STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335275	A. BUILDING _____ B. WING _____	04/04/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAPPHIRE NURSING AT WAPPINGERS	37 MESIER AVENUE WAPPINGERS FALLS, NY 12590

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during a recertification survey, the facility did not ensure for 1 of 5 residents (#18) reviewed for dignity that care was provided in a manner to maintain dignity. Specifically, the resident's urinary (Foley) catheter drainage bag was not concealed to prevent direct observation by other residents, families, and guests to maintain dignity and privacy. The findings are: Resident #18 has [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS; a resident's assessment and screening tool) dated 10/21/17 indicated that the resident had severely impaired cognition, required assistance of one person for most aspects of activities of daily living and had an indwelling Foley catheter. The resident was observed on the following dates and times in a four-bedded room with three other residents: - 3/22/18 at approximately 11:00 AM, the resident was in bed and the urine bag was observed hanging over the bed rails filled with dark urine and was visible to other residents and visitors from the hallway. - 3/25/18 at about 12:00 PM was in bed with a urine bag fully exposed and was visible from the hallway to other residents and visitors. The unit Licensed Practical Nurse (LPN) was interviewed on 3/29/18 at 10:45 AM and she stated that she is not certain if staff were informed to use a cover over the Foley catheter drainage bag while the resident is in bed and conveyed to the surveyor that she understood that privacy and dignity could be compromised. The resident was observed again on 4/4/18 in bed with the Foley catheter drainage bag containing urine and fully exposed to others in his room and to those entering the room, and partially to those in the hallway passing by. 415.5(a)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on interview and record review conducted during a recertification survey, the facility did not ensure that it fully implemented the investigation component of its abuse prohibition protocol for 1 of 3 residents (#25) reviewed for abuse, neglect and mistreatment. Specifically, the facility did not thoroughly investigate an allegation that a staff member hit resident #25 to rule out abuse and mistreatment. The findings are: Complaint #NY 417 The facility's policy and procedure on Abuse and Neglect - Clinical Protocol section on Cause Identification dated 12/2017, stated that the staff will investigate alleged occurrences of abuse and neglect to clarify what happened and identify possible causes. The facility's Investigation Guide stated that it is important that the facility investigations are thoroughly investigated. Statements from roommates, volunteers, visitors and any other individuals who may have been in the area the incident took place and may have been a witness to the incident must be obtained. The Record of Complaint dated 1/1/18 documented that another resident reported to Resident #25's family member that a staff member hit Resident #25. This record indicated that statements were gathered from staff members, body audit was completed and the physician was consulted. The conclusion/findings of this record revealed that the resident who reported the incident to the family member has severe cognitive deficits as well as confusion and was not considered to be a reliable source of information and that there was no evidence to support the claim of the resident who reported the alleged incident and that this complaint was unsubstantiated. The Social Worker (SW) who investigated and wrote the report of 1/1/18 was interviewed on 3/28/18 at 1:50 PM. The surveyor brought to her attention that the conclusion that the allegation was not substantiated was made without any evidence that attempts were made to identify potential witnesses who could have known something about this incident. The SW stated that staff should have been interviewed. The Administrator concurred with this on 4/4/18 at 4:16 PM. There was no documented evidence that statements were obtained as to who was on the unit, who possibly had contact with the residents or who witnessed anything across all shifts at least the day or evening close to the date of the allegation. Potential witnesses were not identified and no other method of validating the allegation such as viewing video was attempted in accordance with the facility's policy and procedure on investigation of allegations of abuse, neglect or mistreatment. The facility administrator was interviewed on 4/4/18 at 4:16 PM and stated that this procedure should have been done. 415.4
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during a recertification survey, the facility did not develop and implement a comprehensive person-centered care plan with measurable objectives, time frames and interventions for 1 of 7 residents (#11) reviewed for limited mobility. Specifically, a palm protector splint (used to protect the skin and prevent contractures and [DIAGNOSES REDACTED] of the hand) was not applied in accordance with the physician's orders [REDACTED].>The finding is: Resident #11 was readmitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (a comprehensive resident assessment tool) of 12/23/17 documented that the resident has severely impaired cognition, had functional limitation of range of motion of both upper and lower extremities, and required extensive to total assistance of one person with most aspects of activities of daily living. The physician order [REDACTED]. The comprehensive person-centered care plan for at-risk for skin breakdown and range of motion / activities of daily living (ADL) dated 2/1/18 indicated that the resident was at risk for skin breakdown. These care plans did not include the use of a palm protector or any type of splints.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) The Treatment Administration Record (TAR) for (MONTH) (YEAR) noted documentation for the right-hand palm protector as tolerated. The (MONTH) (YEAR) Resident Care Card (provides instructions to Certified Nurse Aides about the type and level of care to provide the resident) documented the use of right hand palm protector. The CNA accountability sheet attached to this care card revealed there was no section for the assigned CNAs to sign off that the palm protector was applied as ordered. The resident was observed on 3/22/18 at 1:29 PM. The resident did not move his right upper extremity and there was no palm protector splint in place. Further observations on 3/30/18 at 10:34 AM and on 4/3/18 at 2:14 PM revealed there was no device applied to the right hand. The Corporate Occupational Therapist (OT)/Rehabilitation Coordinator was interviewed on 4/3/18 at 1:30 PM and stated that the use of the palm protector splint may be documented on the skin and ADL care plans. The Comprehensive Care Plan was reviewed with the coordinator and, at that time, did not find any documentation addressing the use of any splint or palm protector. Following surveyor inquiry, the coordinator added the use of the palm protector on the care plan for at-risk for skin breakdown. The assigned CNA was interviewed on 4/3/18 at 1:45 PM and stated that the right hand palm protector went bad from washing and had deteriorated so it was being replaced. The CNA stated that the palm protector had been gone for about 4 weeks. The assigned OT was interviewed on 4/3/18 at 2:30 PM and she stated that no one had told her that the resident needed a replacement for the resident's right hand palm protector. 415.11(c)(1)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during a recertification survey, the facility did not ensure that the comprehensive person-centered care plans were revised for (1.) 1 of 7 residents (#18) reviewed for limitation of Range of Motion (ROM) and (2.) 1 of 3 residents (#255) for closed records review on hospitalization . It was determined for Resident #18 that the care plan was not revised to address the resident's behavior of removing and refusing to wear the hand splint in order to determine other alternative interventions if possible. For resident #255, the care plan was not revised to determine possible reasons for the resident's significant weight loss in order to implement timely measures. The findings are: 1. Resident #18 has [DIAGNOSES REDACTED]. According to the Annual MDS dated [DATE], the resident has severely impaired cognition, requires extensive assistance of one person with most aspects of activities of daily living (ADL) and has a limitation of range of motion on his upper extremities to include shoulder, elbow, wrist, and hand. The comprehensive person-centered care plan was initiated on 1/3/18 for the use of a hand splint. This care plan documented the resident's non-compliance and refusal in participating and completing his ADLs, food and fluid intake, and with use of the hand splint. The resident was observed on multiple occasions without a hand splint in the morning of 3/25/18, 3/26/18, 3/29/18 and on 4/4/18. Two Certified Nursing Aides (CNA #10 and #12) were interviewed on 3/29/18 at 2:18 PM and stated that they have not seen the resident with a splint for a while. Two other CNAs (#8 and #11) stated the splint was never present and that they will ask Physical Therapy (PT). The CNA Resident Care Card for (MONTH) (YEAR) did not indicate the use of a splint. The Rehabilitation Director was interviewed on 4/4/18 at 10:43 AM and she stated that the resident no longer wears the splint because he refuses to wear it. She further stated that nursing was supposed to monitor the resident for an increase in his contractures and report back to Physical Therapy, but nursing staff never did. The care plan was not revised to provide the resident with other possible alternative interventions to avoid contractures and prevent further decline in limitation in range of motion. 2. Resident #255 has [DIAGNOSES REDACTED]. The resident was discharged to the hospital on [DATE]. The Quarterly Minimum Data Set (a resident assessment and screening tool) dated 9/25/17 revealed the resident had severely impaired cognition, was totally dependent with assistance of one for eating, had no swallowing problems, was 59 inches tall and weighed 116 pounds, no known significant weight loss or gain, and the nutrition approach was mechanically altered/therapeutic diet. The Nutrition Care Plan initiated on 4/4/17, and updated on 11/8/17, had goals that the resident will take in adequate nutrition and fluids to meet needs as evidenced by consuming more than 75% of meals and the resident will maintain usual body weight of 120 +/- 5 pounds and no weight decline. Interventions to achieve these goals include supplements such as superfoods with meals and snacks, review menu choices by observation, monitor labs as available and for signs and symptoms of altered hydration, difficulty chewing/swallowing/or oral problems, and monitor weekly weights for one month and then monthly. On 11/8/17 when the care plan was updated, it indicated that the resident's weight was 114#, appetite appeared to be stable and meal acceptance continued to vary. The Dietary progress note dated 11/8/17 revealed the resident had inadequate oral intake, breakfast intakes were poor, regular mechanical soft diet with thin liquids; Ensure plus 240 ml; Hi-Cal 90 ml three times a day, 2:00 PM peanut butter and jelly on soft, crust-less bread; Magic Cup 4 oz daily with lunch, and Mighty Shake with breakfast and dinner. Supplement acceptance for Ensure plus was 25-50% as reported, Hi-Cal 50-100%, Magic Cup 50-100%, and to continue present plan of care. Monthly and weekly weights (in pounds) recorded on the following dates revealed: - 6/2017 - 120.8 - 7/2017 - the weight was not available - 8/15/17 - 117.6 - 9/26/17 - 115.4 - 10/24/17 - 116.4 - 11/20/17 - 106.0 (a significant weight loss of 7%) Prior to 11/20/17, the physician progress notes [REDACTED]. Laboratory tests were done including urinalysis with culture and sensitivity to determine the presence of infection and blood tests and to increase fluids to 240 cc during meals, and change the meal consistency to pureed diet. There were no other dietary interventions to address the weight loss. The nursing notes of 11/25/17 revealed that the resident's appetite was poor. On 11/26/17, it was noted the resident was confused, with poor appetite, slight pink-tinged urine, with difficulty swallowing. The resident continued to have poor appetite and intravenous fluids were initiated on 11/27/18. The resident was then transferred to the hospital on [DATE] for [MEDICAL CONDITION] (refers to high sodium level in the blood which can be caused by dehydration, medications and renal condition). The Director of Nursing (DON) was interviewed 3/30/18 at 9:40 AM and stated that when a resident is not eating or drinking the nurse must inform the nursing supervisor (NS); the NS then informs the DON who then contacts the physician. The physician then puts interventions in place which will include informing the Registered Dietitian (RD). When asked if the resident's significant weight loss of more than 5% between 11/2/17 114# and 106# 11/20/17 was addressed, the DON reviewed the record and stated that she did not see any documentation of the resident's significant weight loss noted in the nurses or medical notes. The RD was interviewed in the morning of 3/30/18 and stated that nursing must provide the RD or the Diet Technician (DT) with a verbal report of any significant weight losses. The RD stated that she was not notified of the weight loss or she would have looked at it right away. The unit Nurse Manager who was responsible in communicating weight changes to the DON was interviewed on 4/3/18 at 4:00 PM and stated that she was not employed by the facility at the time of resident's stay in the facility and that the previous nurse manager was no longer employed in the facility. The DT was interviewed on 4/04/18 at 2:04 PM and stated that she did not recall being informed that the resident had had a

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) significant weight loss. The Medical Director was interviewed on 4/04/18 at 3:35 PM and stated that she could not recall if she was told of the resident's significant weight loss, and that if she had been informed, she would have evaluated resident for the etiology of the weight loss. 415.11(c)(2)((i-iii)
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during a recertification survey, the facility did not ensure for 1 of 7 residents (#11) reviewed for positioning and limited mobility that appropriate treatment and services were provided to improve and/or prevent a further decrease in range of motion (ROM). Specifically, Resident #11 did not have a palm protector splint applied on his right hand as ordered by the physician. The finding is: Resident #11 was readmitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS; a comprehensive resident assessment tool) of 12/23/17 documented that the resident has severely impaired cognition, had functional limitation of range of motion of both upper and lower extremities, and required extensive to total assistance of one person with most aspects of activities of daily living. The physician order [REDACTED]. The comprehensive person-centered care plan for at-risk for skin breakdown and range of motion / activities of daily living (ADL) dated 2/1/18, and updated on 3/2018 indicated that the resident was at risk for skin breakdown. The care care plans did not make mention of the use of a palm protector or any type of splints. The Rehabilitation evaluation notes dated 2/1/18 documented functional limitation of ROM upper extremity noted on right side. The (MONTH) (YEAR) Resident Care Card (which provides instructions to Certified Nurse Aides about the type and level of care to provide the resident) documented the use of right hand palm protector. The CNA accountability sheet attached to this care card revealed there was no section for the assigned CNAs to sign off that the palm protector was applied. The Treatment Administration Record (TAR) for (MONTH) (YEAR) noted documentation for the right-hand palm protector as tolerated and was signed off on for the 7 AM - PM shift on 3/22/18 and was not signed on 3/30/18 for the 7 AM-3 PM shift. The resident was observed on the following dates and times: - 3/22/18 at 1:29 PM, the resident was sitting in bed and no palm protector was noted in his right hand. - 3/30/18 at 10:34 AM, the resident was in bed, and no palm protector was noted in his right hand. - 4/03/18 at 2:14 PM, resident was out of bed in recliner in a unit common area, and no palm protector was observed in his right hand. The Corporate Occupational Therapist (OT)/Rehabilitation Coordinator was interviewed on 4/3/18 at 1:30 PM and stated that the use of the palm protector splint may be documented on the comprehensive care plan (CCP) under the skin and ADL care plans. The CCP was reviewed with this coordinator and at that time and did not find any documentation addressing the use of the splint. Following surveyor inquiry, the coordinator added the use of the palm protector on the care plan for at-risk for skin breakdown. The assigned CNA was interviewed on 4/3/18 at 1:45 PM and stated that the right hand palm protector went bad from washing and had deteriorated so it was being replaced. The CNA stated that the palm protector had been gone for about 4 weeks. The assigned OT was interviewed on 4/3/18 at 2:30 PM and she stated that no one had told her that the resident needed a replacement for the resident's right hand palm protector. 415.12(e)(1)(2)
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a recertificaiton survey, the facility did not ensure for 1 of 3 residents (#18) reviewed for urinary catheter or Urinary Tract Infections [MEDICAL CONDITION] that the necessary care and services were provided to prevent recurrent UTIs. Specifically, when the resident began to show a pattern of UTIs, no other measures other than the routine measures already in place were implemented to prevent future episodes. The findings are: Resident #18 has [DIAGNOSES REDACTED]. The nurses notes revealed the following dates when the resident was treated with an antibiotic for a UTI: 6/1/17, 7/24/17, 10/24/17, 12/29/17, 1/28/18 and 3/10/18. The comprehensive person-centered care plan for (MONTH) (YEAR) revealed plans for the use of a Foley catheter and for urinary incontinence. Both plans included a goal addressing UTIs. The Foley catheter care plan dated 12/28/17 noted the goal for the resident was to have decreased risk for UTIs. The interventions to achieve this goal included monitoring intake and output and input, catheter care every shift, changing Foley catheter every 30 days and as needed, if noted with decreased drainage, irrigate catheter and follow-up with the physician or Nurse Practitioner (MD/NP) as needed; follow infection control practices for catheter care and monitor for signs and symptoms of UTI. The Urinary Incontinence care plan dated 1/3/18 noted that the resident is to be free from UTI. The interventions documented on this care plan were for urology consult as needed, observe for skin breakdown, review and administer medications per MD/NP order, encourage adequate fluids, monitor labs and diagnostic testing as scheduled and report to MD as indicated, monitor for signs and symptoms of UTI, monitor for change in bladder function and report as indicated, urine [MEDICATION NAME] and/or culture and sensitivity as indicated, reassess urinary status as indicated and the use of a Foley catheter. The above interventions were routine measures for the care related to the use of a urinary catheter and/or the prevention of a UTI related to incontinence. The NP was interviewed in the morning of 3/29/18 to determine why other than those above-mentioned interventions were not implemented to address the ongoing episodes of UTIs. The NP stated that on 3/23/18 she had requested a urology consultation to address changing of the Foley catheter and use [MEDICATION NAME] interventions to address the recurrent UTIs. She offered no explanations as to why this was not done earlier to prevent further UTIs. 415.12(d)(1)
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews and record review conducted during a recertification survey, the facility did not ensure that sufficient nursing staff was consistently provided for 13 of 19 residents interviewed individually who expressed complaints regarding lack of sufficient staffing, delay in and not receiving care in a timely manner; for 7 out of 7 residents who attended a group meeting (5 of these residents were interviewed individually plus 2 additional residents); and according to records for actual Certified Nurse Aide (CNA) to Resident ratio and staffing levels that were frequently below the levels determined by the facility assessment to be necessary to meet the needs of the residents. The findings are: a. Resident Interviews: During individual interviews conducted at various times during the initial phase of the survey on 3/22/18, 3/23/18 and

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) 3/26/18, 12 out of 19 residents interviewed confidentially stated that the facility did not have sufficient staff. The residents stated they: - don't get to go to bed in the evenings when they want to; - at times, only one CNA (Certified Nurse Aide) on duty at night on each unit resulting in slow response time; - must wait a long time for assistance; - need more CNAs for turning and to get them out of bed by noon; - timely toileting is an issue; - it takes as long as an hour after ringing the call bell to get help which occurs mostly on the 3-11 PM shift and that it does not seem to matter if it is a weekday or a weekend. - sat on bedpans for more than 2 hours; some aides say they are coming back to help you, but they never came back; - on some weekends, they do not get washed; - wait a long time for call bell to be answered and end up urinating in the bed at times; and - must wait half hour to be assisted to the bathroom and they will try to do it by themselves because I don't want to do it in my clothes. During the group meeting conducted on 3/23/18, all seven residents in attendance reported that due to lack of sufficient staff, showers were not done when scheduled. Additionally, three residents stated that call bells were not responded to timely. b. Observations During the initial tour of the facility on 3/22/18, Resident #33, who is alert and oriented, was observed in bed at about 11:30 AM requesting to get out of bed and was complaining that he was wet. On Sunday, 3/25/18 at 11:40 AM, two CNAs were assigned to the North unit and a CNA and a Certified Occupational Therapy Assistant, who was working as a CNA, were assigned to the South unit. The following was observed on 3/25/18: - Resident #44 was observed in bed on the North Unit at 11:45 AM and was asked why she was still in bed. The resident stated that she was waiting for help all morning to get up. - At about 11:50 AM on the North Unit, Resident #39 was heard yelling for someone to get him out of bed. When interviewed at that time, he told the surveyor that he had been yelling for help since 8:30 AM while pointing to the clock on his wall. - Additionally, on the North Unit, four residents were observed in bed in a four-bedded room at 12:00 PM. The Licensed Practical Nurse (LPN) on the unit stated that three of these residents were still in bed because of lack of staff. One of these residents (#33) stated that he wanted to get up and that he was wet. The LPN on the unit provided one of these residents a bed bath after 12 noon. - At about 12:10 PM, three cognitive impaired residents on the South Unit were still in bed. The nursing staff stated that they were still in bed because of lack of staff. - The lunch trays arrived on the South Unit at 12:25 PM. At 12:55 PM, four residents, who needed assistance, were not yet served. Further observation revealed that on 3/28/18 at 10:41 PM on the North Unit, Resident #39 was heard yelling for someone to get him out of bed. When interviewed at that time, he told the surveyor that he had been yelling for help since 8:30 AM while pointing to the clock on his wall. c. Staff Interviews - CNA #2 was interviewed on 3/28/18 at 12:15 PM and stated that she is frequently responsible for 13 residents on the day shift. When there are only 2 CNAs, she is not able to complete the showers. She also stated that she has to work overtime frequently. - CNA #3 was interviewed on 3/28/18 at 12: 20 PM and stated that she is frequently responsible for 15 residents on the day shift. She stated that at those times assigned showers were not done and that she felt rushed. She stated she is required to work a lot of overtime which she reported to management and management's response was that there was a lot of call-ins and there was no one to come in. - CNA #4 was interviewed on 3/28/18 at about 2:30 PM and stated that when there are 3 CNAs on the unit she is usually assigned to 10 residents on the day shift. Lately there has been less than 3 CNAs a lot and also a lot of call-ins. As a result, she stated that she does not get to do cares in a timely manner and not able to get the residents up on time based on their preferences. - CNA #5 was interviewed on 3/28/18 at 2:48 PM and she stated that frequently there are only 2 CNAs on the unit and when there are only 2 CNAs she is not able to spend adequate time with the residents. She stated that some residents get out of bed late and she had difficulty meeting their small individual needs. - CNA #6 was interviewed on 3/28/18 at 5:12 PM and stated that recently there have been only 2 CNAs on the unit. When there are 2 CNAs she is not able to take breaks and she has to rush sometimes and is not able to give showers. She reported this to her supervisor who told her to do the best she can. She stated further she has been required to work a lot of overtime since the former Director of Nursing (DON) left. - CNA #7 who is assigned to the night shift was interviewed on 3/28/18 at 5:25 PM and stated that some residents are assigned to the night shift for morning care. She is not able to provide this care when there are only 2 CNAs on the night shift. - The Administrator was interviewed on 4/4/18 at about 4:00 PM and stated that the goal is to have 6 CNAs on the day shift. The former DON left on 3/9/18 and a lot of nursing staff left around the same time. The Administrator stated there have been a lot of call outs to include during the days of the recertification survey, which is unique. The Administrator further stated that the facility is actively recruiting CNAs. She noted that the facility has been using minimum staffing levels a lot recently and that the goal is to work with the maximum. The Administrator stated that the number of CNAs assigned to all shifts have declined and worsened after the former DON left. d. Record Review - During visit to the facility on Sunday, 3/25/18, the Report of Nursing Staff Directly Responsible for Resident Care form revealed that the resident census was 54. The number of CNAs per shift included: - Day shift, 3 CNAs and a Certified Occupational Therapist working as a CNA were assigned, an average of 13.75 residents each. - Evening shift, 4 CNAs an average of 13.75 residents each; and - Night shift, 2 CNAs, an average of 27 residents each. The Facility Assessment section on Staffing and Competencies addressing the number of CNAs needed per shift to meet the needs of residents was reviewed. This assessment dated [DATE] determined, based on maximum capacity of 62 residents, the following CNA staffing levels/shift/census are: - Day (7-3) shift, Maximum (Max) - 6 and minimum (Min) - 4 (10.33 to 15.5 residents each) - Evening (3-11) shift, Max - 5 and Min - 3 (12.4 to 20.70 residents each) - Night (11-7) shift, Max - 3 and Min - 2 (20.70 to 31.0 residents each) These ratios of CNAs to residents by shift, assuming near or actual full capacity of 62 residents revealed that these ratios were not met frequently as noted below. The nursing staff schedules were reviewed for the months of February, March, and (MONTH) 1 -3, (YEAR). These time periods were divided into 3 shorter time periods - (MONTH) (YEAR), (MONTH) 1-17, (YEAR), and (MONTH) 18 - (MONTH) 3, (YEAR) (period after the departure of the former DON). The number of CNAs who worked on all shifts was averaged and analyzed as follows: March 18 - (MONTH) 3, (YEAR) with an average census of 55 residents - Day shift - 4.64 (included 7 times with 4 CNAs resulting in a ratio of 1 CNA to 13.75 residents); - Evening shift - 3.97, resulting to 13.76 residents each - Night- 2.41 (including 10 times with 2 CNAs, resulting in 1 CNA to 27.5 residents) March 1 - 17, (YEAR) with an average census of 55 residents - Day shift - 5.35 (including 7 times with 4 CNAs); resulting to 10.28 residents each; - Evening shift - 4. 56, resulting to 12.06 residents each; - Night shift - 2.53 (including 8 times with 2 CNAs), resulting to 21.73 residents each. February (YEAR) with an average census of 56

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	335275	A. BUILDING _____ B. WING _____	04/04/2018

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SAPPHIRE NURSING AT WAPPINGERS	37 MESIER AVENUE WAPPINGERS FALLS, NY 12590

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) - Day shift - 5.4 (including 4 times with 4 CNAs) resulting to 10.37 residents each; - Evening shift - 4.89 resulting to 11.45 residents each; - Night= 2.75 (including 7 times with 2 CNAs) resulting to 20.36 residents each. 415.(a)(1)(i-iii)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during recertification survey, the facility did not ensure that 1 out of 3 residents (Resident #18) reviewed for unnecessary medications had an appropriate justification to continue the use of an antipsychotic medication with no attempts to reduce its use. Specifically, [MEDICATION NAME], an antipsychotic medication, was initiated to address worsening of the resident's behavioral symptoms condition and continued without any dose reduction after it was determined that the resident had had a medical condition which potentially could have caused the escalation in the resident's behavior. The findings are: Resident #18 is a [AGE] year-old male with [DIAGNOSES REDACTED]. A review of the resident's clinical record revealed that since at least (MONTH) (YEAR), the resident was prescribed [MEDICATION NAME] (an antidepressant), [MEDICATION NAME] (an antianxiety medication) and [MEDICATION NAME] (an antipsychotic) for depression, anxiety and mood disorder, respectively. The nurses' notes of (MONTH) (YEAR) to (MONTH) (YEAR) revealed that while the resident was on these medications, he had isolated incidents of agitation including: 1/18/17- cursing staff, increased agitation; 2/09/17- increased agitation; 3/01/17- very agitated after lunch; 3/06/17- appeared weepy and yelling out; and 4/06/17- noted with increased agitation, yelling, spitting and cursing. Additional nurses' notes during this time period showed that the resident's behavior escalated seven days before he was diagnosed with [REDACTED]. - 5/25/17, resident out of bed yelling and swearing, cursing at everyone very loudly; he was helped to bed but continued his behavior, yelling at his TV and calling it swear words; only stopped to take his medications, unable to be redirected; -5/26/17, at 6:30 PM, resident was yelling and cursing loudly; threw his dinner dish on the floor while yelling die to roommate, unable to redirect resident, just yelling curse words; -5/27/17, resident agitated and aggressive, cursing Certified Nurse Aide (CNA) and threw cup of coffee at her, resident told nurse that she was dead; -5/28/17, resident was in bed screaming at the top of his lungs, kicked writer. -5/28/17, the physician requested urinalysis and culture and sensitivity to determine if the resident had a UTI; resident was confused, yelling most of the evening; and -5/29/17- the resident was yelling get out, get out; kicking at staff and was cursing. On 6/1/17 the physician was notified of the urinalysis and positive culture and sensitivity results. A new order was obtained for Bactrim, an antibiotic to treat UTI. The physician's orders [REDACTED]. There was one additional behavioral incident documented from 6/1/17 to 10/11/17. This was documented on 6/16/7 and described the resident as being agitated and kicking a nurse after being shaved. Multiple behavioral incidents of yelling and agitation were noted from 10/12/17 - 10/18/17. On 10/24/17, the resident was noted to have a UTI. From 10/24/17 to 12/10/17, isolated behavioral incidents were documented as follows: -11/17/17, resident became upset when put in wheelchair and threw unopened pudding; -12/1/17, resident woken up by roommates yelling at each other; resident began to yell; and -12/7/17, resident yelling. On 12/10/17 the resident was found unresponsive. He was then hospitalized until 12/28/17 with [DIAGNOSES REDACTED]. As of 5/25/17 there was no specific plan in place with goals and timetable to address the ongoing use of [MEDICATION NAME]. The psychoactive medications care plan dated 1/3/18 noted that the goal for the resident was to have medications gradually reduced when indicated. This plan made no specific reference to [MEDICATION NAME]. The Nurse Practitioner, who began working at the facility in (MONTH) (YEAR), was interviewed on 3/29/18 at 9:55 AM and stated that [MEDICATION NAME] is usually started at 0 .25 mg and increased gradually if necessary. The physician, who began working in (MONTH) (YEAR), was interviewed on 3/29/18 at 12:43 PM. She stated that there was a reduction in [MEDICATION NAME] (reduced from 30 mg to 15 mg on 2/22/18) instead of [MEDICATION NAME]. The psychiatrist was interviewed on 3/29/18 at 1:50 PM via telephone regarding the initiation of [MEDICATION NAME] and lack of dose reduction. He stated that [MEDICATION NAME] should have been reduced gradually or possibly not started. 415.18(c)(1)
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% or greater. This was evident for 2 of 4 residents (#39 and #49) observed during a medication pass for a total of 27 opportunities for observation that resulted in a total medication error rate of 11%. The findings are: 1. Resident #49 has [DIAGNOSES REDACTED]. A medication observation was conducted on 3/28/18 at 10:30AM on the South side unit. The Registered Nurse Unit Manager (RNUM) administered Vitamin D3 400 IU tablet from a stock bottle to the resident. The physician orders [REDACTED]. The resident did not receive the ordered dose. The RNUM was interviewed on 3/28/18 following review of the orders and stated that she thought she gave the ordered dose. The RNUM was observed removing the Vitamin D3 400 IU stock bottle from the medication cart following the interview. 2. Resident # 39 has [DIAGNOSES REDACTED]. A medication observation was conducted on 3/29/18 at 10:29AM on the North side unit. The Licensed Practical Nurse (LPN # 2) administered Sennosides 8.6mg tablet, 2 tablets from a stock bottle, and Foltanx RF ([MEDICATION NAME] Folate-Algae-Vitamin B 12-B6 cap 3- -2-35mg) capsule oral to the resident. (LPN #2 left for the day before an interview was conducted). Review of the physician discontinued order dated 3/7/18 revealed that the Foltanx medication was discontinued on this day. The physician renewal order dated 3/17/18 revealed that the resident was receiving the Foltanx ([MEDICATION NAME]) (Agal oil) 3mg-35mg-2mg-90.314 mg capsule two times a day for restless leg syndrome, which was discontinued on 3/7/18. The physician order [REDACTED]. Review of the Medication Administration Recorded (MAR) 3/1-31/2018 revealed that the Foltanx medication was not discontinued, as ordered, and the resident continued to receive the medication until the day of the medication observation on 3/29/18 at 10:29AM. The resident received the Foltanx medication that was discontinued, and Sennoside medication without the 50mg [MEDICATION NAME] Sodium dose as part of the ordered medication.

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) The attending physician was interviewed on 3/30/18 at 9:52AM and stated that the Foltanx medication was discontinued on 3/7/18. The attending physician further stated that the nurses should have discontinued the medication on the MAR. The vendor pharmacist was interviewed on 3/30/18 at 10:16AM and stated that the (YEAR) MAR was sent prior to the discontinuation of the medication. The vendor pharmacist further stated that the nurses should have checked the order and MAR and discontinue the medication. LPN # 2 was interviewed on 3/30/18 at 12:47PM, via telephone, and stated that she saw the Sennoside label on the bottle, but thought it contained the [MEDICATION NAME] medication. LPN # 2 stated that she was not aware that the Foltanx medication was discontinued. 415.12(m)(1)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during a recertification survey it was determined for 2 of 2 facility unit medication storage rooms (South Unit and North unit), that expired medications in the emergency boxes were not stored beyond their expirations dates and were replaced for emergency use. Additionally, the medication storage and preparation areas were not maintained in a clean, safe and sanitary manner. The findings include: The facility policy on Storage of Medications policy and procedure revealed that the nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner; compartments, including, but not limited to, drawers, cabinets, rooms, refrigerators; and carts and boxes containing drugs and biologicals shall be locked when not in use. The facility policy and procedure on Refrigerator and Freezers revealed that medication room refrigerator temperatures will be recorded on the monthly temperature log daily by the shift nurse assigned to medications; the nurse will notify the environmental services department monthly when the medications freezer needs defrosting; and the housekeeping staff will surface clean the refrigerator daily. 1. South Unit Observation of the medication storage room was conducted on 3/27/18 between 9:36 AM and 10:13 AM and revealed the following: - the unlocked emergency medication box which was dispensed from the pharmacy on 12/28/17, contained an expired Vitamin K (used in helping in blood clots and preventing excessive bleeding) ampoule dated 3/1/18 and one [MEDICATION NAME][MEDICATION NAME] 40 mg vial was missing from the box; - the interior of the medication refrigerator was soiled with multiple sticky-to-touch dried reddish and brownish-colored dried spills; - an opened, undated, unlabeled 8 oz. container of Ensure supplement was stored on the door; - the freezer compartment had thick ice buildup and contained an opened food package containing an ice cream cone; and -the (MONTH) (YEAR) Temperature Log was not completed for 16 out of 27 days to determine whether the medications were stored at acceptable temperature. The unit medication Licensed Practical Nurse was interviewed at that time and stated that the procedure for maintaining the emergency medication box includes daily checks of the medication list and expiration dates. If a medication is removed from the box, the nursing supervisor is notified and takes the medication from the box and fills in a form, and the LPN signs off on the form. The LPN further stated that she did not know why the box was not locked and that she will inform the nursing supervisor. The unit housekeeper was interviewed on 3/27/18 at 10:31 AM and stated reported that the medication room floor is cleaned daily and that he does not clean the medication room refrigerator. The housekeeper stated he thinks the kitchen or maintenance staff do that. 2. North Unit Observation of the medication storage room was conducted on 3/27/18 at 11:15 AM and revealed the following: - the emergency medication box dispensed on 9/26/17 contained one expired Vitamin K ampoule dated 3/1/18. - the medication refrigerator was soiled with multiple dried spills on the doors and on the bottom shelf and the freezer had thick ice buildup; - the refrigerator floor was soiled with dirt and debris; - the grill of the wall fan inside the room was partially covered with thick dust and three ceiling tiles had brown stains; and - the (MONTH) (YEAR) Temperature Log was not completed for 22 out of 27 days to determine whether the medications were stored at acceptable temperature. The Director of Nursing (DON), who was present at the time of the North Unit observation, was interviewed on 3/27/18 at 10:55 AM and stated that the refrigerator was supposed to be locked and acknowledged that the emergency box was missing a lock and a label. The DON further stated that nursing should contact maintenance to defrost and clean the refrigerator. At that time, the DON confirmed that there were missing medications in emergency box. The Director of Environmental Services (DES) was interviewed on 3/27/18 at 11:24 AM and stated that nursing had not informed him that the medication refrigerators needed cleaning. He stated he has been going through a project of stripping and waxing floors and has not gotten to the medication storage room floors yet. He stated further that there are two housekeeping staff on each day for each unit and they should be responsible in cleaning the floor in the medication rooms each day. The Consultant Pharmacist (CP) was interviewed on 4/4/18 at 3:30 PM and stated that once the emergency medication box is opened, the staff is to fill out a form with the name of the resident and the contents of the box is then exchanged. The CP stated that there should be some swing boxes available in the facility to replace opened boxes. When asked about how the medication rooms and emergency boxes are monitored, the CP revealed that he inspect the medication rooms and refrigerators monthly and does not document his findings. 415.18(e)(1-4)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during a recertification survey, the facility did not ensure that its staff followed proper hand hygiene and gloving technique during wound care for 2 of 5 residents (#36 and #51) reviewed for pressure ulcer to prevent cross contamination and infection. The findings are: 1. Resident #36 has [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (a resident assessment tool) dated 2/20/18 revealed that the resident has impaired cognition, and has a Stage 4 pressure ulcer wound to the coccyx area. The Physician order [REDACTED]. A dressing observation was conducted on 3/30/18 at 11:55 AM for Resident #36 and the following were observed: The Licensed Practical Nurse (LPN #1) donned a pair of gloves, removed the soiled dressing and placed it on the incontinence briefs that the resident was wearing by partially folding incontinence briefs underneath the resident without placing a protective barrier between the wound and the incontinence briefs. LPN #1 removed the soiled gloves, sanitized her hands, then donned a pair of gloves and then opened a 4x4 clean gauze dressing and the normal saline bottle. LPN #1 then proceeded to cleanse the surrounding coccyx wound using the same saline-saturated gauze several times to clean the surrounding skin of the wound. LPN #1 then applied Santyl ointment and Calcium Alginate treatment inside the wound bed without cleansing the inside of the wound. During the wound care procedure, LPN #1's soiled gloves came in contact with the normal saline bottle. Following completion of the wound procedure, LPN #1 returned the normal saline bottle back into the treatment cart.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) LPN #1 was interviewed on 3/30/18 immediately following the wound care procedure and stated that she was a new nurse at the facility. LPN #1 stated that she was not trained to perform wound care at the facility. LPN #1 stated that she did not review the facility's wound care policy and procedure, nor did she inform anyone that she had no experience in wound care. 2. Resident #51 has [DIAGNOSES REDACTED]. The Admission MDS (a resident assessment tool) dated 3/8/18 indicated the resident has impaired cognition and had a (sacral area) pressure ulcer . The Physician order [REDACTED]. A dressing change observation was conducted on 4/3/18 at 10:00 AM and the following were observed: The resident was in bed lying in a urine-soaked incontinence briefs. LPN #3 partially folded the incontinence briefs underneath the resident's buttock and the resident's wound was in direct contact with the urine-soaked incontinence briefs. LPN # 3 donned a pair of gloves, opened several clean 4x4 gauze dressings and placed them directly on the outside of the gauze wrappers, then proceeded to saturate them with normal saline solution. Some of the saturated 4x4 gauze dressings came in contact with the uncovered table. Following completion of the wound procedure, LPN #3 removed her gloves. Without sanitizing or washing her hands, LPN #3 took the excess unused 4x4 gauze dressings, the ointment tubes, and the bottle of normal saline and placed them back in the treatment cart. The wound care procedure was conducted while the resident was lying on a urine soaked incontinence briefs. LPN #3 was interviewed on 4/3/18 immediately following the wound care procedure and stated that she was not aware that the incontinence briefs were soaked with urine and she should have instructed the CNA to change the resident prior to the dressing change. LPN #3 further stated that she should have washed her hands and disinfected the containers of the wound care items including the ointments and saline bottle before returning them back into the treatment cart. CNA #1 was interviewed on 4/3/18 following the wound care procedure and stated that she was aware that the resident's incontinence briefs were wet, but she was waiting until the nurse finish the procedure to change the resident. 415.19(b)(4)