keeping his feet on the foot rests and leg rests.
On 2/9/11 at 9:50am, CNA #2 was interviewed and stated that she removed the resident's leg rests when she noticed that his pants were getting caught in them a few days prior to the incident. She further stated that she believed that she removed them on a Friday and the incident happened the following week. She also stated that she told the Licensed Practical Nurse that the resident may not need the leg rests because he could hurt himself and received no response or instruction. The CNA stated that she then took the leg rests off the wheelchair.
On 2/9/11 at 9:57am, the LPN was interviewed and stated that she did not remember being informed of any problem with the resident's leg rests. She further stated that rehab should be called for an assessment prior to removing or discontinuing any equipment. She also stated that the CNAs should not stop using equipment on their own.
On 2/9/11 at 1:30pm, the Registered Nurse (RN) Manager was interviewed and stated that the resident has always had a low bed and bed alarm to her knowledge. She further stated that she does check to see that alarms are checked on the sheets, but she did not remember any issue with resident not being on the list or not having an alarm. She also stated that she does rounds herself to check that alarms are in place.
On 2/10/11 at 3:30pm, the Director of Nursing was interviewed and stated that she realizes that the CNAs should be in-serviced. She further stated that she was preparing an in-service with the Rehab Director on positioning because she was aware that it was a problem, but it has not been completed yet.

2) During the annual environmental tour conducted on 02/04/11 to 02/09/11 between 9:00am and 3:30pm, the following was observed:
1) Protruding metal screws in sections of handrails provided in resident unit corridors. For example on the 6th floor, it was observed in the corridor by the linen chute, at the corner of the elevator lobby, by room 605, by the 6th floor nurse's station and at the corner of the elevator lobby opposite the day room. Examples not all inclusive.
2) Radiators lacked proper covers there by exposing some sharp edges of the radiator. Radiators with exposed sharp edges were observed in rooms 626, 722, 716 (examples not all inclusive).
In an interview with the Assistant Administrator on 02/08/11 at approximately 11:50am, he stated that these issues noted would be addressed.
415.12(h)(1)
415.12(h)(2)

Based on interviews and record review during an abbreviated survey, the facility did not ensure that residents were provided with adequate supervision to prevent elopement. This was evidenced by 2 of 6 sampled residents (Resident # 1 and #2). Resident #1 and #2, identified as at risk for elopement and on 30 minute visual monitoring, eloped from the facility unnoticed for approximately 2 hours. The residents eloped during two separate incidents.

This resulted in no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

Complaint ID#s NY00095137 and NY00096246

The findings are:

Resident #1 is a 49 year old admitted to the facility on 7/15/10. His diagnoses included Vascular Dementia, Psychosis and Aphasia. The Minimum Data Set Assessment 3.0 (MDS) dated 10/21/10 documented that the resident has severely impaired cognition. The resident is independent in ambulation and bed mobility and requires supervision with all other Activities of Daily Living (ADLs).

The Elopement Assessment Guide documented that the resident was evaluated on 8/10/10 and 10/25/10 as at risk for elopement with a score of 5. The evaluation on 8/10/10 included that the resident refused wander guard placement.

A Comprehensive Care Plan (CCP) implemented on 7/15/10 documented that the resident is at risk for elopement related to confusion and independent ambulation. Interventions included monitoring behaviors, redirecting away from exit doors, 30 minute visual checks and a wander guard to the left wrist. An update to the CCP dated 8/10/10 and 8/31/10 documented that the resident removed the wander guard and refused to have it placed. The resident is on 30 min visual checks and "monitored closely for safety." An update on 11/25/10 documented that security reported that the resident was observed pacing around the main lobby door. He was redirected back to the unit and refused attempts to place a wander guard. Visual checks every 30 minutes were continued.

Visual Observation Monitoring Sheet dated 12/13/10 documented that the Certified Nursing Assistants (CNA) signed the 30 monitoring sheet indicating that the resident was in his room at 6:00 PM, 6:30 PM and 7:00 PM.

A Nurse's Notes dated 12/14/10 as late entry for 12/13/10 documented that at 3:40 PM the resident was in his room. At approximately 4:15 PM the resident was given his medication and then took a shower. He was served his dinner in his room and then returned the tray to the cart. At approximately 8:10 PM - 8:20 PM the resident did not respond when the nurse called out his name to give his medication. The nursed continued with the medication pass intending to come back to the resident later. At 8:40 PM the CNA informed the nurse that the resident was missing. Security and the Nursing Supervisor were notified and Code Butterfly was activated immediately. 911 was called and the family was notified. At 11:30 PM the resident was still missing.

A Nurse's Notes dated 12/14/10 at 8:00 PM documented that the resident returned at 5:45 PM with his family. When the resident was interviewed he was able to state that he left the facility by climbing the fence. He then walked to the hospital, where he went inside for warmth and shelter. The Police took him to his mother's house. The resident returned in stable condition. With the family's encouragement a wander guard was applied to his right ankle and he was as placed on one to one observation.

The Facility Investigation dated 12/21/10, completed by the Director of Nursing (DON), documented that the resident has a history of removing his wander guard and refused have it reapplied. His refusal was respected and he was maintained on 30 minute visual checks. On 11/25/10 the resident started walking out the front door. He never left the lobby but security felt that he was ready to exit. He was redirected to the unit where the nurse attempted to place a wander guard on him. He refused and again remained on 30 minute visual checks. On 12/13/10 the resident eloped from the facility by climbing over a six foot fence. According to the 30 minute visual check sheet the resident was last seen at 7:00 PM. However, after reviewing the video surveillance, it was learned that the resident left the facility at 6:15 PM. It was determined that the CNAs initialed the 30 minute visual check sheet without actually seeing the resident at 6:30 and 7:00 PM. The CNAs responsible were terminated and staff were educated on the importance of 30 minute visual checks.

CNA # 5 was interviewed on 12/15/10 11:00 AM via telephone. She stated she worked the 3:30-11PM shift on Monday 12/13/10. She stated that the resident walks around independently and is supposed to wear a wander guard but he refuses. The resident is on 30 minute visual checks and is always in his room. CNA #5 stated that CNAs take turns doing the 30 minute checks. She was on break from 6:30-7:30PM and the resident was on the floor when she left. When she returned she took care of other residents. She then knocked on his door but he wasn't there. She did not inform anyone that she did not observe the resident at the 8:00 PM visual check. She handed over the 30 minute check sheets at 8:30PM to another CNA and also informed her that she did not see the resident at 8:00 PM.

The Director of Building Operations was interviewed on 12/15/10 at 11:30AM. He stated that the resident was found at his mother's house and was then returned to the facility. The Director of Building Services that the resident stated that he "jumped the fence like Superman."

The Director of Social Work (DSS) was interviewed at 12:10PM on 12/15/10. The DSS stated that the resident told her he left because "he was bored." He mixed people meeting on the first floor in the Adult Day Care area, went out to the patio and jumped the fence.

The 3-11:00 PM Licensed Practical Charge Nurse was interviewed on 12/15/10 at 2:50 PM. The LPN stated that she saw the resident at 6:30PM when he put his dinner tray on the cart. She was never informed that the resident was not observed at 7:30 or 8:00 PM. She was informed that he was not seen at the 8:30PM check and was missing.

The DON was interviewed on 1/3/11 at 3:15PM via telephone. She stated that CNAs involved did not see the resident at the times they signed for on the 30 minute visual check sheet. They were terminated by

the facility.

Resident #2 is an 89 year old admitted to the facility on 09/01/2010. Her diagnoses include Dementia with Psychosis, Arthritis, Hypertension, Paranoid Delusions, Hypothyroidism and Anemia. Minimum Data Set Assessment (MDS) 3.0 dated 12/05/2010 documented that the resident has moderately impairment cognition and uses a walker for mobility.

The Elopement Assessment documented that the resident was evaluated on 09/01/2010, 10/02/2010, and 12/10/2010, as at risk for elopement with a score of 10. The evaluation on 10/02/2010 included that the resident removed the wander guard and refused to have a new one applied. The resident remained on 30 minute checks. The evaluation on 12/10/2010 included that the resident is risk for elopement and is monitored closely every 30 minutes.

A Comprehensive Care Plan (CCP) implemented on 09/03/2010 documented that the resident is at risk for elopement. The interventions included providing a calm structured environment, encourage participation in recreation therapy programs, monitor behavior, provide 30 minute checks, and redirect from exit doors as needed.

Certified Nursing Assistant (CNA) Resident Care Plan Directives for January 2011 documented that at high risk for elopement and is on every 30 minute visual checks.

Elopement List dated 01/08/2011 documented that the resident was included on the list, has wander guard in place and is monitored on 30 minute visual checks.

Visual Observation Monitoring Sheet dated 01/08/2011 documented that the CNAs signed the 30 monitoring sheet indicating that the resident was in her room at 1:30 PM, 2:00 PM, 2:30 PM, and 3:00 PM.

A Nurse's Note dated 01/08/2011 11:45 PM documented that 30 minute monitoring was done by CNA and resident was not on the unit. The charge nurse was notified. A search for the resident was immediately started on the unit and other floors through out the building. Security and the Nursing supervisor were notified. Code butterfly was initiated. An officer from the Police Department called at 6:58 PM stating that the resident will be transferred to the hospital for evaluation for change in mental status. The family member was notified of the situation and the resident's hospitalization.

The Facility's Investigation and Occurrence Report dated 01/08/2011 documented that the resident was missing from the unit. Code butterfly was initiated and thorough search of the building and external grounds were done, but the resident was not located. A call was received from the police department stating that the resident was found and was being transferred to the hospital for evaluation. As per staff interviews conducted by the Assistant Director of Nursing (ADON) the resident was last seen by CNA #1 at 1:30 PM when she delivered the resident's lunch tray. CNA #1 stated that the resident was sleeping at that time and she woke her up to eat lunch. CNA #2, the assigned CNA, went to the resident's room at 2:00 PM and heard "laughing and man's voice." CNA #2 stated that she did not actually see the resident. CNA #2 stated that she signed the 30 minute observation sheet for 2:30 PM and 3:00 PM but she did not physically see the resident. Security Officer #1 was on duty during the day shift on 01/08/2011. He stated that once the code butterfly was initiated, he looked at the resident's picture and realized that he may have mistaken her for a visitor as she exited the building around 2:00 PM. Video surveillance was reviewed and the resident was seen exiting thru the front door at 2:16 PM. The facility concluded that CNA #2 failed to follow facility policy on performing and documenting 30 minute observation resulting in the resident eloping from the facility unnoticed.

On 01/25/2011 at 2:30 PM, review of the video surveillance was done. It showed that the resident was able to get out of the building thru the front door by walking past the Security Officer.

An interview with the Director of Nursing (DON) was conducted on 01/25/2011 at 10:00 AM. She stated that on 1/8/2011, CNA # 2 did not physically see the resident between 2:00 PM and 3:00 PM. At 3:40 PM CNA #3 checked for the resident in her room PM but she was not there and reported to the nurse. The DON stated that the resident was able to get out of the building by exiting thru the front door. She stated that if residents refuse to wear wander guard then the security officer cannot identify if the resident is an elopement risk. After the incident the policy was reviewed and found to be sufficient. The cause of this incident was "human error."

An interview was conducted with Security Officer #1 (SO #1) on 01/25/2011 at 11:30 AM. He stated that that on 1/8/2011, he received a phone call from the resident's floor between 5:00 PM to 5:30 PM. The staff asked him if he saw the resident downstairs and he stated "No." Code butterfly was announced and

search of the entire building was conducted. SO #1 stated that at about 6:05 PM, he received a phone call from the Police Department stating that they found the resident. SO # 1 stated that the video surveillance revealed that the resident walked past him. He stated that the resident looked like a visitor that he was familiar with and she was surrounded by other visitors. The resident's arm band was not visible and the resident was dressed up for winter.

An interview was conducted with the Administrator on 01/25/2011 at 1:50 PM. The Administrator stated that he "looked at the whole picture" and felt that SO #1 was not neglectful in his job duties. He was standing at his post as required.

415.12(h)(2)

F226 483.13(c): POLICIES, PROCEDURES PROHIBIT ABUSE, NEGLECT

Scope: Isolated
Severity: Actual Harm
Corrected Date: April 15, 2011

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

Citation date: February 16, 2011

Based on record review, resident and staff interviews, the facility did not implement the abuse protocol policy and procedures. Specifically, the facility did not investigate, protect and prevent incidents of inappropriate sexual behavior by resident #13 toward resident #36 and several unidentified female residents. Additionally, the facility did not protect resident #13 from potential physical abuse by another resident. This was evident for 1 of 30 sampled residents (Resident #13) and 1 out-of-sample resident (Resident #36) and several unidentified female residents.

This resulted in actual harm for resident #36. This resulted in no actual harm with potential for more than minimal harm for resident #13 and for several unidentified female residents.

The findings include but are not limited to:

1) Resident #13 is an 84-year-old with diagnoses which include: Alzheimer's Dementia, Hypertension, and Urinary Retention.
The Minimum Data Set 3.0 assessment (MDS) dated 11/8/10 documented that the resident had severely impaired cognition and displayed physical behaviors and other behaviors that intruded on the privacy of others.
The Behavior CCP (Comprehensive Care Plan) was updated on 4/26/10 with the following: "Hx (history) of going to peers room @ (at) times [with] open gown & (and) exposed genitalia ...Interventions: Provide direction in positive manner & redirect as needed ...Psych (Psychiatric) consult as per MD (physician) order ...Medications. "
On 4/26/10 a second Behavior CCP for "Resident to Resident Altercation (Aggressor) " was implemented. The CCP documented: " On 4/25/10 @ 11:30am - as per statement of ...son, resident ...went to his mother's room [with] exposed genitalia. Charge nurse redirected him to his room ." The CCP also documented the following interventions: "Remove resident from situation utilizing calm approach ...Provide 1:1 supervision until calm ...Asses for injury ...Psychiatric consult as per MD ...Assess for causes of behavior ...Engage in diversional activities i.e.: music, ambulation ...Room change/unit change ...Continuous 1:1 supervision ...Keep resident apart from other resident ...1:1 observation. "
The Patient Activity Log printed on 2/14/11 documented that the resident was moved to the 4th floor on 4/26/10. There is no documented evidence that the facility implemented their abuse protocol.
There was no incident report or investigation for this occurrence for the resident or the victim of his sexual behavior.
The Patient Activity Log printed on 2/14/11 documented that the resident was moved from the 4th floor to the 10th floor on 5/15/10. There is no documented evidence that the facility implemented their abuse protocol.
The Patient Activity Log printed on 2/14/11 documented that the resident was moved from the 10th floor to the 7th floor on 6/14/10. There is no documented evidence that the facility implemented their abuse

protocol.
A Social Services Note dated 6/14/10 documented: " On this date [resident] was transferred from room ...to ...[secondary] to him being inappropriate to another resident."
There was no documented evidence of the nature of the incident that occurred that led to a room change for this resident.
There was no documented evidence that an investigation was done regarding any incident around 6/14/10 for the resident or the victim. There was no documented evidence that the victim was counseled or protected to ensure that no abuse occurred.
A Social Services Note dated 6/15/10 documented " ...phoned resident's wife and made her aware resident has exposed himself to several women on the unit. This date resident was placed on one to one for extra support from staff."
The Behavior CCP was updated on 6/15/10 with the following note " Resident alert and verbally responsive. Inappropriate behavior towards 3 residents on the unit. Supervisor made aware. Staff watched resident, and he is on one to one with a CNA (Certified Nursing Assistant)."
There was no documented evidence that there were any investigations for the 3 unidentified residents.
There was no documented evidence that the abuse protocol was implemented for the 3 unidentified residents.
A Social Services Note dated 6/16/10 documented "Res (resident) has been wandering and touching staff (Females) and other residents (Female). Res (resident) has jump suit and has not been able to disrobe; Res presents as being at risk of harm from other male resident who become angry that res touches women. Res was pushed into a chair by other male res. Room change to be done to protect res from harm."
The "Resident Occurrence Report" dated 6/16/10 documented "Resident Continues to inappropriately touch female Resident/Staff when Resident (resident initials) intervene putting his hand around resident #13 neck stating " You never do that again" Resident separated. Closely Monitor. Continue on 1:1 observation."
The Accident and Incident Investigation dated 6/18/10 documented "...Resident was chocked by another resident after he touched a female staff/resident. Resident (resident initials) was present and yelled at him, "you never do that again" after putting his hand around residents neck. Residents were immediately separated. Resident on 1:1 observation. Residents were in a supervised, but staff was unable to prevent incident...Remained on 1:1 until such time. No evidence of abuse/neglect."
The Behavior CCP was updated on 6/16/10 with the following note: " Continue to walk & touch female resident & staff inappropriately. On 1:1 monitoring due to behavior. Another resident attempted to choke him. No visible injuries noted."
A Social Services Note dated 6/17/10 documented that the resident was transferred to an inpatient psychiatric unit because of his inappropriate sexual behavior.
On 2/16/11 at 12:35pm, the CNA that provided 1:1 supervision on 6/16/10 was interviewed and stated that she did not witness the incident because she went to lunch. She further stated that it is common practice that if there is not enough staff to cover the 1:1, the CNA providing the 1:1 can leave the resident in the day room during lunch in order to take a lunch break. The CNA also stated that she left the resident in the day room for lunch, but the CNAs in the day room are familiar with the resident's behaviors.
A Social Services Note dated 7/6/10 documented that the resident was readmitted and would be monitored.
The Patient Activity Log printed on 2/14/11 documented that the resident was readmitted to the same room on the 7th floor where the 6/16/10 incident occurred.
There was no documented evidence that the facility implemented the abuse protocol to protect resident #13, a cognitively impaired resident, from physical abuse.
A Social Services Note dated 7/12/10 documented that the resident was attempting to touch a female resident while stating sexual advances towards her. The note further documented that the resident was separated from the female and placed on monitoring.
There was no documented evidence that an investigation was done for this unidentified female resident who was touched on 7/12/10 by resident #13.
There was no documented evidence of nursing notes, physicians' notes/orders from April, 2010 to September, 2010 in resident #13 medical record.
The Assistant Director of Nursing was interviewed on 2/14/11 at 5:20pm stated that the resident's entire medical record could not be found from April 2010 to September 2010 in resident #13 medical record.
A Nurses' Note dated 10/9/10 at 11am documented "Touch the resident on her bottom. Behavior discourage by resident."
There was no documented evidence that an investigation was done for the unidentified female resident or that the abuse protocol was implemented.
A Nursing Note dated 10/27/10 at 2:45am documented "Resident was observed in Rm (resident #36 room) wearing night gown and holding his private part in hands towards resident in Rm ...Staff assisted resident to his room and staff members provided 1:1 supervision. Continue to monitor " .

There was no documented evidence that an investigation was conducted and that the abuse protocol implemented for resident #36 concerning the 10/27/10 incident.
The Nursing Notes dated 11/6/10 at 8:15am documented: "The resident in room (resident #36 room) ...told me that the resident #13 came into her room and exposed his private part ...Resident was walking in the hallway and I took him into the day room."
There was no documented evidence that an investigation or the abuse protocol was implemented for resident #36 concerning the 11/6/10 incident.
The Nursing Notes dated 11/7/10 documented: " 7:35am Resident was asleep during walk through round ...7:50am ...observed resident ambulating in hallway and I took him into the dayroom ...8:15am The resident in Room ...told me that the resident in Room ... came to her door and knocked at 8:05am. She said that she recognized his voice and told him to leave her alone " .
There was no documented evidence that an investigation and the abuse protocol implemented for resident #36 concerning the 11/7/10 incident.
On 2/10/11 at 6:50pm the Registered Nurse (RN) Risk Manager (abuse protocol coordinator) was interviewed and stated that she could not find any other incident reports for the resident #13 or for any of the other residents involved in the incidents. She further stated that the documentation regarding touching another resident in the 6/16/10 incident report must be an error, and she was not aware that the resident was exposing his genitalia to other residents or touching other residents. She also stated that if he touched other residents, there should be an incident report and investigation.
The RN Risk Manager was interviewed on 2/16/11 at 1:12pm and stated that she was not informed of any incidents where Resident #13 exposed himself to Resident #36, but she recalled the incident where Resident #13 attempted to come into Resident #36's room but did not enter. She further stated that incidents reports and investigations are done for actual physical contact but not for exposing genitalia unless the resident is cognitively impaired and there is uncertainty about what occurred. She also stated that if the resident is cognitively intact, they can say whether they were touched and no report or investigation is needed. The RN Risk Manager stated that she did speak to the resident about the last incident and she did not seem upset or distraught at the time, and she said she was okay.
On 2/11/11 at 3:20pm, the Social Worker (SW) that was assigned to the resident from 6/14/10 to 1/11/11 was interviewed and stated that she was informed from the previous Social Worker that the resident had an incident with another resident on his previous floor. She was not aware of the nature of the incident. She further stated that the resident touched a cognitively impaired female resident on her knee on 6/16/10 and she provided support, but the female resident is unable to remember. The SW also stated that she was only aware of the resident exposing himself to staff.
On 2/16/11 at 9:45am, the RN Manager was interviewed and stated that the resident usually touched the sexual parts of females and expressed what he wanted to do to them sexually. She further stated that occurrence reports and investigations are done when someone has been touched, but I do not think the resident touched anyone because he was always prevented from doing so.

2) Resident #36 is a 54-year-old with diagnoses which include: Asthma and Endometrial Cancer.
The Minimum Data Set 3.0 Assessment (MDS) dated 11/24/10 documented that the resident had intact cognition.
The resident was interviewed on 2/16/11 at 10:25am. The resident stated that in late October 2010 at approximately 3:00am, Resident #13 came into her room naked, holding his genitalia, and said " look at this " . The resident said she was startled and screamed at him to get out of her room, and the night nurse came to her and tried to calm her down. The resident stated that she was nervous for the next 1 to 2 weeks because she worried that Resident #13 would try to come into her room again in the middle of the night. She would wake up and check the room during the night because Resident #13 was not on 1:1 observation. The resident further stated that about 2 weeks later, Resident #13 came into her room naked and holding his genitalia in the morning around 7:45 during her nebulizer treatment. She said she told the Licensed Practical Nurse (LPN) on duty what the resident had done. The next morning, Resident#13 attempted to enter her room again, dressed in a gown, but he got startled and left. The resident began crying as she told this information to this surveyor. She said the staff did not do anything about the incidents until she threatened to report it to the Department of Health on the day of the 3rd attempt. The resident stated that she told her brother what happened and he came to the facility and demanded to speak to the Administrator, which he did. The resident said that the staff told her they would move the resident closer to the nursing station as a resolution, but they did not ask her how she was doing or whether she felt safe. The resident said she was scared ever since the incidents occurred. When this surveyor asked the resident why she was crying, the resident stated that the incidents scared her, and she still has flashbacks about them.
There was no documentation in the resident's medical record of any incident in October 2010.
A Nursing Note from Resident #13's medical record dated 10/27/10 at 2:45am documented: : " Resident was observed in Rm (room) [room # of Resident #36] wearing night gown and holding his private part in hands towards resident in Rm [room # of Resident #36]. Staff assisted resident to his room and staff

members provided 1:1 supervision. Continue to monitor " .
There was no documented evidence that an investigation was done or that attempts were made to protect the resident. There is no documented evidence that the abuse protocol was implemented.
A Nursing Note dated 11/6/10 at 3pm documented that the resident complained that Resident #13 came into her room, exposing his private parts.
There was no documented evidence that an investigation was done and efforts were made to protect the resident. There is no documented evidence that the abuse protocol was implemented.
A Nursing Note dated 11/7/10 at 8:15am documented that the resident told the LPN that Resident #13 came to her door and knocked at 8:05am, and she recognized his voice and told him to leave her alone.
There was no documented evidence that an investigation was done and efforts were made to protect the resident. There is no documented evidence that the abuse protocol was implemented.
On 2/16/11 at 9:45am and 11:35am, the Registered Nurse (RN) Manager was interviewed and stated that she was not aware of Resident #13 exposing his genitalia to Resident #36 on two occasions. She stated that Resident #36 told the staff and her brother about the attempt to come into her room, and the resident was reassured that Resident #13 would be moved closer to the nursing station.
On 2/16/11 at 11:25am, the Social Worker was interviewed and stated that the resident was very disturbed by what happened, and she spoke to the resident and provided support. She further stated that she was only aware of one incident where Resident #13 came to her room and was redirected. She also stated that she was not aware that Resident #13 had ever exposed his genitalia to Resident #36. The resident's brother spoke to the Administrator about the matter, and Resident #13 was moved. The SW stated that the resident was never tearful, and she had no idea that she was fearful or continued to be upset by the incidents. She further stated that if she had known, the resident would have been referred to the psychologist so she could talk about what happened and her feelings.
The RN Risk Manager was interviewed on 2/16/11 at 1:12pm and stated that she was not informed of any incidents where Resident #13 exposed himself to Resident #36, but she recalled the incident where Resident #13 attempted to come into Resident #36's room but did not enter. She further stated that incidents reports and investigations are done for actual physical contact but not for exposing genitalia unless the resident is cognitively impaired and there is uncertainty about what occurred. She also stated that if the resident is cognitively intact, they can say whether they were touched and no report or investigation is needed. The RN Risk Manager stated that she did speak to the resident about the last incident and she did not seem upset or distraught at the time, and she said she was okay. When asked about whether acts could be abusive even if there was no touching involved, she stated that abuse could be verbal or mental.

3) Resident #17 is a 97 year old female with the diagnosis that include Dementia, Depression, Anxiety Disorder, Hip Fracture, Osteoporosis, and Diabetes.

The MDS 3.0 dated 12/8/10 documented moderately impaired cognition with short term memory problem.

Observed resident's room on initial tour on 2/4/11. Resident had full side rails on her bed. Again observed resident's room on 2/8/11 around 10 am and resident had full side rails. Observed resident on 2/8/11 at 12 PM finishing physical therapy.

The nurses' notes dated on 2/15/10 at 11:20 PM documented "resident came to nurses station upset says that there is a man in her room who wants to touch her. Brought to dayroom comforted resident. Afraid, crying reassured allowed to ventilate. Brought back to bedroom. Reassured and put back to bed. No further episode. To be follow up."

On nurses' notes dated on 2/15/10 at 10 AM documented "CNA reports that resident states " A man came in my room last night and pushed his finger in my panties; trying to have sex with me." Resident interviewed by the nurse manager and reported the same. Manager, Social Worker, the CNA'S of the evening tour for previous day - they reported that there was no visitors to resident and that resident has been saying "I want sex" for sometime now. Manager placed resident for a psychiatric evaluation for further follow up.

On nurses' notes dated on 2/17/10 at 6 PM documented "Resident in dayroom had supper was calm conversing with all at table during supper. Medicated went to bed. Noted teary eye saying "the man touched me in my private area." Agitated, crying and talking loudly. Calmed continued to ventilate becoming more and more agitated. Asked to go to the dayroom, agreed brought resident to dayroom informed staff and monitored until 10PM calmed escorted back to room no further period of agitation or talks of a man.

There is no documented evidence that these incidents were investigated. There is no documented evidence that the abuse protocol was implemented.

An interview with the Charge Nurse that works the shift 3:30 PM to 11:30 PM was conducted by phone on 2/9/11 at 12:15 PM. The nurse stated that the resident came out of her room and was crying. The nurse went into her room and consoled the resident. The nurse calmed her down and reassured the resident that there was no stranger there. When these incidents reoccurred staff would have the resident sit near the nursing station or dayroom and would monitor the resident. The nurse stated she would document the incidents in the chart and would make the supervisor aware. The process is that you inform the supervisor and the supervisor would follow up and Accident and Incident Report would be initiated by the nursing office. The Nurse stated that the resident was never sexually preoccupied, that is not the type of person she is. The resident never stated she wanted sex.

An interview with the Nurse Consultant who was the Director of Nursing when these incidents occurred was interviewed on 2/9/11 at 1:20 PM. She stated that she recalls that the nurse manager at the time who no longer works in the facility verbally stated that she interviewed all the evening staff. The Nurse consultant continued to state "that the resident stated that a man came in her room and pushed his finger in her panties." She continued to state that the evening supervisor passed the report to the day supervisor who did the investigation.

There is no documented evidence this was done.

An interview with the DNS was conducted on 2/9/11 at 11:25 am. The DNS stated there was no investigation done for the sexual abuse in February 2010.

A family interview was conducted with the daughter on 2/11/11 at 10 AM. The daughter stated that when the incident occurred the mother described the situation that you believed it really happened. The mother still speaks about the situation, the last time she spoke about it was three weeks ago.

415.4(b)

F498 483.75(f): PROFICIENCY OF NURSE AIDES

Scope: Isolated
Severity: Actual Harm
Corrected Date: April 15, 2011

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Citation date: February 16, 2011

Based on record review and staff interviews, the facility did not ensure that nurse aides demonstrated competency in skills and techniques necessary to care for residents' needs. Specifically, a resident's wheelchair leg rests were removed by CNA (Certified Nurse Assistant) #2 and three days later, while being pushed by CNA 31, the resident fell out of the wheelchair without leg rests in place. Subsequently, the resident was hospitalized for seven days and sustained a right Subdural Hematoma. This was evident for 1 of 30 sampled residents (Resident #6).

This resulted in actual harm that is not immediate jeopardy.

This is a repeat deficiency.

The finding is:

Resident #6's Minimum Data Set 3.0 Assessments (MDS) dated 3/6/10 and 1/3/11 documented that the resident has severe cognitive impairment, and is totally dependent on staff for eating, dressing, transfers, personal hygiene, and bathing.

The resident occurrence report dated 12/21/10 documented "...Nurse was in the process of Medication pass when nurse heard a loud thud coming from the elevators. Upon writers' observation, resident was noted lying on the floor in front of the wheelchair with his face down on the floor. Nurse also observed minimal bleeding to the forehead with superficial cut. As per CNA I was wheeling resident to the dayroom

when he fell forward..."
The following statements were attached to the resident occurrence report dated 12/21/10:
1) The CNA Statement dated 12/21/10, written by CNA #1, documented "Resident was sitting in w/c (wheelchair) in the hallway. I took resident from the hallway and was wheeling him to the dayroom when he fell forward out of the chair".
2) A Statement Form dated 12/24/10, written by CNA #2, documented that CNA #2 was assigned to the resident on 12/21/10. CNA #2 wrote that she noticed a few days prior that the resident's pant leg got caught in the foot rest of the w/c while he was doing his "foot dance." The statement further documented that the Resident always put his feet on the floor, and she notified the nurse.
3) An addendum to the statement written by CNA #2, dated 12/21/10, was written by the Registered Nurse (RN) Risk Manager and documented: "I removed his leg rest because he was moving his legs around and it banged against the leg rest. His feet was resting on the metal of footrest so I removed them. I saw the therapist on the unit and was going to show him, but [resident] fell before I could do it".
The Radiology Report, from the hospital, dated 12/21/10 documented "CT Head Without Contrast ...Impression: Large mixed right subdural, small left acute posterior and tentorial subdural. Possible trapped left lateral ventricle".
There was no documented evidence in the medical record that any rehab consult was requested to assess the resident's equipment needs in the wheelchair prior to the incident on 12/21/10.
The Nursing Supervisor's Review of Accident/Incident dated 12/24/10 documented: "...Upon investigation, resident has behavior of placing his feet on the ground off the leg rest. Staff removed leg rest upon noticing that resident legs were resting on the metal base of same to avoid injury. Resident was due for evaluation by rehab on same day. Staff was unable to prevent fall. Resident does not keep his feet on the leg rest and would often be seen dancing his legs around ...Corrective Action: Transferred to hospital for evaluation; Rehab evaluation; 72hr bed mobility evaluation; Stop drop to footrest of wheelchair". There is no documented evidence of any corrective action/inservice implemented for the CNAs involved in this accident/incident as of 2/10/11 (51 days after the resident's fall).
The resident is an 81-year-old readmitted to the facility on 12/28/10 with diagnoses which include right Subdural Hematoma, Dementia, Hypertension, and Renal Mass.

On 2/8/11 at 12:26pm, CNA #1 was interviewed and stated that she was in the process of wheeling the resident from the hallway to the day room when he fell forward. She further stated that she could not remember how it happened or whether the resident moved in any way. She also stated that she was not assigned to the resident, and the resident did not have any legs rests on his wheelchair at the time.
On 2/8/11 at 12:43pm, the Occupational Therapist (OT) was interviewed and stated that the resident is supposed to have leg rests on the wheelchair, and the leg rests do prevent the resident from falling forward. She further stated that she went to the unit immediately after the fall and found the leg rests in the resident's room. The OT also stated that she was not informed of any problems with the resident's leg rests prior to the incident, and she is on the unit at least four times per week. In addition, she stated that she had never seen the resident have problems with keeping is feet on the foot rests and leg rests.
On 2/9/11 at 9:50am, CNA #2 was interviewed and stated that she removed the resident's leg rests when she noticed that his pants were getting caught in them a few days prior to the incident. She further stated that she believed that she removed them on a Friday and the incident happened the following week. She also stated that she told the Licensed Practical Nurse (LPN) that the resident may not need the leg rests because he could hurt himself and received no response or instruction. The CNA stated that she then took the leg rests off the wheelchair.
On 2/9/11 at 9:57am, the LPN was interviewed and stated that she did not remember being informed of any problem with the resident's leg rests. She further stated that rehab should be called for an assessment prior to removing or discontinuing any equipment. She also stated that the CNAs should not stop using equipment on their own.
On 2/10/11 at 3:30pm, the Director of Nursing was interviewed and stated that she realizes that the CNAs should be in-serviced. She further stated that she was preparing an in-service with the Rehab Director on positioning because she was aware that it was a problem, but it has not been completed yet.

415.26(c)(1)(iv)

F325 483.25(i): RESIDENT MAINTAIN NUTRITIONAL STATUS UNLESS UNAVOIDABLE

Scope: Isolated
Severity: Actual Harm
Corrected Date: April 15, 2011

Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) 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; and (2) Receives a therapeutic diet when there is a nutritional problem.

Citation date: February 16, 2011

Based on observation, record review and staff interviews, the facility did not ensure that acceptable parameters of nutritional status were maintained. Specifically, the facility did not administer supplements as planned for residents with nutritional deficits, significant weight loss and a decrease in their albumin levels (Residents #4, and #6). Additional Resident #6 was identified as being a high risk for pressure ulcers and developed 4 new pressure ulcers. This was evident for 2 of 30 sampled residents. (Resident #4 and #6)

This resulted in actual harm that is not immediate jeopardy.

This is a repeat deficiency.

The finding is:

1) Resident #6 is an 81-year-old readmitted to the facility on 12/28/10 with diagnoses which include Right Subdural Hematoma, Dementia, Hypertension, and Renal Mass.

The Minimum Data Set 3.0 Assessment (MDS) dated 1/3/11 documented the resident has severe cognitive impairment, and is totally dependent on staff for eating, dressing, transfers, personal hygiene, and bathing.

On 2/7/11 at 12:11 pm the resident was observed in the day room during lunch. The resident consumed all of his food. He was fed by a Licensed Practical Nurse (LPN). The food was blenderized. There was no supplement on the tray.

On 2/7/11 at 2:40 pm the resident was observed receiving an 8oz. (ounce) can of Two Cal HN supplement. The resident consumed the entire supplement.

The Monthly/Weekly Weight Record for 2010 documented a weight of 139.12 lbs (pounds) on 12/28/10.

An Interim Physician's Order dated 12/29/10 documented a lab order for CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel).

A Dietary Order Form dated 12/29/10 documented "Start Diet: NAS (No Added Salt) Blenderized; Start Supplement: Health Shake 6oz. TID (3 times per day) and LPS 15/30 30cc TID". LPS 15/30 is a protein supplement.

A Nutrition Assessment (for Readmission) dated 12/29/10 documented the following: "DBW (Desired Body Weight) 142 +/- 10%...Health Shake ...for weight maintenance. [No] s/s (sign and symptoms) p/u's (pressure ulcers) at this time ...7# (pounds) (4.7%) [lost] during hosp (hospital) stay. Will continue weekly weights". The desired body weight range is 156.2 - 127.8 lbs.

A laboratory report dated 1/4/11, for a specimen collected 12/30/10, documented an Albumin level of 2.9 g/dL (grams per deciliter) - a low level [reference range 3.2 - 4.7].

A review of the Medication Administration Record dated 12/30/10 documented no administration of LPS 15/30 and Health Shake from 12/31/10 to 1/15/11.

A Nurse Practitioner (NP) Progress Note dated 1/10/11 documented: "Noted around 1x1 cm (centimeter) redness on L (left) lateral foot near the small toe. Site clean. No s/s of infection ...Continue to monitor".

A Dietary Progress Note dated 1/11/11 documented: "As of 1/11/11 new p/u on (L) lat (lateral) foot stage II 1x1 cm. Currently on LPS and Health Shake Suppl. (supplement) for nutritional support".

The Physician's Monthly Order dated 1/13/11 did not contain orders for supplements.

A review of the MAR dated 1/14/11 revealed that no LPS 15/30 or Health Shake was administered from

1/15/11 to 2/6/11.

The Daily Accountability of Assignment records for December 2010, January 2011, and February 2011 were reviewed. There was no documented evidence that any nourishments were given to the resident.

A Dietary Progress Note dated 1/26/11 documented: "Wt 137# as of 1/23/11. 1# [loss] x 1wk. Will provide 2x Super Cereal @ (at) B (breakfast) meal for [increased] calories to deter wt loss. Shake provided 3x day along [with] LPS Suppl. for nutritional support. As of 1/21/11 (L) lateral foot remains Stg II 1x1 cm."

The Weight Sheet for 2011 documented the following weights:
1/3/11 - 138 lbs
1/20/11 - 137.5 lbs
1/23/11 - 137 lbs
1/28/11 - 137 lbs
2/3/11 - 134.8 lbs
2/8/11 - 130.12 lbs

(The resident experienced a significant weight loss of 5.7% from 1/3/11 to 2/7/11.)

A Nurse Practitioner Progress Note dated 2/3/11 documented: "L (left)buttock skin opening-noted with slough in the middle of the wound [with] pinkish red skin at the edges. No drainage ...Cleanse [with] NS (normal saline) & (and) apply Collagenese daily. Monitor."

The Weekly Pressure Ulcer Progress Assessment Update, initiated 2/4/11, documented a stage 2 left buttock ulcer measuring 2x4 cm.

A Nurse Practitioner Progress Note dated 2/7/11 at 10:15 am documented: "Resident noted to have pressure ulcers on L hip & R (right) buttock. Resident evaluated [with] wound nurse ...R buttock - stage II pressure ulcer has pink skin 2x1cm. No drainage, no foul odor. L hip - stage II pressure ulcer. Has pink skin 5x1 cm - [no] drainage, [no] foul odor. L buttock - unstageable - Has slough in wound bed. L lateral foot drying blister - stage II ...Supplements Vit (vitamin) C & Zinc ordered".

An addendum to the NP Progress note dated 2/7/11 at 10:25am documented: "D/C (Discontinue) Vit C & Zinc. Resident is on LPS as per dietician".

A Dietary Progress Note dated 2/7/11 documented: "New p/u on (L) Buttock Stg II 2x4 cm as of 2/4/11. (L) Lat foot stg II 0.5x0.5 as of 2/4/11. New (L) Hip Stg II 5x1cm and (R) Buttock II 2x1 cm as of today. Presently on LPS 15/30 ...[changed] to LPS Critical Care TID ...Health Shake D/c'd (discontinued) [changed] to 2 Cal HN 8 oz TID ...for [increased] cal (calories) / Pro (protein) to assist [with] wound healing and deter weight loss. Wt as of 2/3/11 135#...Reweigh pending. Calorie Count pending".

An Interim Physician's Order dated 2/7/11 documented: "CBC, CMP, Prealbumin".

A Dietary Order Form dated 2/7/11 documented: "Discontinue: LPS 15/30 and Health Shake ...Start Supplement: LPS Critical Care 30cc TID and 2 Cal HN 8oz TID".

A Laboratory Report dated 2/9/11 documented an Albumin level of 2.7 g/dL (reference range 3.2 - 4.7) and a Prealbumin level of 16.30 mg/dl (milligrams per deciliter) (reference range 20.00 - 40.00 mg/dl).

(The Albumin level decreased by 0.2 g/dL from 12/30/10 to 2/8/11.)

On 2/8/11 at 2:45pm the Registered Dietician (RD) was interviewed and stated that the resident was supposed to be on LPS 15/30 and Health Shake prior to her supplement changes on 2/7/11. She further stated that she reviews the Physician's Orders as needed, but when she reviewed them on 2/7/11 she did not realized the supplements were not reordered on the monthly. She also stated that the LPS is supposed to help with wound healing.

On 2/8/11 at 3:07pm the Physician was interviewed and stated that if there was no order to discontinue the supplements then they should have been carried over on the monthly orders. He further stated that he must have missed it when reviewing the monthly orders.

On 2/10/11 at 10:55am the Licensed Practical Nurse (LPN) who was the second nurse to review the 1/13/11 monthly orders, was interviewed and stated that the monthly orders are checked against the interim orders and MAR to see if anything was missed. She further stated that the supplements should

have been added to the orders or the nurse should have called the Physician to order them. She also stated that the LPS and Health Shake are documented on the MAR when given.

On 2/10/11 at 11:05pm the NP was interviewed and stated that she did assess the resident on 2/7/11. She was not aware that the resident was not receiving the supplements ordered. The lack of supplements could possibly contribute to the skin breakdown, but the resident has been declining.

2) Resident #4 is a 90 year old female with diagnosis that include Hypertension, Dementia, Depression, Hyperlipidemia.

The MDS (Minimum Data Set) 3.0 dated 12/27/10 documents that the resident's cognition is moderately impaired with long term memory problems. This MDS documented the resident's weight as 101# (pounds).
The weight sheet documented the following monthly weights for 2010:
August - 105#; September - 102.8#; October - 102.8#; November - 102#; and December - 101#.
The weight sheet documented the following for 2011:
January 4 - 100.04#; January 12 - 98#; January 17 - 91#; January 21 - 91.9#; February 1 - 97#; and February 7 - 96.04#

The "Nutritional Assessment" dated 1/5/11 documented that the resident is 56 inches (4 feet 7 inches), Weight 100.04#, DBW (desirable body weight) 95-114 # BMI (Body Mass Index) 22.5 (Normal Weight). " Greater than or equal to 7.5 %change in 3 months: No...Greater than or equal to 10% Change in 6 months: No....Assessment: Po intake (By mouth) is 25 -50 % breakfast/lunch and 50 - 75% dinner. Resident just started on LPS 15/30 30 ml (milliliters) BID (twice a day) to address low albumin 2.5 and low total protein 5.9. Weight is 100.04 lbs. (pounds). No significant change in weight over the past six months. Resident started on weekly weights times 4 weeks. Ensure plus provided once daily. Continue to monitor."

The "Dietary Interim Notes" dated 1/21/11 documented that the resident loss 9.1 lbs. from December 2010 to January 2011. Weight loss is significant at 9%. Dietitian will start resident on Booster diet and start three day calorie count on Monday 1/24/11. Resident will continue with weekly weights and be started on Weight Loss Monitoring Report.

The "Dietary Interim Notes" dated 1/31/11 documented calorie count as follows: Day 1: 624 calories and 24 grams of protein consumed. Day 2: 1722 calories and 47 grams of protein. Day 3: 978 calories and 29 grams of protein. Dietitian will increase supplement to TID (three times a day). Continue to monitor.

The "Dietary Interim Notes" dated 2/4/11 Diet upgraded to mechanical soft. New Diet reads: Mechanical Soft, NAS (No Added Salt), booster diet. Resident was not eating the puree food except for the mashed potatoes. Appetite expected to increase with new diet. Continue to Monitor.
Resident has right lower extremity (LE) swelling, which may cause fluctuations in weight. Right LE DVT (Deep Vein Thrombosis) as well. Continue to monitor.

There was no documented evidence that the Ensure Plus 8 oz (ounces) TID was ordered.

There was no documented evidence in the Nursing notes from August 2010 to February 2011 regarding the resident's weight loss.

There was no documented evidence in the Physician notes that the physician addressed or was aware of the weight loss from August 2010 to February 2011.

On 2/7/11 at 4 PM the resident was interviewed with the RN manager present. The surveyor asked the resident how she likes her supplement. The resident responded by saying that she likes the supplement and today is the first day she received it twice.

On 2/8/11 at 4:10 PM the Certified Nursing Assistant (CNA) was interviewed. The CNA stated that this resident eats okay and when you see her not eating the CNA's give her encouragement to eat her meal. The resident will tell the CNA's based on her mood if she will eat. The CNA's offer the resident an alternative, like Peanut Butter and Jelly sandwich which the resident may take.

An interview was conducted with the dietitian on 2/7/11 at 12:15 PM. The dietitian stated that she put in the order for Ensure 1 can po TID on 1/31/11 and assumed the resident was getting it three times a day, she was not aware that the resident was only receiving the Ensure once a day. The dietitian stated that she usually reviews the physician's orders and this was an oversight.

Another interview was conducted with the dietitian on 2/7/11 at 3pm. The dietitian stated that in the end of August the resident was in her desirable body weight which is her Ideal Body weight range. Since the resident was in her Ideal Body Weight range and she did not have a significant weight loss, she did not put the resident on WLMR (Weight Loss Monitoring Report). The dietitian continued by saying the resident was meeting her estimated needs with her diet and supplement. The dietitian stated that she did not follow up on the albumin level of 2.5. The Dietitian stated that when resident was 91 pounds she started the resident on Ensure Plus 8 ounces TID, Booster Diet, and LPS 15/30 30 ml BID. There is no documented evidence that resident received Ensure Plus three times a day or the LPS 15/30 (protein Supplement).

An interview with the physician was conducted on 2/8/10 at 4:05 PM, and stated that he wrote the order for Ensure once a day based on the recommendation of the transfer papers from the hospital on 1/31/11.

415.12(i)(1)

F223 483.13(b), 483.13(c)(1)(i): RESIDENTS RIGHT TO BE FREE FROM ABUSE

Scope: Isolated
Severity: Actual Harm
Corrected Date: April 15, 2011

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

Citation date: February 16, 2011

Based on observation, record review, and resident and staff interviews, the facility did not ensure that each resident was free from abuse. Specifically, resident #36 was not free from repeated incidents of inappropriate sexual behavior by resident #13, and the resident tearfully expressed that she was scared of resident #13. This was evident for 1 out of 30 sampled residents (Resident #36).
This resulted in actual harm that is not immediate jeopardy.
The finding is:
Resident #36 is a 54-year-old with diagnoses which include: Asthma and Endometrial Cancer.
The Minimum Data Set 3.0 Assessment (MDS) dated 11/24/10 documented that the resident has intact cognition.
The resident was interviewed on 2/16/11 at 10:25am. The resident stated that in late October, 2010 at approximately 3:00am, Resident #13 came into her room naked, holding his genitalia, and said "look at this." The resident said she was startled and screamed at him to get out of her room, and the night nurse came to her and tried to calm her down. The resident stated that she was nervous for the next 1 to 2 weeks because she worried that Resident #13 would try to come into her room again in the middle of the night. She would wake up and check the room during the night because Resident #13 was not on 1:1 observation. The resident further stated that about 2 weeks later, Resident #13 came into her room naked and holding his genitalia in the morning around 7:45 during her nebulizer treatment. She said she told the Licensed Practical Nurse (LPN) on duty what the resident had done. The next morning, Resident #13 attempted to enter her room again, dressed in a gown, but he got startled and left. The resident began crying as she told this information to this surveyor. She said the staff did not do anything about the incidents until she threatened to report it to the Department of Health on the day of the 3rd attempt. The resident stated that she told her brother what happened and he came to the facility and demanded to speak to the Administrator, which he did. The resident said that the staff told her they would move the resident closer to the nursing station as a resolution, but they did not ask her how she was doing or whether she felt safe. The resident said she was scared ever since the incidents occurred. When the surveyor asked the resident why she was crying, the resident stated that the incidents scared her, and she still has flashbacks about them.
A Nursing Note from Resident #13's medical record dated 10/27/10 at 2:45am documented "Resident was observed in Rm (room) [room # of Resident #36] wearing night gown and holding his private part in hands towards resident in Rm [room # of Resident #36]. Staff assisted resident to his room and staff members provided 1:1 supervision. Continue to monitor."
There was no documented evidence of the 10/27/10 incident in resident #36's medical record and/or documented evidence of interventions for resident #36 to prevent further incidents with resident #13.
A Licensed Practical Nurse note dated 11/6/10 at 8:15am in resident #13 record documented that "the

resident in Room (resident #36 room) told me that the resident come into her room and exposed his private part..."
A Licensed Practical Nurse note dated 11/6/10 at 3pm in resident #36 record documented that the resident complained that Resident #13 came into her room, exposing his private parts.
There was no documented evidence in resident #36's medical record of efforts made to protect resident #36 from resident #13.
A Nursing Note dated 11/7/10 at 8:15am in resident #36 record documented that the resident told the LPN (Licensed Practical Nurse) that Resident #13 came to her door and knocked at 8:05am, and she recognized his voice and told him to leave her alone. She stated the resident left after she told him to leave her alone.
There was no documented evidence in resident #36 record of interventions to address the repeated episodes with resident #13.
On 2/16/11 at 9:45am and 11:35am, the Registered Nurse (RN) Manager was interviewed and stated that she was not aware of Resident #13 exposing his genitalia to Resident #36 on two occasions. She stated that Resident #36 told the staff and her brother about the attempt to come into her room, and the resident was reassured that Resident #13 would be moved closer to the nursing station.
On 2/16/11 at 11:25am, the Social Worker was interviewed and stated that the resident was very disturbed by what happened, and she spoke to the resident and provided support. She further stated that she was only aware of one incident where Resident #13 came to her room and was redirected. She also stated that she was not aware that Resident #13 had ever exposed his genitalia to Resident #36. The resident's brother spoke to the Administrator about the matter, and Resident #13 was moved. The SW stated that the resident was never tearful, and she had no idea that she was fearful or continued to be upset by the incidents. She further stated that if she had known, the resident would have been referred to the psychologist so she could talk about what happened and her feelings.
The RN Risk Manager was interviewed on 2/16/11 at 1:12pm and stated that she was not informed of any incidents where Resident #13 exposed himself to Resident #36, but she recalled the incident where Resident #13 attempted to come into Resident #36's room but did not enter. She further stated that incidents reports and investigations are done for actual physical contact but not for exposing genitalia unless the resident is cognitively impaired and there is uncertainty about what occurred. She also stated that if the resident is cognitively intact, they can say whether they were touched and no report or investigation is needed. The RN Risk Manager stated that she did speak to the resident about the last incident and she did not seem upset or distraught at the time, and she said she was okay. When asked about whether acts could be abusive even if there was no touching involved, she stated that abuse could be verbal or mental.
415.4(b)(1)(i)

F456 483.70(c)(2): ESSENTIAL EQUIPMENT IN SAFE OPERATING CONDITION

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

Citation date: February 16, 2011

Based on observation and staff interview, it was determined that the facility did not ensure that equipments are maintained in a safe operating condition. Reference is made to:
1) Elevator car # 1 that was not maintained to function in a safe condition and elevator car # 4 that was noted not functioning/operable at different times.
2) Alcohol Based Hand Rub (ABHR) dispensers and soap dispenser that were not dispensing as designed.
This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During the annual environmental survey conducted from 02/04/11 to 02/09/11 between 9:00 a.m. and 3:30p.m., the following was noted in the facility:
1) On 02/04/11 at approximately 10:30am, the door to elevator car #1 was observed open in the basement level. The door was noted in this position (open) for at least 12 minutes even though buttons

(for floor levels above) had been pressed requesting/indicating that the elevator travel upwards. At the time of this occurrence, two housekeeping staffs in the basement explained that this is how elevator car #1 operates; that until another elevator car travels down to the basement and opens up, the door to elevator car #1 will remain open. When elevator cars # 2 and 3 travelled down to the basement and the doors opened, elevator car # 1 door was then observed to close and then it travelled to the floors requested/indicated. This situation was also observed (2nd observation) by a DOH staff to occur on the 2nd floor on 02/08/11. At this time, the door to elevator car #1 was noted to stay open between 2:00pm and 2:20pm (approximately). The door closed when elevator car # 3 travelled to the 2nd floor and opened up.
Furthermore, at different times on 02/07/11 and 02/08/11 elevator car #4 was observed not functioning (i.e. out of service). In an interview with the Assistant Administrator on 02/08/11 at approximately 2:25pm, he stated that the issue with elevator car # 4 would be brought to the attention of the staff from the elevator company who was present in the facility at that time. He added that elevator car # 4 was out of service from the previous day, and in the morning of 02/08/11, a staff from the elevator maintenance company had fixed it. The Director of Engineering then stated that the cause of elevator (#4) being out of service the previous day was different from the problem that made it out on 02/08/11. Ha added that the staff from the elevator maintenance company was present in the facility to address the issues with the elevators. At approximately 2:45pm that same day, the staff from P&W Elevators (i.e. the facility elevator maintenance company) stated that the previous day, elevator car # 4 had problems with the safety edge and that it had been fixed but that at that time, the issue with it is that it is going out of steps (for example if it on the 7th floor it indicates 6) and that it is also being fixed. He further stated that the problem with elevator car # 1 is the fact that its relay located upstairs is obsolete.

2) The Alcohol Based Hand Rub (ABHR) dispensers was observed to not dispense hand sanitizers when tested. Examples of locations where it was noted include but are not limited to:
i) One of two in the facility's main entrance.
ii) On the 6th floor by room 613 and also by the elevator lobby. In these locations mentions, sanitizer packs were provided in the dispensers; however, they did not dispense.
Furthermore, the soap dispenser in the 4th floor staff bathroom did not dispense soap when tested.
In an interview on 02/08/11 at approximately 2:55pm, the Assistant Administrator stated that he will instruct the maintenance staffs to address the issue. He added that he was not sure if there was any PM schedule in place to ensure that the dispensers function properly.
415.29(b)

F490 483.75: FACILITY ADMINISTERED EFFECTIVELY TO OBTAIN HIGHEST PRACTICABLE WELL BEING

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

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.

Citation date: February 16, 2011

Based on on observations, record reviews and staff interviews, the facility is not being administered in a manner in which resident's needs and environment are maintained and enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident.

This resulted in no actual harm with the potential for more than minimum harm that is not immediate jeopardy.

The findings are:

The facility has repeat deficiencies as follows:

F 241: The Administrator did not ensure that the facility promoted care for residents in a manner which

enhanced each resident's dignity.

F 246: The Administrator did not ensure that residents received reasonable accomodation of individual needs.

F 250: The Administrator did not ensure that medically related social services were provided for residents to attain or maintain their highest level of psycho-social wellbeing.

F 253: The Administrator did not ensure that resident's environment was maintained in a manner that is sanitary and comfortable.

F 323: The Administrator did not ensure that each resident received adequate supervision to prevent accidents and did not ensure that the environment was free of accident hazards.

F 325: The Administrator did not ensure that residents maintained acceptable parameters of nutritional status. This deficiency is repeated at "G" level - actual harm that is not immediate jeopardy.

F 498 The Administrator did not ensure that Certified Nurse Assistants demonstrated competency and skills necessary to care for resident's needs. This deficiency is repeated at harm level that is not immediate jeopardy.

Additionally, the facility has "G" level deficiencies (actual harm that is not immediate jeopardy) for F 223, F 226, F 323, F 325 and F 498.

415.26

F520 483.75(o)(1): FACILITY MAINTAINS QA COMMITTEE

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

Citation date: February 16, 2011

Based on observation, record review and staff interviews, the facility did not have a Quality Assessment (QA) and Assurance (QAA) program that readily and consistently identified issues that have the potential to cause harm to the residents and quality deficiencies as evidenced by:
1) not ensuring that grievances voiced at the Resident Council were addressed in a timely manner.
2) not identifying residents who lacked clothing and did not implement a program to provide clothing to those in need.
3) not identifying environmental issues within the facility and did not implement a program to ensure that repairs were done in a timely basis.

This resulted in no actual harm with the potential for more than minimum harm that is not immediate jeopardy.

The findings are:

1) F244
The facility did not ensure that grievances voiced in the Resident Council meetings were acted upon by the staff and that the resolutions were brought back to the resident's group.

The Administrator was interviewed on 2/16/11 at 11:05 AM and said that he attends the Resident Council if he is invited by its President and that the minutes from the this meeting and Floor Captain's meeting are emailed to him. He continued that the floor captains and President to monitor the issues and of the President to bring the issues forward to the Director of Recreation. He continued that if issues from the Floor Captain's meetings are not brought up again at the Resident Council meeting, that means that they have been resolved.
"Hopefully they are taken care of the right way."

2) F250:ne During the 2009 annual recertification survey, 2 residents were identified as dressed in dirty clothing. The facilities Plan of Correction included audits of residents and their clothing to address their dignity in regard to clothing. It documents that the Administrator developed an audit tool to track resident's satisfaction with the provision of Social Services and that audit finding will be presented to the QA committee quarterly with follow up as indicated. There is no documented evidence that this was done.

The Director of Social Work was interviewed on 2/14/111 at 2:30 PM and stated that the staff were on all shifts were inserviced to identify those who need clothing. He said that they had stopped working on the issue once they completed the "Plan of Correction" dated 3/10/10 and that the facility felt they had a good handle on the problem. He continued to say that he felt that the nursing department had a "good handle" on the resident's clothing needs.

The Director of Quality Assurance was interviewed on 2/16/11 at 12:20 PM and stated that they developed and ran a clothing drive and put a separate storage area in the basement to receive clothing for the residents. She did not know who went through the clothing stored in the basement to see what kind of condition it was in and did not know if anything had been done since last March.

3) F253:
During the 2009 annual recertification survey the facility was given a citation for housekeeping which included dirty ceiling tiles, shower rooms and feeding pumps and broken soap dispensers and ceiling tiles. The Plan of Correction included replacement of missing and broken tiles and broken soap dispensers and accumulated dirt on numerous floors in the facility. The Plan of Correction included daily rounds of the facility utilizing log sheets to ensure appropriate identification repair/replacement of equipment. It also documented that weekly reporting to the Administration on identified issues with findings reported to the QA committee on a quarterly basis. There is no documented evidence that this was done.

The Administrator was interviewed on 2/14/11 at approximately 3:15 PM and stated that after last years survey they began to look at the cleanliness of the tube feeding pumps and they also looked at the wheelchairs. He said that they look at the environmental issues as they come up and did not develop an audit tool. He said that they used to use a log book to monitor the environmental and housekeeping issues but they found that word of mouth worked better.

The Administrator was interviewed again on 2/16/11 at 11:05 and stated that he attends the Resident Council if he is invited by its President and that the minutes from the this meeting and Floor Captain's meeting are emailed to him. He continued that the floor captains and President to monitor the issues and of the President to bring the issues forward to the Director of Recreation. He continued that if issues from the Floor Captain's meetings are not brought up again at the Resident Council meeting, that means that they have been resolved.
"Hopefully they are taken care of the right way."

There is no documented evidence that the Quality Assurance committee continued to look at the issues and implemented appropriate plans of action for issues identified during the previous recertification survey. There is no documented evidence that issues brought to the attention of the staff during the Resident Council including the environment and staff behavior were identified for possible QA.

415.27 (a-c)

F244 483.15(c)(6): FACILITY MUST LISTEN/RESPOND TO RESIDENT/FAMILY GROUP

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

Citation date: February 16, 2011

Based on record review and staff interviews, the facility did not ensure that grievances voiced in the Floor Captains meetings and Resident Council meetings were acted upon and resolutions discussed at Resident Council meetings.

This resulted in no actual harm with potential for minimal harm.

The finding is:

The "Resident Council Floor Captains" minutes dated 2/20/10 documented that residents complained that "...maintenance staff goes on the elevators with there carts and do not let the residents get on the elevator..."; and "...staff are not allowing residents on the elevators..; they are being rude to the residents and lying to the residents when the residents ask which way the elevator is going..." These minutes further documented that one of the medication nurses talks on her cell phone while giving out medication and that another nurse was giving out the wrong medication to a resident.

The Resident Council Meeting dated 2/24/10 documented that the "Staff not allowing residents on the elevator - administrator asked that residents get names and times so that the staff may be addressed..." There is no documented evidence that the residents' complaint of staff being rude was addressed by the facility or any other plan by the facility concerning the residents issue with the use of the elevator. Additionally, the minutes further documented that the Director of Nursing was out sick and that the nursing issues were being put on hold. There is no documented evidence that the issues of the medication nurses talking on her cell phone during medication administration and a resident receiving the wrong medication was ever addressed by the facilty.

The Floor Captains minutes dated 5/5/10 documented that the residents complained that every weekend the housekeeping staff take the elevators and leave the residents waiting.

The Resident Council minutes dated 5/26/10 documented that the residents should give the names of staff members who are not allowing residents on the elevator to the housekeeping director so he could speak with them. There is no documented evidence of any plan by the facility concerning the residents issue with the elevator. The elevator problem has existed since 2/10 (3 months).

The Floor Captains minutes dated 7/22/10 documented that the residents on the 6th floor stated that the staff were rude to the residents and residents on the 3rd floor had a long wait for call bells to be answered.

The Resident Council minutes dated 7/28/10 documented that a few department heads were unable to attend the meeting and the issues concerning their departments would be checked at a later date. There is no documented evidence that the staff being rude to residents and that there were delays in answering the call bells was ever addressed the facility.

The Floor Captains minutes dated 9/28/10 documented that the residents from the 8th floor complained about the staff being rude.

The September, 2010 Resident Council Meeting was cancelled.

The Floor Captains minutes dated 10/21/10 documented that the residents had continued issues with "delayed response to the call bells"; and "Staff is frustrated and some they are not as pleasant as they have been in the past..."

The Resident Council minutes dated October 27, 2010 did not address residents complaints of staff being rude and the delay in the staff answering call bells.

There were documented Floor Captain meetings held on 11/16/2010, 1/14/2011, and 1/20/2011.

The Resident Council meeting for November, 2010 was postponed, the December, 2010 Resident Council meeting was cancelled and the January, 2011 Resident Council meeting was postponed.

The President of the Resident Council was interviewed on 2/16 /11 at 9:15 AM and stated that the Floor Captains usually meet a week before the Resident Council meeting. At the Floor Captains meetings, any issues that come up are emailed to the department heads. The department heads have a week to get them fixed. He said that if a department head does not attend the Resident Council meeting that usually means that the problem has been resolved.

The Administrator was interviewed on 2/16/11 at 11:05 AM and said that he attends the Resident Council if he is invited by its President and that the minutes from the meetings and Floor Captain's meeting are emailed to him. He continued that the floor captains and the President of the Resident Council monitor the issues and the President of the resident council bring issues forward to the Director of Recreation. He continued that if issues from the Floor Captain's meetings are not brought up again at the Resident Council meeting, that means that they have been resolved. "Hopefully they are taken care of right away."

The Director of Risk Management was interviewed on 2/16/11at 11:30 AM and stated that she will attend the Resident Council if invited. She said that she did not know the last time that she saw a copy of the Floor Captain's meeting report or Resident Council meetings and that no one brought to her attention that staff behavior had come up as an issue in any of the meetings. She continued that it would be part of her responsibility to look into this and follow up.

The ADON (Assistant Director of Nursing) was interviewed on 2/16/11 at 11:55 AM and stated that the Nursing department receives an e-mail from the Director of Recreation with issues presented at the Floor Captains meetings. They will try and resolve nursing issues prior to the Resident Council Meeting which usually takes place the following week. She said that a member of the nursing department will attend the meetings if invited or if there are unresolved nursing issues. She also stated that she was not aware of that any of the nurses had been using their cell phones when giving care or that resident's had voiced that nursing staff were sometimes rude. She continues that she had did not remember seeing minutes from the Floor Captain's meeting or the Resident Council meeting in a number of months.

The Director of Recreation was interviewed on 2/16/11 at 1:20 PM and explained that the issues are brought up at the Floor Captains meetings. All residents are invited to attend and issues discussed are emailed to the department heads for follow-up. If there is a problem within a department, the department heads are automatically invited to the Resident Council which usually takes place the following week to discuss the resolutions. She said that sometimes the resolutions are taken directly back to the individual who voiced the grievances and resolved at that time so that the Department Heads may not need to attend the Resident Council meetings.
The Director of Recreation continued that if a problem is addressed on an individuals basis and it is not brought back up again by the resident, they consider it resolved. She could not say how the resident' complaints in the group were acted upon or how resolutions to the grievances were presented when the the Resident Council meetings were cancelled.

415.5(c)(6)

F253 483.15(h)(2): HOUSEKEEPING AND MAINTENANCE SERVICES

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

Citation date: February 16, 2011

Based on observations, record reviews and staff interviews, the facility did not ensure that housekeeping and maintenance services were provided to ensure that the resident's environment was sanitary, orderly and comfortable as evidenced by: elevators were dirty, the resident rooms contained peeling paint and dirt on the window sills, exposing metal on the handrail, faded window and privacy curtains, dirty radiator covers, blankets and sheets covering windows to prevent drafts and lights not functioning in the bathroom. This was evident for 12 of 12 units.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

This is a repeat deficiency.

The findings include but are not limited to:

1.) During the tour of the 3rd floor unit on 02/04/2011 at 9:50 AM, the following observations were made:
Room 308 - A crack on the wall next to the resident's bedside table
Room 309 - a metal waste basket had rust
Room 309A - was a bariatric bed and the mattress was shorter than the bed frame. Approximately, 6 inches of the bed frame was exposed
Room 311- the window sill contained peeling paint and the window was covered with a blanket and a white bed sheet.
Room 319 - oxygen tubing, tracheal collar was observed on the bedside table without covers.

The 3rd floor dining room tables that were covered with debris and dried brownish stains. The window sill contained peeling paint. The corner of the dining room contained 2 grocery bags full of empty plastic bottles and cans, used cups and 2 boxes of Christmas decorations.

2) On the Fourth Floor Unit on 02/04/2011 at 11:15 AM, the following observations were made:
Room 401 - the radiator top was loose and contained dust and dirt.
The privacy curtain around the resident's bed was not able to be pulled completely around the bed. The window venetian blind mechanism to open and closed the blind was broken.
Room 401B - the resident has no dresser table.
Room 404 - the toilet had dried yellow stains on the stand and bowl. The window sill contained peeling paint and dirt.
Room 407 - the window sill contained dust, dried stains and peeling paints
Room 411 and 412 - radiators were dirty
Room 416 - there is a crack on the wall near the resident's head board. The curtains at the window are faded, with visible stains.
Room 417 - the tiles near the entrance way to the bathroom are multiple colors: 2 tiles are brown, 3 tiles are gray, and 2 are green - black color.
Room 420 - the radiator bottom is coming off the hinges exposing dirt.
4th floor pantry, the coffee maker, the top of the refrigerator and the ice machine scoop holder contained dirt and dust. The following rooms had thread bare and faded curtains and window blinds' mechanisms to raise and lower the blind were not functioning:
Rooms: 403, 404, 412, 413, 415, 416, 417, 418, 419, 420, 421, 422, and 423.

3) On the 5th Floor Unit on 02/04/2011 at 10:20 AM, the following observations were made:
Room 503 - window sill contained peeling paint and dirt
Room 504 - window sill with dried brownish stains and dirt.
Room 505B - the night table had a drawer missing. The resident who was in the room at the time of the observation stated "It has been missing for so many months now."
Room 509 - wall at the side of the bed had peeling paint and multiple scratches .
Room 511 - wall next to the bathroom has cracks and was dirty
Room 524-- door edge loosen at the hinges .
The handrail in the hallway near room 524 had had exposed metal measuring 1 inches by 4 feet length.
Room 526 - the window sill is covered with blanket and a bed sheet .
The resident who was in the room at the time of tour stated " it is cold, the draft is coming from there ".
The weather report on the day of the tour (according to the weather bureau) was cold and windy.

Immediate interviews with the Unit RN (Registered Nurse) Managers who accompanied the surveyor at the time of the tour of the units 3-5 all stated they call and informed the housekeeping and maintenance department if they have any housekeeping of maintenance issues on the units. They further stated that the curtains are old, faded and thread bare. One RN Manager stated "I understand your concern, we call and inform housekeeping. They come and change the curtains." She continued that they are the same curtains that are washed and returned. As you can see they are old and there is nothing much we can do about it ."

4) On 02/08/2011 at 10:45 AM, in the 15th floor dining room, it was observed that numerous tables had coffee stains, crumbs, dried juice stains, sugar and supplements.

The CNA (Certified Nursing Assistant) assigned to the 15th floor at this time was interviewed and stated "the housekeeping lady comes and clean the tables after breakfast."

The housekeeping maid was interviewed and stated that she usually cleans the area after meals but "I will

do it now. "

The Director of Maintenance/Housekeeping was interviewed on 2/14/11 and stated that he has been in his position since February of 2010 and stated that the system had changed in April of 2010. He explained that a log book is no longer kept on the floors and that all requests are called downstairs to the directly secretary or left on the voice mail. He explained that all maintenance and housekeeping staff are given forms to document that the work has been done. The forms are put on file at the end of the shifts.

The secretary for Maintenance/Housekeeping was interviewed on 2/14/11 at 2:45 PM and stated that when a call for work is received downstairs she transcribes them onto work orders.

5) On 2/4/11, during the initial tour of the 12th floor, the following was observed:
At 9:38 am, the nursing station was observed to have the laminate covering peeled off on the right and left sides, revealing the brown board underneath. The laminate that remained in the middle was cracked and had holes where pieces of the laminate had fallen off. The wallpaper and wall coverings in the hallway were streaked and stained with light brown stains throughout the corridors.
At 10:43 am, in room 1206, the wall by the window was observed to have a dent. The light fixture in the bathroom would not turn on.
At 10:43 am, the door frame outside the soiled utility room door was observed to be lifting off the wall.
At 10:46 am, in room 1202, the duct tape was observed holding the radiator cover to the wall underneath the window, and the radiator vent grate on top was covered with rust. The over-bed light covering for the " B " bed was frayed on the right side edge.
At 11:00 am, in the dayroom, the radiator cover of the right radiator was observed to be coming apart on the right side, exposing the mechanics underneath. All the radiator covers in the room had peeling paint.
At 11:04 am, the Biohazard Room was observed to have a large hole in the wall approximately 3 feet in height.
6) On 2/4/11, during the initial tour of the 14th floor, the following was observed:
At 11:25 am, the nursing station was observed with peeling and cracked laminate, exposing the brown board underneath. The walls behind the nursing station were streaked with light brown and red stains.
Room 1407 was observed to have a small amount of brown substance on the floor.
At 12:31 pm, the shower room was observed with a dirty, stained visitors chair inside. There was a dirty Hoyer lift pad in the tub. Also a broken piece from s soap dispenser was sitting on the rim of the tub.
At 12:37 pm, in room 1421, the soap dispenser in the bathroom was ripped off the wall, sitting on a chair in the tub. There was a brown spot where the dispenser used to be.
At 12:40pm, in room 1423, the soap dispenser in the bathroom was broken, and there was a bar of soap sitting in-between the sink faucets.

complaint case #:NY00094027/95042/97732
7) During the annual environmental tour conducted from 02/04/11 to 02/09/11 between 9:00am and 3:30pm, the following issues were observed:
Cracked walls were observed in rooms 301 (by bed A), 623 (by the radiator), 906 and 910 (by bed B), room 922, in the alcove by the nurse's station on the 6th , 9th and 10th floors, the 7th floor soiled utility room and the 10th floor clean linen storage room (examples not all inclusive).
8) The grouting in the 7th floor shower room and the 11th floor soiled utility room were dirty. Rust like discoloration was noted along the grout edges in the 7th floor shower room. ln room 301 bathroom, a blackish mold-like stain (measuring approximately 3 feet) was observed along the grout line (i.e. between the wall tiles and the shower tub). Also, the floor tiles in the 11th floor soiled utility room were dirty.
9) The plastic door protectors/ guards/frames in resident unit doors for example the 6th floor shower room, 9th floor shower room (by room 921), rooms 919, 921, 1202, 1219 and 1221 were either cracked or ripped. Examples not all inclusive. The door from for room 718 was dirty; in the bathroom by room 1219 the door frame was rusty. Scratch marks were observed on the door to room 920.
Broken and /or cracked wall tiles were observed on the 6th floor bathroom (by room 602), the 7th floor shower and 10th floor main shower rooms (by room 1020). The wall behind the refrigerator in the 7th floor pantry was broken. A hole was noted in the wall on the 7th floor clean linen storage and the 11th floor soiled utility room (this measured approximately 1 ft X 1 ft).
10) The cabinets in the 7th and 10th floor pantry rooms (in which disposable wares were stored) were rusty. Also, the cabinets underneath the sink in the clean utility room on the 6th , 8th (by room 818), 9th and 10th floor have their bottom edges all chipped off exposing rough edges of the sawed wood.
11) The wall paper in the corridor by room 914 was ripped. Scratch marks were noted in the wall paper in room 1006 and 1009 (behind bed A).
12) The window in room 714 was broken. An obvious gap was observed between the window and the wall i.e. the window did not fit into its track.
13) On the 11th floor the paint was chipping through out the hallway. In addition, on the 10th floor there

was paint chipped on the doors.
In an interview with the Assistant Administrator, he stated that he would assign maintenance staffs to address all environmental issues that have been brought to his attention.
This deficiency was cited in the survey of 12/18/09. The facility POC showed that corrective actions were implemented, that systemic changes will be made and monitoring/audits would be done and presented to the QA committee for evaluation and follow up. However in the survey of 2/16/11, more related findings in the 2009 SOD still exists.
415.5(h)(2)

F252 483.15(h)(1): SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

Citation date: February 16, 2011

complaint case #:NY00095377/96151
Based on observation and interview it was determined that the facility did not ensure that a clean, comfortable and homelike environment is provided to the residents. Reference is made to:
1) Dirty elevator floors
2) Stained Ceiling tiles .
3) Dusty mechanical exhaust vents.
4) Scratch marks on radiator covers and dusty radiators.
5) Ripped linoleum covering on the nurses' station desk in numerous resident units.
6) Ripped off cove bases.
7) Chipped off slip-proof strips on resident room floors.
8) Broken laundry hampers.
9) Leaking tub faucet.
10) Dirty Black slippers in the Dayroom.
This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During the annual environmental inspection conducted from 02/4 - 9/11 between 9:00am and 3:30pm, the following were observed:

1) The four passenger elevator floors were observed dirty. There was accumulation of dirt especially at the corners of the elevator floors.
2) Stained ceiling tiles were observed in locations which include but are not limited to 1st floor day room, rooms 611 (and its bathroom), 618, 1432, the bathrooms in rooms 710 and 714, room 909, the 15th floor clean utility room and in the dishwashing section in the kitchen. The ceiling tile in room 1219 was observed to bulge downwards while peeling ceiling paint (with a wet look) was observed in the 8th floor shower room. Wall paint in the 6th and 7th floor clean linen storage rooms were observed peeling.
3) Dusty mechanical exhaust vents were noted in the following areas - room 301 bathroom rooms 611, 622, 709 bathrooms, 14th floor porters closet, 15th floor alcove by the nurse's station and linen chute room. Examples not all inclusive.
4) Scratch marks were observed in the radiator covers in rooms 614, 708, 715, 716, 722, 902, 905, 915, 922, 1006, 1014, 1025, 1110, 1111, 1209, 1210, 1212 and the 9th floor day room (examples not all inclusive). Accumulation of dust underneath the radiator in room 716. Dusty radiators were observed in rooms 1109, 1210, 1510 (examples not all inclusive).
5) The linoleum covering on the nurse 's station desks in residents units (floors 4, 5, 6, 8, 9, 10, 11, 12, 14 and 15) were observed to have either peeled off completely (thereby exposing the bare wood) or ripped off at its edges. On 02/07/11 at approximately 11:25am, the Assistant Administrator stated that the facility is in the process of replacing /refurbishing the nurses' station desks, that they are working in stages and that the ones on the 3rd and 7th floor had been changed.
6) The cove bases at various locations were either completely detached from the wall or missing.

Examples of locations where such observations were made include the corridor by rooms 508, 715, 721 and by the 7th floor porter's closet.
7) The slip-proof strips on the floors of resident rooms 706, 1109 were observed chipped.
8) The laundry hamper for the residents in rooms 703 and 822 were observed broken.
9) The faucet in the tub of the 7th floor tub room was observed leaking. On 02/08/11 at approximately 11:10am, the Assistant Administrator stated that it would be fixed.
10) The bathtub enamel in room 612 had a large chip on it's edge.
11) Ceiling metal ridges and cross bars and floor tiles in the kitchen dishwashing area were rusty.
12) One pair of black men slippers were dirty with a thick layer of dust was observed in the dayroom with no label of resident's name and/or room number.
On 02/09/11 at approximately 12:10am, the Assistant Administrator stated that he had brought the issues noted through the environmental tour to the attention of maintenance staffs and that they have begun addressing all issues gradually.
415.5 (h)(1) 415.29(j)(1)

F246 483.15(e)(1): ACCOMMODATION OF NEEDS AND PREFERENCES

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

Citation date: February 16, 2011

Based on observation, record review and staff interviews, the facility did not ensure that residents received reasonable accommodation of needs and services as evidenced by not repairing the head of a bed for a resident with a breathing problem and not providing a dairy and gluten free diet for a resident who is a vegetarian and lactose intolerant. This was evident for 2 of 30 sampled residents (Residents #19, and #20).

This resulted in no actual harm with potential for more than minimum harm.

This is a repeat deficiency.

The findings are:

1) Resident #19 is a 47 year old male with diagnoses which include Gastroesophageal Reflux, Obstructive Sleep Apnea, Morbid Obesity and Hypertension.

The MDS (minimum data set) 3.0 dated 1/4/11 documented that he is cognitively intact.

The Physician's order dated 11/15/10 to 12/30/10 documented that the resident uses a BIPAP machine (bilevel positive airway pressure) at night.

The resident was interviewed on 2/7/11 at 10:30 AM and stated that the motor on his bed has been broken for about a month and he has been having trouble getting it fixed. He said that he has reported it to department heads but no one has gotten back to him on it.

The resident was observed and interviewed in his room on 2/7/11 at approximately 2:00 PM. He was siting in his wheelchair at the side of his bed which had 3 pillows on it. There was a BIPAP by the side of his bed. The resident pointed toward his bed and he stated that the motor on his bed had stopped working about 4 weeks before. He said that he cannot sleep flat and he needs to keep the head of his bed elevated when he sleeps because he has trouble breathing, which is why he is using 3 pillows. He stated that he has been using the pillows at night since the bed has not working properly. The resident continued that he had spoken to the Registered Nurse about it about a month ago and that maintenance had come up to take a look at it about a few weeks ago. The resident was told that that the motor can't be fixed and they would have to get him another one. The resident stated that nobody got back to him and no options were offered.

The Registered Nurse was interviewed on 2/7/11 at approximately 2:30 PM and said that she remembers the resident talking to her about it, although she could not remember when. She said "if he said it was a month ago it probably was" . She continued that they used to keep a log book on the floor for maintenance issues but now they are calling issues directly down to the maintenance department. She stated that she did not know of any efforts to find him a replacement bed or put other interventions into place since he first informed her that the bed was broken. She said that everything goes through the secretary of maintenance who coordinates maintenance issues in the facility.

A copy of the "Maintenance Work Order" dated 1/24/11 was sent up from the maintenance department at that time. The form docuemnted "Head of bed isn't going up or down". The "Job Resolution" documented the serial number of the motor but did not include a resolution to the problem of the bed not working.

The secretary from the maintenance department was interviewed on 2/7/11 at 2:35 PM and stated that she completed the Maintenance Work Order form on 1/24/11 but she could not say exactly when the call came in from the floor that the bed was broken "Maybe the day before". She said that requests for work go directly to the work order form and then they are assigned.

The Director of Environmental Services was interviewed on 2/7/11 at 3:00 PM and stated that his department became aware of the problem on 1/24/11. He said that the motor on the bed needs to be replaced and that someone from the company who supplies them need to come in but has not been available. He said that there was no replacement bed available to meet the resident's needs.

On 2/7/11 at 3:05PM, the resident received a new bed.

2) Resident #20 is a 48 year old female with diagnoses including Muscular Sclerosis, Gastroesophageal Reflux Disease, Depression.

The Social Work progress note dated 9/17/10 documented "...requires a vegetarian diet."

The Nutrition Assessment dated 9/13/10 documented "Allergies/Intolerances: eggs, dairy, gluten-per resident ... resident is a vegan who does not eat any animal products. Resident also does not eat any foods containing gluten. "

The 12/16/10 Nutritional Assessment documents that that the resident does not eat dairy and that resident is sensitive to foods containing gluten.

The Dietary note dated 1/14/11 documents that the resident is gluten sensitive and does not eat pasta/bread.

The Physician's order dated 1/23/11 documented Enlive 6.7 oz (ounces) daily at 2:00 PM.

The resident's meal ticket dated 2/7/11 documents "Allergic to eggs/seafood/dairy....Vegetarian".

The resident was interviewed on 2/9/11 at 1:45 AM and she said that she is lactose intolerant, has problems digesting gluten and is a vegan. She said that she told the dietician that she she does not want to eat anything with dairy in it or bread. She continued that they have given her Enlive as a supplement and she then presented the Enlive box which listed milk as one of the ingredients. She also showed the piece of whole wheat bread which she said was placed on her meal tray.

The Registered Dietician was interviewed on 2/9/11 at 3:30 PM and she said that the facility does not have a gluten free diet as one of their choices so the resident was given whole wheat bread because it has less gluten. She also said that she was not aware that Enlive was a milk product and she would look into alternatives.

415.5(e)(1)

F278 483.20(g) - (j): ACCURACY OF ASSESSMENTS/COORDINATED WITH PROFESSIONALS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.

Citation date: February 16, 2011

Based on observation, record review and interview, the facility did not ensure that a resident's assessment accurately reflected his status. This was evident for 1 of 30 sampled residents (Resident #19)

This resulted in no actual harm with potential for more than minimal harm.

The finding is:

Resident #19 is a 47 year old male with diagnoses including Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Obstructive Sleep Apnea and Morbid Obesity.

The resident was observed on 2/7/11 at 10:30 AM ambulating to his wheelchair with the assistance of a straight cane. The resident was observed and interviewed in his room on 2/7/11 at approximately 2:00 PM. At that time he stated that he is able to do almost everything for himself and the thing he needs the most help with is putting on his shoes.

The quarterly MDS (minimum data set) 3.0 dated 1/4/11 documented that the resident had unclear speech and was "rarely/never understood" and "rarely never understands".
The" Functional Status" section of the MDS documented that the resident is dependant on the staff for all of his activities of daily living including transfers, mobility, dressing, eating and personal hygiene. No mobility devices were documented on the MDS. The active diagnoses for the resident were documented as dementia, seizure disorder and cerebral atrophy.

The Comprehensive Care Plan for the resident dated 1/7/11 documented that resident is independent in his decision making with no evidence of short or long term memory impairment. It documented that he is independent in bed mobility, hygiene and eating. It documented that he uses a straight cane while walking and a wheelchair independently.

The Registered Nurse was interviewed on 2/8/11 at 11:50 AM and stated that she was not responsible for completing the MDS but that the completed MDS does not accurately refect the resident's status. She stated that the resident does not suffer from seizures and does not have cerebral atrophy. She stated that he is very independent and only occasionally needs help with his activities of daily living.

The MDS coordinator was interviewed on 2/8/11 at 12:00 noon and said that the MDS was completed by a nurse who comes in per diem. She said that she had signed off on the form after she had determined all of the sections had been completed and that her signature does not mean the form is accurate.

415.11(b)

F319 483.25(f)(1): APPROPRIATE TREATMENT FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to

correct the assessed problem.

Citation date: February 16, 2011

Based on record review and staff interviews, the facility did not ensure that a resident who displayed mental and psychosocial adjustment difficulty received appropriate treatment and services to correct the assessed problem. Specifically, the facility did not ensure that interventions were implemented and re-evaluated for effectiveness for a resident with continuous sexual behaviors/inappropiateness. Subsequently, the resident was physically abused by other residents. This was evident for 1 of 30 sampled residents (Resident #13).
This resulted in actual harm with the potential for more than minimal harm that is not immediate jeopardy.
The finding is:
Resident #13 is an 84-year-old with diagnoses which include: Alzheimer's Dementia, Hypertension, and Urinary Retention.
The Minimum Data Set 3.0 assessment (MDS) dated 11/8/10 documented that the resident had severely impaired cognition and displayed physical behaviors and other behaviors that intruded on the privacy of others.
The Comprehensive Care Plan (CCP) for Behavior dated 4/16/10 documented that the resident had a history of socially inappropriate and disruptive behaviors. This care plan did not document any interventions to address these behviors.
The "Psychiatry Follow-Up Evaluation" dated 4/19/10 documented ".... Chart reviewed & (and) staff consulted, ... wanders, intrusive towards female residents c (with) sexually inappropriate Beha (behavior) ...Assessment/Plan:.. 1 Depakote 125mg (milligrams) po (by mouth) bid (twice a day) 2 Prozac 10 mg po daily 3 will f/u (follow-up)..."
The Behavior CCP was updated on 4/19/10 with the following interventions: "Check resident for unmet needs & address, i.e. : thirst, hunger, fatigue, discomfort, pain ...Monitor & Assess behaviors/identify patterns/causes ...Engage in diversional activities i.e.: snack". Staff also updated the evaluation section, documenting that the resident verbalized sexual intentions to staff and exposed himself. An additional intervention of "Jumpsuit to be worn" was written with no dated of implementation.
The Behavior CCP was updated on 4/26/10 with the following: "Hx (history) of going to peers room @ (at) times [with] open gown & exposed genitalia ...Interventions: Provide direction in positive manner & redirect as needed ...Psych consult as per MD (physician) order ...Medications".
On 4/26/10 a second Behavior CCP for "Resident to Resident Altercation (Aggressor)" was implemented. The CCP documented: "On 4/25/10 @ 11:30am - as per statement of ...son, resident ...went to his mother's room [with] exposed genitalia. Charge nurse redirected him to his room". The CCP also documented the following Interventions: "Remove resident from situation utilizing calm approach ...Provide 1:1 supervision until calm ...Asses for injury ...Psychiatric consult as per MD ...Assess for causes of behavior ...Engage in diversional activities i.e.: music, ambulation ...Room change/unit change ...Continuous 1:1 supervision ...Keep resident apart from other resident ...1:1 observation".

The Patient Activity Log documented that the resident was moved to the fourth floor unit on 4/26/10.
The social service progress note dated 4/28/10 documented "Res (resident) on unit 4, team to monitor Res for any inappropriate Beh toward other female residents, psych did see last week w/ (with) new recom (recommendation) as per NSG (nursing). Res to Be monitored closely."
The Behavior CCP was updated on 5/14/10 with the following: "Resident was observed to be sexually inappropriate towards another resident ...Redirected immediately by staff. SW (Social Work) aware for possible unit change, 1:1 observation started pending change of unit". The CCP documented that 1:1 observation was implemented 5/14/10 and discontinued 5/27/10.
The CCP for "Resident to Resident Altercation (Aggressor)" was updated on 5/18/10 with a note that documented that there were no further incidents after 4/26/10 and 1:1 monitoring was continued.
The Patient Activity Log documented that the resident was moved to the tenth floor unit on 5/15/10.
The Behavior CCP was updated on 5/29/10 with the intervention of "Every 30 minute checks".
The Behavior CCP did not contain any new interventions to address the resident's continued behavior since 5/29/10.
A Social Services Note dated 6/14/10 documented "On this date [resident] was transferred from room ...to ...[secondary to] him being inappropriate to another resident".
The Patient Activity Log documented that the resident was transferred to the seventh floor unit on 6/14/10.
A Social Services Note dated 6/15/10 documented "...phoned resident's wife and made her aware resident has exposed himself to several women on the unit. This date resident was placed on one to one for extra support from staff".

The Behavior CCP was updated on 6/15/10 with the following note: "Resident alert and verbally responsive. Inappropriate behavior towards 3 residents on the unit. Supervisor made aware. Staff watched resident, and he is on one to one with a CNA (Certified Nursing Assistant)".
An invoice from Apparel dated 6/15/10 documented that 3 anti-stripper suits were ordered for the resident.
A Social Services Note dated 6/16/10 documented: "Res (resident) has been wandering and touching staff (Females) and other residents (Female). Res has jump suit and has not been able to disrobe; Res presents as being at risk of harm from other male resident who become angry that res touches women. Res was pushed into a chair by other male res. Room change to be done to protect res from harm".
The Behavior CCP was updated on 6/16/10 with the following note: "Continue to walk & touch female resident & staff inappropriately. On 1:1 monitoring due to behavior . Another resident attempted to choke him. No visible injuries noted".
A Social Services Note dated 6/17/10 documented that the resident was transferred to an inpatient psychiatric unit because of his inappropriate sexual behavior.
A Social Services Note dated 7/6/10 documented that the resident was readmitted and would be monitored.
The Patient Activity Log dated documented that the resident was readmitted to the seventh floor to the resident's same room.
A Social Services Note dated 7/12/10 documented that the resident was seen attempting to touch a female resident while stating sexual advances toward the resident. The note further documented that the resident was separated from the female and placed on monitoring.
A Social Services Note dated 8/20/10 documented that the resident continued to have inappropriate behavior toward female staff on a daily basis and remained on close supervision.
A Nursing Note dated 10/9/10 at 11am documented: "Touch the resident on her bottom. Behavior discourage by resident".
The CCP was not updated with any new interventions to address the resident's behavior on 10/9/10.
A Nursing Note dated 10/27/10 at 2:45am documented: "Resident was observed in Rm (room) ...wearing night gown and holding his private part in hands towards resident in (female resident's room) ...Staff assisted resident to his room and staff members provided 1:1 supervision. Continue to monitor".
The CCP was not updated with any interventions to address the resident's behavior on 10/27/10.
The Nursing Notes dated 11/6/10 at 8:15am documented: "The resident in room (resident #36)... told me that the resident came into her room and exposed his private part ...Resident was walking in the hallway and I took him into the day room".
The CCP did not document any evidence of any new interventions to address the resident's behavior on 11/6/10.
The Nursing Notes dated 11/7/10 documented: "7:35am Resident was asleep during walk through round ...7:50am ...observed resident ambulating in hallway and I took him into the dayroom ...8:15am The resident in Room (resident #36) ...told me that the resident in Room (resident #13) ... came to her door and knocked at 8:05am. She said that she recognized his voice and told him to leave her alone".
There was no documented evidence of 30 minute monitoring done for this resident.
The Activities CCP dated 12/4/09 was not updated with any interventions in attempt to provide diversional activities to address the resident's behaviors.
There was no documented evidence that staff attempted to find new diversional activities as the behaviors continued.
The resident's complete medical record dated from April 2010 to September 2010 was missing. There were no nursing notes available for this timeframe.
On 2/14/11at 11:50am, the Therapeutic Recreation Leader (TR) #1 that was assigned to resident upon admission was interviewed and stated that she kept resident seated next to her in order to divert any behaviors during group activities like Bingo, bowling, ball toss, and trivia. She further stated that she did provide magazines and the resident's wife visited often at that time.
On 2/14/11 at 12:00pm and 2/16/11 at 1:03pm, the Registered Nurse (RN) Manager #1 was interviewed and stated that all diversional activities were provided by recreation. She further stated that the resident's behaviors should be reported to the nurse so they can be documented in the progress notes by nursing. She also stated that she did not recall the resident having any sexual preoccupation prior to the first incident, and he was put on 1:1 immediately and transferred to another unit.
On 2/16/11 at 9:45am, the RN Manager #2 was interviewed and stated that the resident was provided with a jumpsuit while on her floor, which he wore during the day. She further stated that the resident was on 1:1 initially for about a month and then was on close monitoring and 30 minute observation. She also stated that the resident did not wear the jumpsuit at night, but he was still on monitoring when he entered the room of another resident and exposed himself. She stated that diversional activities provided were talking, reading the newspaper, television, and radio.
On 2/16/11 at 12:21pm TR#2 was interviewed and stated that she would try to keep the resident away from other residents and try to engage him in sing-along and 1:1 discussion groups. She further stated

that the resident was not able to participate in physical activities and did not show interest in coloring or reading magazines placed in front of him. She also stated that the resident had a jumpsuit within 2 weeks of coming to her floor and she never witnessed him touching other residents, just verbally inappropriate behavior. TR#2 stated that she did not work with nursing on coming up with new activities or diversional activities to address the resident's behavior.
On 2/16/11 at 12:35pm the CNA that provided 1:1 supervision on 6/16/10 was interviewed and stated that she did not witness the incident because she went to lunch. She further stated that it is common practice that if there is not enough staff to cover the 1:1, the CNA providing the 1:1 can leave the resident in the day room during lunch in order to take a lunch break. The CNA also stated that she left the resident in the day room for lunch, and that the CNAs in the day room are familiar with the resident's behaviors.

415.12(f)(1)

F514 483.75(l)(1): CLINICAL RECORDS MEET PROFESSIONAL STANDARDS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

Citation date: February 16, 2011

Based on record reviews and staff interviews, the facility did not ensure that the medical record was complete and accurately documented. This was evident for 1 of 30 sampled residents (Resident #13).

The finding is:

Resident #13 is an 84-year-old with diagnoses which include: Alzheimer's Dementia, Hypertension, and Urinary Retention.
The Minimum Data Set 3.0 assessment (MDS) dated 11/8/10 documented that the resident had severely impaired cognition and displayed physical behaviors and other behaviors that intruded on the privacy of others.
There was no documented evidence of the resident's complete medical record from April 2010 to September 2010.
On 2/14/11 at approximately 5:20pm, the Assistant Director of Nursing was interviewed and stated that no other portions of the resident's chart have been located. She further stated that medical records has searched and it is possible that portions of the chart have been misfiled.

415.22(a)(1-4)

F160 483.10(c)(6): CONVEYANCE OF RESIDENT FUNDS UPON DEATH

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

Citation date: February 16, 2011

Based on record review and staff interviews, the facility did not ensure that the resident's personal funds were convey to a resident within 30 days of discharge. This was noted for 1 of 3 closed records. (Resident #28).

This resulted in no actual harm with potential for more than minimal harm.

The finding is:

Resident #28 was admitted to the facility with diagnoses including Seizure Disorder, Chronic Obstructive Pulmonary Disease and Anxiety.

Record review reveals that the resident was discharged to an assisted living facility on 10/26/10.

A review of the accounting ledger for this resident dated 12/31/11 documented that she still had a balance in her account of $55.03.

The Director of Finance was interviewed on 2/14/11 at 2:20 PM and he stated that a check should have been issued within 30 days of her discharge. He said that he gets the information about discharges from the facility through various sources including census reports and social services. He said that he is the one ultimately responsible.

415.26(h)(5)(iv)

F468 483.70(h)(3): CORRIDORS HAVE FIRMLY SECURED HANDRAILS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must equip corridors with firmly secured handrails on each side.

Citation date: February 16, 2011

Based on observation and staff interview it was determined that the facility did not ensure that:
1) The handrails provided were firmly secure to the wall .
2) Handrails were not missing in joints/sections of the corridor .
This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During the annual environmental inspection conducted from 02/04/11 to 02/09/11 between 9:00am and 3:30pm, the following was observed:
1) The handrails provided in the resident unit corridors were not firmly secure; they were loose to touch. Examples of locations where these observations were made include but are not limited to the corridor by the 6th floor linen chute and by the 6th floor elevator lobby, by room 719, the 8th floor porters' closet (opposite room 802), 9th and 10th floor corridors by the elevator lobby.
2) Also, corner pieces/sections of handrails were missing in areas which include but are not limited to on the 7th floor corridor by the staff coat room.

In an interview with the Assistant Administrator on 02/08/11 at approximately 11:15am, he stated that he will instruct the Maintenance staff to address all issues with the handrails immediately.

10NYCRR 415.29

E722 402.6(d): CRIMINAL HISTORY RECORD CHECK TEMPORARY APPROVAL PENDING RESULTS/ SUPERVISION REQUIRED

Scope: Isolated

Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

Section 402.6 Criminal History Record Check Process. ..... (d) A provider may temporarily approve a prospective employee while the results of the criminal history record check are pending. The provider shall implement the supervision requirements identified in section 402.4 of this Part, applicable to the provider, during the period of temporary employment.

Citation date: February 16, 2011

Based on record review and staff interviews, the facility did not ensure that newly hired employees were supervised while waiting for Criminal History Record Check (CHRC). This was evident for 6 employees hired by the facility in the past four months.

This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1) Staff #1, a Certified Nursing Assistant, was hired on 1/18/11. Staff #1 worked from 1/21/11 to 2/12/11 with no documented evidence that the staff was supervised and monitored.

2) Staff #2, a Certified Nursing Assistant, was hired on 1/18/11. Staff #2 worked from 1/26/11 to 2/12/11 with no documented evidence that the staff was supervised and monitored.

3) Staff #3, a Certified Nursing Assistant, was hired on 1/18/11. The staff # 3 worked from 1/22/11 to 2/11/11 with no documented evidence that the staff was supervised and monitored.

4) Staff #4, a Certified Nursing Assistant, was hired on 1/18/11. Staff #4 worked from 1/21/11 to 2/05/11 with no documented evidence that the staff was supervised and monitored.

5) Staff #5, a Certified Nursing Assistant, was hired on 1/18/11. Staff #5 worked from 1/21/11 to 2/11/11 with no documented evidence that the staff was supervised and monitored.

6) Staff #6, a Certified Nursing Assistant, was hired on 1/18/11. SSSSff # 6 worked from 1/23/11 to 1/24/11 with no documented evidence that the staff was supervised and monitored.

There was no documented evidence of supervision for these six staff members prior to receiving the CHRC final response letter.

An interview with the Human Resources/Administration Personnel, was conducted on 2/11/11 at 10:30 AM. He stated that he is responsible for getting the paper work, profile and hiring the agency workers (such as CNA's, food service workers and housekeeping). Once the agency workers come to work at the facility he would then provide the information to the CHRC Appointed person to do the criminal history background check.

F241 483.15(a): DIGNITY

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must 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.

Citation date: February 16, 2011

Based on observations, record reviews and staff interviews the facility did not promote care for a resident in a manner that enhances the resident's dignity. Specifically, a resident who requires assistance with dressing was observed wearing a sweater with holes in it The sole of the sneaker the resident was wearing

on her right foot was coming apart at the heel.
This involves the following residents but not limited to (Resident #18).

The finding is:

Resident #18 is a 52-year-old re-admitted 9/30/08 with diagnoses which include: Seizure Disorder, Schizophrenia, Depression, Obesity, and History of Subarachnoid Hemorrhage with Ventriculo-Peritoneal Shunt placement.

The Minimum Data Set 3.0 Assessment (MDS) dated 1/21/11 documented that the resident has severe cognitive impairment and requires limited assistance of one person for dressing.

On 2/7/11 at 11:33am, the resident was observed sitting in day room. She had two small holes in the back of her sweater. The sole of the sneaker on her right foot was coming apart at the heel.

On 2/8/11 at 4:15pm, the resident's clothing was observed in her closet and drawers. The resident had 1 pair of boots (too small), 1 pair of darco shoes (mismatched in size), 1 pair of underwear, 3 bras (1 was tattered with holes in it), 10 pairs of pants, 13 shirts (many which were sleeveless and summer weight), and 9 skirts. Some of the clothes were faded.

There was no documented evidence in the medical record that social services was working on obtaining clothing or money for the resident.

There was no documented evidence that attempts were made to obtain clothing from the resident's family.

On 2/8/11 at 10:00am, the Certified Nursing Assistant (CNA) assigned to the resident was interviewed and stated that the resident did have 2 holes in her sweater yesterday, but she likes the sweater. She further stated that she noticed the resident's sneakers were getting worn but had not informed the nurse so new ones could be ordered. The CNA stated that the resident is not able to wear the boots in the closet because they are too small. She also stated that there is a clothing sale two or three times per year and the CNAs are asked to write down what the resident needs, but the resident does not get any items.

On 2/8/11 at 3:39pm, the resident's Social Worker (SW) was interviewed and stated that the resident has not had any money since re-admission in 2008 because her brother has been receiving her Social Security checks but denies having any money for the resident. She further stated that the brother has not been seen since October 2010 and she has been in contact with Social Security to get the resident's funds transferred to the facility. The SW stated that she was aware that the resident needed clothing and new shoes, but the facility does not receive a lot of donated clothing in plus sizes. She further stated that she has discussed the resident's issues with clothing with the Director of Social Work in the department meetings.

On 2/8/11 at 4:35pm, the Director of Social Work was interviewed and stated that when a resident has no money and is in need of clothing, he requests permission from the Administrator to obtain petty cash in order to allow staff to purchase the clothing needed. He further stated that he did not do this for the resident.

415.5(a)

Based on observations, record reviews and staff interviews the facility did not ensure to maintain residents dignity and respect in full recognition of his or her individuality. The facility did not provide appropriate clothing for the residents. This involves the following residents but not limited to (Resident #18).

This resulted in no actual harm with the potential for more than minimal harm.

This is a repeat deficiency.

The findings are:

F469 483.70(h)(4): MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

Citation date: February 16, 2011

Based on interviews conducted and record review, it was determined that the facility did not maintain an effective pest control program to ensure that the facility is free of pests. Reference is made recent sightings of pests in the facility as indicated in the pest logs and resident interview. .
This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The findings are:

complaint case #:NY00096454

In an interview conducted with resident # 1 on 02/08/11 at approximately 3:12pm, she stated that residents sight roaches in the shower rooms and that the previous day she sighted a baby roach in the bathroom in her room. She added that if baby roaches are still being sighted, then it is evident that the adult roaches are not far away.

A review of the pest logs maintained in the nurses' station on the resident units reveals that there had been pest sightings in various locations of the facility in recent times (especially between November, 2010 and January, 2011) For example, the logs show the various sightings in the dates and locations indicated:
1/27/11 a mouse on the 11th floor (1102)
1/23/11 a mouse was 15th floor (1517)
1/18/11 roaches on the 11th floor (1120)
1/16/11 mice in the 14th floor day room.
1/12/11 mice on the 14th floor day room and hall way
1/12/11 roaches sighted in rooms 907, 910, 916 and 9th floor pantry
1/10/11 mice in rooms 1402, 1407, 1420, 14th floor nurses' station and shower room; and
1/7/11 rats on the 10th floor (1006). Examples not all inclusive.

On 02/08/11 at approximately 2:30pm Assistant Administrator stated that the facility is contracted with a company called All States Pest Control and that they are responsible for addressing the issues with Pest control in the facility. He added that they come in weekly and that there is a book (i.e. the pest log) maintained in every resident unit, at the nurses' station, in which all complaints of pest sightings and issues are recorded. He further stated that when the staff from the pest control company comes to the facility, he goes over the complaints logged into the pest logs at the nurses' station on the residents' units and addresses those areas; he then addresses other areas as needed. Finally, he stated that the personnel for the pest company had gone through the entire building and sealed up the radiators and points of entry of pests.
In an interview with the Director of Engineering on 02/08/11 at approximately 2:45pm, he stated that there are instances of pest sightings in the facility and that the different construction works going on close to the facility contributes to this.

415.29(j)(5)

F250 483.15(g)(1): MEDICALLY RELATED SOCIAL SERVICES

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Citation date: February 16, 2011

Based on observation, record reviews, and resident and staff interviews, the facility did not ensure that medically-related social services to attain or maintain the highest practicable physical, metal, and psychosocial well-being of each resident were provided. Specifically, assistance to obtain appropriate clothing was not given to residents with torn, worn, and ill-fitting clothing (Resident #18), and discharge planning options and social services were not provided to a resident that was medically stable (Resident #21). This was evident for 2 of 30 sampled residents (Residents #18, and #21).

This resulted in no actual harm with potential for more than minimal harm.

This is a repeat deficiency.

The findings are:

1) Resident #18 is a 52-year-old re-admitted 9/30/08 with diagnoses which include: Seizure Disorder, Schizophrenia, Depression, Obesity, and History of Subarachnoid Hemorrhage with Ventriculo-Peritoneal Shunt placement.

The Minimum Data Set 3.0 Assessment (MDS) dated 1/21/11 documented that the resident had severe cognitive impairment and required the limited assistance of one person for dressing.

On 2/7/11 at 11:33am, the resident was observed sitting in the day room. She had two small holes in the back of her sweater. The sole of the sneaker on her right foot was coming apart at the heel.

On 2/8/11 at 4:15pm, the resident's clothing was observed in her closet and drawers. The resident had 1 pair of boots (too small), 1 pair of Darco shoes (mismatched in size), 1 pair of underwear, 3 bras (1 was tattered with holes in it), 10 pairs of pants, 13 shirts (many which were sleeveless and summer weight), and 9 skirts. Some of the clothes were faded.

There was no documented evidence in the medical record that social services was working on obtaining clothing or money for the resident.

There was no documented evidence that attempts were made to obtain clothing from the resident's family.

On 2/8/11 at 10:00am, the Certified Nursing Assistant (CNA) assigned to the resident was interviewed and stated that the resident did have 2 holes in her sweater yesterday, but she likes the sweater. She further stated that she noticed the resident's sneakers were getting worn but had not informed the nurse so new ones could be ordered. The CNA stated that the resident is not able to wear the boots in the closet because they are too small. She also stated that there is a clothing sale two or three times per year and the CNAs are asked to write down what the resident needs, but the resident does not get any items.

On 2/8/11 at 3:39pm, the resident's Social Worker (SW) was interviewed and stated that the resident has not had any money since re-admission in 2008 because her brother has been receiving her Social Security checks but denies having any money for the resident. She further stated that the brother has not been seen since October 2010 and she has been in contact with Social Security to get the resident's funds transferred to the facility. The SW stated that she was aware that the resident needed clothing (sometimes she does not have a bra on) and new shoes, but the facility does not receive a lot of donated clothing in plus sizes. She further stated that she has discussed the resident's issues with clothing with the Director of Social Work in the department meetings.

On 2/8/11 at 4:35pm, the Director of Social Work was interviewed and stated that when a resident has no money and is in need of clothing, he requests permission from the Administrator to obtain petty cash in order to allow staff to purchase the clothing needed. He further stated that he did not do this for the resident.

2) Resident #21 is a 50-year-old with diagnoses which include: Aortic Stenosis, Aortic Perivalvular Leak with Bioprosthetic Aortic Valve, and History of Endocarditis.
The Minimum Data Set 3.0 Assessment (MDS) dated 11/4/10 documented that the resident had intact cognition and was independent with transfers, ambulation, dressing, and eating.
On 2/11/11 at 11:55 am, the resident was interviewed and stated that he had not seen his social worker since last year. He further stated that no one had ever discussed his discharge planning options with him, but he would like to be independent and live in a rented room or apartment in the future.
A Social Work Quarterly Evaluation dated 1/10/11 documented that the resident was uncertain about whether he had a preference to return to the community or discuss discharge plans. The evaluation also documented that the social worker would assist the resident with securing concrete services and assist

with discharge planning at the resident's request.
On 2/11/11 at 1:10pm, the Social Worker (SW) was interviewed and stated that she had not seen the resident since last year, but the social work interns have seen the resident and completed the MDS assessments. She further stated that she completed her assessments from the verbal reports that the interns provided from what they discussed with the resident. In addition, the SW stated that, since his last surgery, the resident had not been coming to see her and seemed more complacent. She said that she did not know that he was interested in discharge.

415.5(g)(1)(i-xv)

F225 483.13(c)(1)(ii)-(iii), (c)(2) - (4): NOT EMPLOY PERSONS GUILTY OF ABUSE

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Citation date: February 16, 2011

Based on resident interview, record review, and staff interviews, the facility did not ensure that all alleged violations of abuse or neglect were investigated, or thoroughly investigated and that the residents were protected to prevent further potential abuse. This was evident for 3 of 30 sampled residents (Residents #6, #13, and #17) and 1 out-of-sample resident (Resident #36).
This resulted in no actual harm with potential for more than minimal harm.
The findings include but are not limited to:
1) Resident #6 is an 81-year-old readmitted to the facility on 12/28/10 with diagnoses which include Right Subdural Hematoma, Dementia, Hypertension, and Renal Mass.

The Minimum Data Set 3.0 Assessment (MDS) dated 1/3/11 documented that the resident has severe cognitive impairment, and is totally dependent on staff for eating, dressing, transfers, personal hygiene, and bathing.

The Comprehensive Care Plan (CCP) for Accidents dated 10/19/09 included the interventions of low bed, mattress at bedside, PT/OT (Physical Therapy/Occupational Therapy) evaluation, and bed alarm.
The Certified Nursing Assistant Resident Care Plan Directives dated August 2010 documented that as of 10/5/10 the resident required the use of a Hoyer lift and 2 persons to transfer from bed to wheelchair. It also documented that the resident had a bed and chair alarm.
The Daily Bed/Chair Alarm Check Sheet dated 11/6/10 did not contain resident's name for having alarms that needed to be checked.
Nursing Notes on 11/7/10 at 6:43 am documented "Resident observed on floor in room lying on his (R) (right) side on (L) (left) side of bed. [No] visual injuries, denies pain. Able to move ...extremities. Alert, confused ...Monitor closely by staff " .
The A/I (Accident/Incident) dated 11/7/10 contained an incomplete CNA (Certified Nursing Assistant) statement that was blank for all questions regarding alarms used and if they were in place, bed in lowest position, and whether mats were used and in place.
The Daily Bed/Chair Alarm Check Sheet dated 11/7/10 did not contain the resident's name for having

alarms that needed to be checked.
Nursing Notes dated 11/8/10 at 2:20am documented "Resident observed on (L) side of bed on his (L) side. [No] Visible injuries ...denied pain. No distress noted ...to be monitored closely by staff ...Resident tends to lean to (L) side of bed ...Instruct staff to make sure Resident is positioned to middle of bed " .
A Nursing Note dated 11/8/10 at 6:30am documented "Bed alarm functioning and in place on bed."
A Nursing Note dated 11/8/10 at 6:40am documented "son notified of incident. Wants a mat placed on floor and 1 side rail. Will f/u (follow-up).
The CNA Statement dated 11/8/10 did not address the questions regarding alarms and floor mats used and if they were in place.
Nursing Notes dated 12/21/10 at 11:40am documented "While in the process of medication pass, writer heard a loud thud coming from the elevator. Upon my investigation writer observed resident lying on the floor in front of wheelchair. Nurse also observed a superficial cut (2cm) (centimeter) to forehead with minimal bleeding... NP...notified ordered to transfer resident to hosp (hospital) ...for CT (CAT scan) of the head."
The Radiology Report, from the hospital, dated 12/21/10 documented " CT Head Without Contrast ...Impression: Large mixed right subdural, small left acute posterior and tentorial subdural. Possible trapped left lateral ventricle " .
The following statements were attached to the A/I dated 12/21/10:
1) The CNA Statement dated 12/21/10, written by CNA #1, documented: " Resident was sitting in w/c in the hallway. I took resident from the hallway and was wheeling him to the dayroom when he fell forward out of the chair " .
2) A Statement Form dated 12/24/10, written by CNA #2, documented that CNA #2 was assigned to the resident on 12/21/10. CNA #2 wrote that she noticed a few days prior that the resident's pant leg got caught in the foot rest of the w/c while he was doing his " foot dance. " The statement further documented that the Resident always put his feet on the floor, and she notified the nurse.
3) An addendum, dated 12/21/10, was written by the Registered Nurse (RN) Risk Manager on the back of CNA #1s statement and documented: " I removed his leg rest because he was moving his legs around and it banged against the leg rest. His feet was resting on the metal of footrest so I removed them. I saw the therapist on the unit and was going to show him, but [resident] fell before I could do it " .
The Nursing Supervisor's Review of Accident/Incident dated 12/24/10 documented: " ...Upon investigation, resident has behavior of placing his feet on the ground off the leg rest. Staff removed leg rest upon noticing that resident legs were resting on the metal base of same to avoid injury. Resident was due for evaluation by rehab on same day. Staff was unable to prevent fall. Resident does not keep his feet on the leg rest and would often be seen dancing his legs around ...Corrective Action: Transferred to hospital for evaluation; Rehab evaluation; 72hr (hour) bed mobility evaluation; Stop drop to footrest of wheelchair " .
There was no statement included from the staff regarding how the resident was able to fall out the wheelchair or how the resident was positioned in the wheelchair.
There was no documented evidence that the incident was thoroughly investigated to determine how the resident was able to fall out of the wheelchair while being supervised by the CNA.
On 2/8/11 at 12:57pm, the Registered Nurse (RN) Risk Manager was interviewed and stated that the statement added on the back of CNA #1s statement was made by CNA #2. She further stated that although the cause of how the resident fell was unknown, she does not believe the leg rests could have prevented the fall. She also stated that she could have obtained a statement from the nurse that problems were reported.
On 2/10/11 at 3:30pm, the Director of Nursing was interviewed and stated that she realizes that the CNAs should be in-serviced. She further stated that she was preparing an in-service with the Rehab Director on positioning because she was aware that it was a problem, but it has not been completed yet.
2) Resident #13 is an 84-year-old with diagnoses which include Alzheimer's Dementia, Hypertension, and Urinary Retention.
The Minimum Data Set 3.0 assessment (MDS) dated 11/8/10 documented that the resident had severely impaired cognition and displayed physical behaviors and other behaviors that intruded on the privacy of others.
The Behavior CCP was updated on 4/19/10 with the following interventions: " Check resident for unmet needs & address, i.e. : thirst, hunger, fatigue, discomfort, pain ...Monitor & Assess behaviors/identify patterns/causes ...Engage in diversional activities i.e.: snack " . Staff also updated the evaluation section, documenting that the resident verbalized sexual intentions to staff and exposed himself. An additional intervention of " Jumpsuit to be worn " was written with no dated of implementation.
The Behavior CCP was updated on 4/26/10 with the following: " Hx (history) of going to peers room @ (at) times [with] open gown & exposed genitalia ...Interventions: Provide direction in positive manner & redirect as needed ...Psych consult as per MD (physician) order ...Medications " .
On 4/26/10 a second Behavior CCP for " Resident to Resident Altercation (Aggressor) " was implemented. The CCP documented: " On 4/25/10 @ 11:30am - as per statement of ...son, resident ...went to his

mother's room [with] exposed genitalia. Charge nurse redirected him to his room " . The CCP also documented the following Interventions: " Remove resident from situation utilizing calm approach ...Provide 1:1 supervision until calm ...Asses for injury ...Psychiatric consult as per MD ...Assess for causes of behavior ...Engage in diversional activities i.e.: music, ambulation ...Room change/unit change ...Continuous 1:1 supervision ...Keep resident apart from other resident ...1:1 observation " .
The Patient Activity Log dated 2/14/11 documented that the resident was moved to a different unit on 4/26/10.
There was no incident report or investigation for this occurrence for the resident or the victim of his sexual behavior.
The Patient Activity Log dated 2/14/11 documented that the resident was moved to a different unit on 5/15/10.
A Social Services Note dated 6/14/10 documented: " On this date [resident] was transferred from room ...to ...[secondary] to him being inappropriate to another resident " .
There was no documented evidence of the nature of the incident that occurred that led to a room change for the resident.
There was no documented evidence that an incident report and investigation was done regarding any incident around 6/14/10 for the resident or the victim. There was no documented evidence that the victim was counseled or protected to ensure that no abuse occurred.
A Social Services Note dated 6/15/10 documented: " ...phoned resident's wife and made her aware resident has exposed himself to several women on the unit. This date resident was placed on one to one for extra support from staff " .
The Behavior CCP was updated on 6/15/10 with the following note: " Resident alert and verbally responsive. Inappropriate behavior towards 3 residents on the unit. Supervisor made aware. Staff watched resident, and he is on one to one with a CNA (Certified Nursing Assistant) " .
There was no documented evidence that there were any occurrence reports and investigation made for the resident or the 3 unidentified victims. There was no documented evidence that the 3 victims were protected and that the facility ensured that they were not negatively affected by the incidents.
A Social Services Note dated 6/16/10 documented: " Res (resident) has been wandering and touching staff (Females) and other residents (Female). Res has jump suit and has not been able to disrobe; Res presents as being at risk of harm from other male resident who become angry that res touches women. Res was pushed into a chair by other male res. Room change to be done to protect res from harm " .
The Behavior CCP was updated on 6/16/10 with the following note: " Continue to walk & touch female resident & staff inappropriately. On 1:1 monitoring due to behavior. Another resident attempted to choke him. No visible injuries noted " .
A Social Services Note dated 6/17/10 documented that the resident was transferred to an inpatient psychiatric unit because of his inappropriate sexual behavior.
A Social Services Note dated 7/6/10 documented that the resident was readmitted and would be monitored.
The Patient Activity Log dated 2/14/11 documented that the resident was readmitted to the same room.
There was no documented evidence that measures were taken to ensure that the resident was separated from his aggressors because the resident was readmitted to the same room.
A Social Services Note dated 7/12/10 documented that the resident was seen attempting to touch a female resident while stating sexual advances towards her. The note further documented that the resident was separated from the female and placed on monitoring.
There was no documented evidence that any occurrence report and investigation was done for the resident or the female resident he touched on 7/12/10
A Nurses' Note dated 10/9/10 at 11am documented: " Touch the resident on her bottom. Behavior discourage by resident " .
There was no documented evidence that an occurrence report and investigation were done for the resident or the female resident he touched.
A Nursing Note dated 10/27/10 at 2:45am documented: " Resident was observed in Rm(room) ...wearing night gown and holding his private part in hands towards resident in Rm ...Staff assisted resident to his room and staff members provided 1:1 supervision. Continue to monitor " .
There was no documented evidence that an incident report and investigation were done for the resident and victim (Resident #36) of his sexual behavior on 10/27/10.
Nursing Notes dated 11/6/10 at 8:15am documented: " The resident in room ...told me that the resident came into her room and exposed his private part ...Resident was walking in the hallway and I took him into the day room " .
There was no documented evidence that an incident report and investigation were done for the resident and the victim (Resident #36) of his sexual behavior on 11/6/10.
Nursing Notes dated 11/7/10 documented: " 7:35am Resident was asleep during walk through round ...7:50am ...observed resident ambulating in hallway and I took him into the dayroom ...8:15am The resident in Room ...told me that the resident in Room ... came to her door and knocked at 8:05am. She

said that she recognized his voice and told him to leave her alone " .
There was no documented evidence that an incident report and investigation were done for the resident and victim (Resident #36) of his behavior on 11/7/10.
The Assistant Director of Nursing stated that the resident's entire medical record could not be found from April 2010 to September 2010. There were no nursing notes available for that timeframe.
On 2/10/11 at 6:50pm the Registered Nurse (RN) Risk Manager was interviewed and stated that she could not find any other incident reports for the resident or the victims. She further stated that the documentation regarding touching another resident in the 6/16/10 incident report must be an error, and she was not aware that the resident was exposing his genitalia to other residents or touching other residents. She also stated that if he touched other residents, there should be an incident report and investigation.
On 2/11/11 at 3:20pm, the Social Worker (SW) that was assigned to the resident from 6/14/10 to 1/11/11 was interviewed and stated that she was informed from the previous Social Worker that the resident had an incident with another resident on his previous floor. She was not aware of the nature of the incident. She further stated that the resident touched a cognitively impaired female resident on her knee on 6/16/10 and she provided support, but the female resident is unable to remember. The SW also stated that she was only aware of the resident exposing himself to staff.
On 2/16/11 at 9:45am, the RN Manager was interviewed and stated that the resident usually touched the sexual parts of females and expressed what he wanted to do to them sexually. She further stated that occurrence reports and investigations are done when someone has been touched, but I do not think the resident touched anyone because he was always prevented from doing so.
3) Resident #36 is a 54-year-old with diagnoses which include: Asthma and Endometrial Cancer.
The Minimum Data Set 3.0 Assessment (MDS) dated 11/24/10 documented that the resident had intact cognition.
The resident was interviewed on 2/16/11 at 10:25am. The resident stated that in late October 2010 at approximately 3:00am, Resident #13 came into her room naked, holding his genitalia, and said " look at this " . The resident said she was startled and screamed at him to get out of her room, and the night nurse came to her and tried to calm her down. The resident stated that she was nervous for the next 1 to 2 weeks because she worried that Resident #13 would try to come into her room again in the middle of the night. She would wake up and check the room during the night because Resident #13 was not on 1:1 observation. The resident further stated that about 2 weeks later, Resident #13 came into her room naked and holding his genitalia in the morning around 7:45 during her nebulizer treatment. She said she told the Licensed Practical Nurse (LPN) on duty what the resident had done. The next morning, Resident#13 attempted to enter her room again, dressed in a gown, but he got startled and left. The resident began crying as she told this information to this surveyor. She said the staff did not do anything about the incidents until she threatened to report it to the Department of Health on the day of the 3rd attempt. The resident stated that she told her brother what happened and he came to the facility and demanded to speak to the Administrator, which he did. The resident said that the staff told her they would move the resident closer to the nursing station as a resolution, but they did not ask her how she was doing or whether she felt safe. The resident said she was scared ever since the incidents occurred. When this surveyor asked the resident why she was crying, the resident stated that the incidents scared her, and she still has flashbacks about them.
There was no documentation in the resident's medical record of any incident in October 2010.
A Nursing Note from Resident #13's medical record dated 10/27/10 at 2:45am documented: : " Resident was observed in Rm (room) [room # of Resident #36] wearing night gown and holding his private part in hands towards resident in Rm [room # of Resident #36]. Staff assisted resident to his room and staff members provided 1:1 supervision. Continue to monitor " .
There was no documented evidence that an investigation was done or that attempts were made to protect the resident.
A Nursing Note dated 11/6/10 at 3pm documented that the resident complained that Resident #13 came into her room, exposing his private parts.
There was no documented evidence that an investigation was done and efforts were made to protect the resident.
A Nursing Note dated 11/7/10 at 8:15am documented that the resident told the LPN that Resident #13 came to her door and knocked at 8:05am, and she recognized his voice and told him to leave her alone.
There was no documented evidence that an investigation was done and efforts were made to protect the resident.
On 2/16/11 at 9:45am and 11:35am, the Registered Nurse (RN) Manager was interviewed and stated that she was not aware of Resident #13 exposing his genitalia to Resident #36 on two occasions. She stated that Resident #36 told the staff and her brother about the attempt to come into her room, and the resident was reassured that Resident #13 would be moved closer to the nursing station.
On 2/16/11 at 11:25am, the Social Worker was interviewed and stated that the resident was very disturbed by what happened, and she spoke to the resident and provided support. She further stated that

she was only aware of one incident where Resident #13 came to her room and was redirected. She also stated that she was not aware that Resident #13 had ever exposed his genitalia to Resident #36. The resident's brother spoke to the Administrator about the matter, and Resident #13 was moved. The SW stated that the resident was never tearful, and she had no idea that she was fearful or continued to be upset by the incidents. She further stated that if she had known, the resident would have been referred to the psychologist so she could talk about what happened and her feelings.
The RN Risk Manager was interviewed on 2/16/11 at 1:12pm and stated that she was not informed of any incidents where Resident #13 exposed himself to Resident #36, but she recalled the incident where Resident #13 attempted to come into Resident #36's room but did not enter. She further stated that incidents reports and investigations are done for actual physical contact but not for exposing genitalia unless the resident is cognitively impaired and there is uncertainty about what occurred. She also stated that if the resident is cognitively intact, they can say whether they were touched and no report or investigation is needed. The RN Risk Manager stated that she did speak to the resident about the last incident and she did not seem upset or distraught at the time, and she said she was okay. When asked about whether acts could be abusive even if there was no touching involved, she stated that abuse could be verbal or mental.
4) Resident #17 is a 97 year old female with the diagnosis that include Dementia, Depression, Anxiety Disorder, Hip Fracture, Osteoporosis, and Diabetes.

The MDS 3.0 dated 12/8/10 documented moderately impaired cognition with short term memory problem.

The nurses' notes dated on 2/15/10 at 11:20 PM documented "resident came to nurses station upset says that there is a man in her room who wants to touch her. Brought to dayroom comforted resident. Afraid, crying reassured allowed to ventilate. Brought back to bedroom. Reassured and put back to bed. No further episode. To be follow up.

The nurses' notes dated on 2/15/10 at 10 AM documented "CNA reports that resident states " A man came in my room last night and pushed his finger in my panties; trying to have sex with me." Resident interviewed by the nurse manager and reported the same. Manager, Social Worker, the CNA'S of the evening tour for previous day - they reported that there was no visitors to resident and that resident has been saying "I want sex" for sometime now. Manager placed resident for a psychiatric evaluation for further follow up".

The nurses' notes dated on 2/17/10 at 6 PM documented "Resident in dayroom had supper was calm conversing with all at table during supper. Medicated went to bed. Noted teary eye saying "the man touched me in my private area." Agitated, crying and talking loudly. Calmed continued to ventilate becoming more and more agitated. Asked to go to the dayroom, agreed brought resident to dayroom informed staff and monitored until 10PM calmed escorted back to room no further period of agitation or talks of a man".

There is no documented evidence that these incidents were investigated.

An interview with the Charge Nurse that works the shift 3:30 PM to 11:30 PM was conducted by phone on 2/9/11 at 12:15 PM. The charge nurse stated that the resident came out of her room and was crying. The charge nurse went into her room and consoled the resident. The charge nurse calmed her down and reassured the resident that there was no stranger there. When these incidents occur they would have the resident sit near the nursing station or dayroom and would monitor her. The charge nurse stated she would document the incidents in the chart and would make the supervisor aware. There were no accident or incident reports done. The process is that you inform the supervisor and the supervisor would follow up and an accident and incident report would be initiated. The Charge Nurse stated that the resident was never sexually preoccupied, that is not the type of person she is. The resident never stated she wanted sex.

An interview with the Registered Nurse Consultant who was the Director of Nursing when these incidents occurred was interviewed on 2/9/11 at 1:20 PM. She stated that she recalls that the nurse manager at the time who no longer works in the facility verbally stated that she interviewed all the evening staff. The Registered Nurse consultant continued to state "that the resident stated that a man came in her room and pushed his finger in her panties." She continued to state that the evening supervisor passed the report to the day supervisor who did the investigation.

There is no documented evidence that an investigation was conducted.

An interview with the Director of Nursing Services (DNS) was conducted on 2/9/11 at 11:25 am. The DNS stated there were no investigation conducted for the incidents of sexual abuse.

A family interview was conducted with the daughter on 2/11/11 at 10 AM. The daughter stated that when the incident occurred the mother described the situation that you believed it really happened. The mother still speaks about the situation, the last time she spoke about it was three weeks ago.

415.4(b)(1)(ii)

F161 483.10(c)(7): SURETY BOND OR OTHER ASSURANCE

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

Citation date: February 16, 2011

Based on record review and staff interviews it was determined that the facility did not purchase a Surety Bond or have another mechanism in place to assure the security of the residents' personal funds deposited with the facility.

This resulted in no actual harm with potential for minimal harm.

The finding is:

The Administrator was asked to provide a copy of the financial statements showing the amount of resident funds on deposit with the facility and documentation showing how these funds are protected on 2/14/11.

On 2/14/2011 at 3:00PM the Administrative Assistance submitted the requested financial statements of patient fund as of 02/14/2011. The account balance totaled $ 349,554.55.

The facility submitted a copy of the insurance. The insurance was titled Certificate of Property Insurance and the insured is Bay Park Center For Nursing And Rehabilitation LLC.

The Facility administrator was interviewed on 02/14/2011 at 3:45 PM and stated " that is the surety bond; we included crime and patients' funds at the amount of $1,000.000."

415.26(h)(5)(v)

K29 NFPA 101: HAZARDOUS AREAS - SEPARATION

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

Citation date: February 16, 2011

Based on observation and interview, it was determined that the facility did not ensure that the door to a hazardous area was designed and maintained to be self-closing or automatic closing. This was evidenced by the linen chute door not maintained to self close in that there were numerous bags of soiled linen wedged between the chute door and its frame.

The findings include:
On February 7th 2011 at approximately 12:00 pm, the following was observed:
The door to the linen chute room was noted to be propped open with a bag of dirty laundry. Upon closer inspection it was noted that the soiled linen room was overflowing with soiled linen. The door to the soiled linen chute was noted to be propped open with bags of soiled linen as well.

In an interview with Director of engineering at approximately 12:15 pm on 2/7/11, he stated that the housekeeping staff comes around approximately 3 times per shift to remove the soiled linen to prevent the blockage. He further stated that he would inform the housekeeping staff of the present situation so that something can be done immediately. The director of Engineering also stated that the linen chute door is equipped with a fusible link for the door to be shut in the event of fire, however he doubts the door would close due to the overload of soiled linen bags, wedged within the door frame.

711.2 (a) (1)

K62 NFPA 101: SPRINKLER SYSTEM MAINTENANCE

Scope: Pattern
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

Citation date: February 16, 2011

1998 NFPA 25 Chapter 2-2.1.1
Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g. upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.
2-3.2* Gauges.

Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced
2-3.3* Alarm Devices.
Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type water flow devices, and pressure switches that provide audible or visual signals shall be tested quarterly.

Based on observation and staff interview, it was determined that the facility did not ensure that the automatic sprinkler system is maintained, inspected, and tested as required by NFPA 25 in that:
1) Sprinklers in the kitchen section were corroded.
2) The sprinkler system flow test was not being conducted as per code requirement (i.e. on a quarterly basis).
3) No documentation was presented to show that the pressure gauges for the sprinkler system were tested (calibrated) and/or replaced in the past five years.
This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

On 02/04/11 between 9:00am and 12:00pm, the sprinkler heads in the kitchen area were noted corroded. In an interview with the Director of Dietary services on the same day at approximately 9:55am, she stated that she will bring it to the attention of the Director of Engineering.

Also, during the review of facility's maintenance logs on 02/08/11 between 1:00pm and 3:30pm, no documentation was presented to show that the pressure gauges for the sprinkler system had been tested (calibrated) and/or replaced within the last five years. Furthermore, it was observed that the sprinkler maintenance documentation provided (showing when the flow test was done) was dated from 09/16/10 to 01/25/11. This document showed that the sprinkler flow test was done in 11/18/10. No other documentation was available or provided to show if any other flow tests were conducted in the past

calendar year. The waterflow test for the sprinkler system should be conducted on a quarterly basis.

In an interview with the Assistant Administrator on the same day at approximately 2:40pm, he stated that he did not know when last the sprinkler gauges were changed and that there are no other records to provide. He stated that the last Director of Engineering was licensed and he did his own tests, had his own logs, and that those logs were unavailable at this time of the survey. Finally, the Assistant Administrator stated that going forward, they will ensure that the necessary tests are being done and the logs maintained.

1998 NFPA 25; 2-1
10 NYCRR 711.2 (a) (1)

K18 NFPA 101: CORRIDOR DOORS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.

Citation date: February 16, 2011

Based on observation and staff interview, it was determined that the facility did not ensure that corridor doors are maintained to resist the passage of smoke and that there is no impediment to closing. Reference is made to the main door to the kitchen and the double doors leading to the loading dock, both located in the basement. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.
The findings are:
During the LSC inspection conducted on 02/04/11 at approximately 9:45am, the main door to the kitchen was observed to not close tightly/properly to resist the passage of smoke. The door rubs off against the kitchen floor and this impedes it from closing. Also, on 02/09/11 at approximately 11:40am the double doors leading to the loading dock was observed to not close tightly. One door leaf is noted with a loose hinge hence it overlaps the other leaving a gap of approximately inch between the door leaves.
In an interview with the Director of Dietary Services on 02/04/11 at approximately 9:50am, she stated that she will bring the issue to the attention of the Director of Engineering. On 02/09/11 at approximately 11:45am the assistant administrator stated that he will instruct the maintenance staff to fix the problem with the doors leading to the loading dock immediately.
711.2 (a) (1)

K160 NFPA 101: EXISTING ELEVATOR REQUIREMENTS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2

Citation date: February 16, 2011

Based upon observation and staff interview, it was determined that the facility did not ensure that two (2) of six (6) facility elevators were equipped with the fire fighters service phase I and phase II recall systems in accordance with ASME/ANSI A 17.3. Reference is made to the two elevators that are not equipped with the smoke detector automatic recall.
This resulted in no actual harm but with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

During the LSC survey conducted between 02/04/11 to 02/09/11, the facility is provided with six elevators equipped with the fighters key recall. On 02/09/11 between 12:00pm and 1:00pm, the facility elevators were tested using the 2nd floor elevator lobby smoke detectors in order to determine if they were equipped with the smoke detector automatic recall.
The 1st and 2nd observations (at approximately 12:30pm and 12:47pm) revealed that elevator car numbers 2 and 5 were not equipped with the smoke detector automatic recall as they continued normal service, particularly in the upward direction, upon testing (for example elevator car # 2 moved from the 5th to the 12th floor during the 2nd observation).

In an interview with the Director of Engineering on 02/09/11 at approximately 12:50pm, he stated that there is probably a problem with elevator car #2 and that the staffs from the elevator maintenance company were in the facility at that time; the Assistant Administrator then added that it will be fixed immediately.
At approximately 2:25pm that same day, the Director of Engineering stated that the elevator maintenance company is working on the communicator for elevator car # 2 and that once the work is completed, they will retest the elevator that day.

711.2 (a) (1)

K45 NFPA 101: EXIT LIGHTING

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

> Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

Citation date: February 16, 2011

Based on observation and interview, it was determined that the facility did not ensure that the continuous illumination of exit discharge is provided by arranging lighting fixtures so that the burning out any single lighting fixture (bulb) will not leave the area in darkness.

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings include:
On February 7th 2011, between 9:30 AM to 3:00 PM, it was observed that the exit discharge area from at least the South side exit stair is provided with only one lighting fixture containing only one bulb. The arrangement or number of illuminated fixtures/bulbs provided at all exit discharges must be such that the burning out of any one fixture or any one bulb will not leave the area in darkness. On February 7, 2011, at approximately 1:00 PM, the facility's Director of Engineering stated that all exit discharges will be provided with multiple illumination fixtures or the lighting fixture will contain multiple bulbs so that the continuous illumination of exit discharges will be ensured at all times.

711.2 (a) (1)

K54 NFPA 101: SMOKE DETECTOR MAINTENANCE

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3

Citation date: February 16, 2011

Based on observation and staff interview, it was determined that the facility did not ensure that smoke detectors are inspected in accordance with the requirements of NFPA 101 9.6.1.3. Reference is made to the lack of records for inspection of smoke detectors. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.
The findings are:
During the review of facility documentation on 02/08/11 between 12:00pm and 3:30pm, no documentation for the semiannual inspections of the smoke detectors was available for review upon request. Sensitivity testing for the smoke detectors was done on 09/15/10 and the previous one in 08/14/09; however, no inspection of the smoke detectors was done.
In an interview with the Assistant Administrator on 02/08/11 at approximately 2:35pm, he stated that the document he had was for the sensitivity testing, and that the required inspection was not in effect prior to the survey. He added that going forward, he will ensure that smoke detector inspections and testing are done as per requirements.
1999 NFPA 72 7-3.1 711.2 (a) (1)

Z560 713-1: STANDARDS OF CONSTRUCTION FOR NEW EXISTING NURSING HOME

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 15, 2011

Citation date: February 16, 2011

713-2.5(4)
Based on observation and interview it was determined that the facility did not ensure that the call system was provided in that the 9th and 10th floors pantry rooms and in the 9th floor clean and soiled utility rooms call systems did not registered a visual signal when tested. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.
The findings are:
During the annual environmental inspection conducted on 02/07/11 between 9:00am and 3:30pm, the call system was observed to not register a visual signal in the 9th and 10th floors pantry rooms and in the 9th floor clean and soiled utility rooms
In an interview on 02/07/11 at approximately 12:10pm, the Assistant Administrator stated that they will change the call bell light bulbs since they had the bulbs in house.

K70 NFPA 101: SPACE HEATERS

Scope: Pattern
Severity: Potential for no more than Minimal Harm
Corrected Date: April 15, 2011

Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8

Citation date: February 16, 2011

The following requirement of the Life Safety Code has been previously waived. Repeat waivers are granted based on previous justifications by the owner, previous NYSDOH and USDHHS reviews and certification that the conditions under which the waivers have been granted have not changed. Include your request for renewal of this waiver or plan of correction in the space provided on this form.

42 CFR 483.70(a):

Life Safety Code 19.7.8, SS:B

K 70 S/S=B

In the basement, at least two gas burning space heaters are installed and used in the dietary storage area. Fuel burning space heaters are not permitted in nursing homes.

711.2 (a)(1)

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Page last modified: February 20, 2015