STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26464 Based on observation, record review, and interviews during an abbreviated survey (Case #NY00300510), the facility did not ensure that each resident received adequate supervision to prevent accidents for 1 (Resident #1) of 3 residents reviewed for accidents. Specifically for Resident #1, the facility did not ensure they provided adequate supervision to maintain the safety of the resident who had a recent history of self-harm and hospitalization s for mental health issues. Resident #1 made suicide attempts on 7/5/2022 and 8/11/2022. This resulted in actual harm to Resident #1 that was not immediate jeopardy. This was evidenced by: Resident #1 Resident #1 was admitted to the facility with diagnoses of non-suicidal self-harm, suicidal ideations, and major depressive disorder. The Minimum Data Set (MDS-an assessment tool) dated 8/10/2022, documented the resident was cognitively intact, could be understood, and could understand others. The policy and procedure titled Suicide Threats dated 8/2022, documented resident suicide threats shall be taken seriously and addressed appropriately. The Hospital Discharge Summary dated 6/30/2022 at 9:12 AM, documented Resident #1 was admitted to the hospital on 6/6/2022 following an attempt to hurt themselves by cutting their arms with a plastic knife. The resident's family had a history of suicides and the resident stated they were afraid of doing the same. It documented Resident #1 needed the 1:1 sitter for 20 days until the 1:1 sitter was discontinued on 6/26/2022 when the resident was cleared psychologically. The initial Comprehensive Care Plan (CCP) dated 7/1/2022, documented Resident #1 exhibited behavior symptoms such as socially inappropriate, verbally aggressive/abusive, physically aggressive/abusive, hallucinations, delusions, and wandering behaviors. There was nothing in the care plan that documented the resident's recent history of self-harm. The CCP revised on 7/6/2022 for Behavior Symptoms/Provocative with Suicidal Ideation, documented that the resident was to receive paper products, plastic silverware, and no glass or metal utensils. There were no other interventions addressing suicidal ideation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The CCP for Major Depressive Disorder and Anxiety Disorder dated 7/19/2022, documented the resident had a history of several hospitalization s for mental illness. The care plan goal documented the resident would work with psychology and psychiatry services. The intervention dated 7/22/2022, documented the resident's stability and safety would be maintained. The certified nursing assistant (CNA) care card as of 8/15/2022, documented the resident was to receive paper products, plastic silverware and no metal or glass utensils. The Admission Note dated 6/30/2022 at 2:36 PM, documented the resident was admitted from the hospital for long term care. It documented the resident's mood/behavior concerns were sad/depression, anxiety, and potential for violence. The note did not document the resident had been admitted to the hospital because they harmed themselves by cutting themselves with a plastic knife. I added this because it does not document the resident's attempted self-harm that caused their hospitalization . A Health Status Note dated 7/5/2022 at 3:24 AM, written by a Licensed Practical Nurse (LPN), documented that at 2:15 AM, blood was observed on the resident's floor. On assessment by the RN, it was documented the resident was lying in their bed with a large amount of blood on the floor and a 5 cm laceration to their left ankle. The resident stated they had intentionally cut themselves with a piece of glass and wanted to die. They did not want to die a slow death in a nursing home and that they would do better next time. The resident was transported to the hospital via ambulance. A Health Status Note dated 7/6/2022 at 6:12 AM, documented the resident returned to the facility at 4:14 AM with documentation the resident was medically and psychiatrically cleared to return to the facility. The resident was immediately placed on 1:1 supervision per the Supervisor's request. There was no further documentation in the medical record that 1:1 supervision was continued or discontinued. A Physician's Progress Note dated 7/7/2022 at 10:50 AM, documented Resident #1 had returned to the facility after psychiatric clearance from the hospital following their suicide attempt. The resident stated they cut their left ankle with the intention that they did not want to live any longer. The medical doctor (MD) documented the resident would need to be monitored very closely and a psychiatry consult should be obtained. There was no documentation in the medical record that the resident was evaluated by a psychiatrist or psychologist upon return to the facility. Review of the CNA Assignment Sheets for all shifts dated from 7/6/2022- 8/11/2022, did not document that CNAs were assigned for 1:1 supervision of the resident. There were no flow sheets that documented 1:1 supervision was provided for the resident. The document titled Incident and Accident Statement Form: Summary of Investigation dated 8/11/2022 at 3:30 PM, documented the resident self-lacerated both ankles with a sharp object. The resident had a history of psychiatric admissions, suicidal ideation, and attempts. The resident was assessed by a Registered Nurse (RN), placed under 1:1 supervision, first aid was applied to both ankles, Emergency Medical Services was called per the direction of the Nurse Practitioner (NP) on a telehealth call, and the resident was sent to the hospital for treatment and a psychiatric evaluation. The Medical Director was notified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A Health Status Note dated 8/11/2022 at 5:05 PM, documented the Registered Nurse Manager (RNM) was participating in a telehealth conference with the NP and another resident when they were interrupted by a commotion in Resident #1's room. As they started toward the resident's room, they were told it was urgent. Upon entering the room, the RNM observed the resident lying on the floor vomiting and surrounded by blood. There were also blood pools under the bed and on the window side of the room. After a quick assessment, it was determined there were lacerations of the resident's feet. A Code Blue was called, and staff responded. An LPN provided direct pressure on the wounds while other staff attempted to start intravenous fluid (an IV). The NP was still on the telehealth connection. 911 was called, responded, and the resident was sent to the hospital. A Physician Progress Note dated 8/11/2022 at 3:43 PM, documented the NP was on a telemedicine call with nursing when Resident #1 was found in their bedroom on the floor lying in a pool of blood. It was observed that the resident had found a sharp object, possibly a razor blade and lacerated their left ankle. Code Blue was called, and emergency procedures were applied. The NP documented it was not the resident's first suicide attempt, the last suicide attempt was in July (7/5/2022). The resident was being sent to the hospital via ambulance for psychiatric evaluation. It was discussed at length with the Acting Director of Nursing (DON) that the resident should be sent out for psychiatric evaluation as per the facility. During an interview on 8/15/2022 at 10:23 AM, CNA #1 stated they knew the resident but when they were on their assignment, the only thing Resident #1 needed was to have their items set up for their personal hygiene. The resident was independent, would wander around the unit and went off the unit as well. During an interview on 8/15/2022 at 11:16 AM, RNM #1 stated they were not directly involved with Resident #1's first suicide attempt on 7/5/2022 but did state the resident received 1:1 supervision for a few days following their return to the facility. They stated did not know why the supervision was discontinued. RNM #1 stated in retrospect, they could have taken additional measures to attempt to prevent a recurrence following the resident's first suicide attempt. They could have implemented room checks to look for sharp objects and they could have put the resident on safety checks. RNM #1 stated when the second suicide attempt occurred on 8/11/2022, they were on a telehealth conference with the NP regarding another resident when they heard commotion coming from the resident's room. As they approached the room, a CNA stated it was urgent. RNM #1 stated when they entered the room, they saw the resident lying on the floor in a pool of blood and they were vomiting. They requested a code blue be called because they needed more assistance. The RNM stated they did a quick assessment, and the resident was bleeding from both ankles. An LPN held direct pressure on the resident's ankles. The NP was still on the telehealth line and gave direction. 911 was called and they attempted to start an IV but could not access a vein likely due to the resident's blood loss. Emergency Medical Services arrived quickly, and the resident's care was turned over to them. The resident was transported to the hospital. The RNM stated when the CNAs were cleaning up the resident's room, they found a sharp object that looked like a piece of metal with tape wrapped around it. RNM #1 stated following the first incident, the resident was placed on the psychiatrist's list to be seen but they were unsure it the resident was. The DON was unavailable for interview regarding the 7/5/2022 incident. They were on leave with an unknown date of return to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/15/2022 at 12:00 PM, the Acting Director of Nursing (DON) stated because Resident #1 had a history of recent self-harm, staff on the resident's unit should have been made aware of the resident's history when they were admitted so they could monitor the resident and interventions put into place such as to make sure there were no sharp objects in their room they could harm themselves with and nonmetal silverware and paper products on their meal trays. The Acting DON stated the initial care plan should have documented the resident had a history of suicidal ideation with the goal to prevent any further suicide attempts. The Acting DON stated starting and discontinuing 1:1 supervision was a nursing/medical provider judgement. There was no specific sheet to document 1:1 supervision. The Acting DON stated when Resident #1 returned from the hospital for evaluation following the 7/5/2022 incident, they should have been seen psychiatry immediately. During a subsequent interview on 8/17/2022 at 9:01 AM, RNM #1 stated the initial care plan should have addressed the resident's self-harm behavior and suicidal ideation if the nurse that wrote the care plan had picked up on it. The RNM stated the initial care plan would have put a task in the electronic medical record for the CNA Care Card depending on what they felt would have been an appropriate intervention at that point given the resident's history of self-harm. The RNM stated for example, they could have done room searches periodically, not knowing the full extent of the situation on admission and could have removed silverware on admission, but that could have been a dignity issue. A psychological/psychiatric consult could have been done within the first couple of weeks of the resident's admission. RNM #1 stated Resident #1 was not put on any special precautions or observation and nothing official was done for resident supervision following their 7/5/2022 suicide attempt. During an interview on 8/17/2022 at 10:13 AM, the Admissions Coordinator (AC) stated they had been on the unit (on 8/11/2022) to provide the RNM a phone for a telehealth visit with another resident. The AC stated CNA #5 came to the door of Resident #1's door and yelled to call a code. The AC stated they went to the room along with others to see what was happening. When they looked in the room, there was blood everywhere. The resident was on the floor and was vomiting. They were asked to call 911 and they told the dispatcher there was a great amount of blood but did not know where it was coming from, was asked if there was a weapon and if the resident was a harm to anyone else and stated no. They reiterated the resident was on the floor in a lot of blood. The AC stated Emergency Medical Services and the New York State Police responded to the facility. During an interview on 8/17/2022 at 11:28 AM, CNA #3 stated it was sometime after 3:00 PM (on 8/11/2022) when they went to Resident #1's unit because they were giving CNA #4 a ride home. CNA #3 stated a call light went off and a CNA (CNA #5) for the oncoming shift had just arrived and went to answer it. CNA #5 came to the door of the room and yelled for help, that seriously, they needed help. CNA #3 stated they and CNA #4 went to the resident's room and there was blood all over the floor. The CNA stated they had started to look around the room to see what the resident may have used to cut themselves and found a sharp object that was under the covers on the resident's bed. CNA #3 stated they turned it over to the infection control lady and it was put in a safety bag. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/17/2022 at 11:39 AM, CNA #4 stated the last time they saw Resident #1 was at 2:27 PM in the dining room. The CNA stated sometime around 3:00 PM, they were at the desk doing their books when CNA #5 came to the unit to start their shift. Resident #1's call light went off, so CNA #5 went to answer it and found the resident on the floor in blood and vomit. CNA #5 yelled for help and to come quickly. CNA #4 stated they, CNA #3, and the Unit Secretary responded to the room with the RNM. CNA #4 stated a Code Blue was called and other staff responded. CNA #3 was the one who found the blade. CNA #4 stated they were trying to find the source of the bleeding and found it to be at the bottom of resident's left ankle. During an interview on 8/17/2022 at 1:14 PM, the Medical Director stated after Resident #1's 7/5/2022 suicide attempt they insisted on and received medical and psychiatric clearance before they would accept Resident #1 for readmission. The Medical Director stated they were told by the hospital the resident was not a suicide risk and the facility did not need to put any additional interventions in place for the resident. When discussing the 8/11/2022 suicide attempt, the Medical Director stated it was their third attempt. The first was the incident of self-harm the resident was admitted to the hospital for prior to admission to the facility, then the 7/5/2022 and 8/11/2022 suicide attempts. The Medical Director stated they would have expected the resident to be seen by a psychologist following the 7/5/2022 incident. The Medical Director stated sometimes care plan interventions were risk mitigation (reducing the severity or seriousness of something). The Medical Director stated the facility could always learn and do better. They stated they did not like a bad outcome. The facility could make it part of the admission process for residents who have a history of suicidal ideation/attempts to have interventions in place in their care plan. During an interview on 8/18/2022 at 11:17 AM, the Acting Director of Social Work (DSW) stated it was confirmed by the Psychologist they had not met with Resident #1 following their 7/5/2022 suicide attempt and they received an email from the psychiatrist that they had no record of having seen the resident. The Acting DSW stated in order for a resident to receive psychological/psychiatric services, they must be notified a request was being made, the resident must sign a consent form, the referral form was filled out and then it was sent to both the psychologist and psychiatrist. The Acting DSW stated the referral paperwork had been completed for Resident #1 and there was a blank consent form for services with it. They stated they did not know why the consent form was blank or why the referral was never sent. The Social Workers were responsible for obtaining resident consent for services and sending the consent form and referral paperwork to the psychologist and psychiatrist. The Acting DSW stated Resident #1 should have been seen by the psychologist/psychiatrist following the first suicide attempt. I think this was what you were looking for (blue highlighted documentation). It documents the process and the Acting DSW stated they did not know why the referral was sent. Specifically, Resident #1 was admitted to the facility with a recent history of self-harm. On 7/5/2022, Resident #1 made their first suicide attempt using a piece of glass to cut their ankle and stated they did not want to die a slow death in a nursing home and that they would do better next time. The resident was sent to the hospital by ambulance, required stitches, was medically and psychiatrically cleared, and returned to the facility on [DATE]. On 8/11/2022, the resident made their second suicide attempt using a razor blade that had been removed from a disposable razor. The resident sliced both ankles. A Certified Nursing Assistant (CNA) responded to the resident's call light and found the resident lying on the floor in a pool of blood, bleeding profusely and vomiting. The resident was transferred to the hospital by ambulance and was admitted . This is evidenced by: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 8/15/2022 at 12:33 PM, the object the resident cut themselves with was a blade removed from a disposable razor that measured 3.5 centimeters (cm) x 0.50 cm. It was wrapped in dirty plastic tape of the type used to secure dressings, with a sharp edge protruding. 10 NYCRR 415.12(h)(1) The Hospital Discharge Summary dated 6/30/2022 at 9:12 AM, documented Resident #1 attempted to hurt themselves by cutting their arms with a plastic knife. The resident's family had a history of suicides and the resident stated they were afraid of doing the same. The initial Comprehensive Care Plan (CCP) dated 7/1/2022, documented Resident #1 exhibited behavior symptoms such as socially inappropriate, verbally aggressive/abusive, physically aggressive/abusive, hallucinations, delusions, and wandering behaviors. There was nothing in the care plan that documented the resident's recent history of self-harm. The CCP revised on 7/6/2022 for Behavior Symptoms/Provocative with Suicidal Ideation, documented that the resident was to receive paper products, plastic silverware, and no glass or metal utensils. There were no other interventions addressing suicidal ideation. The CCP for Major Depressive Disorder and Anxiety Disorder dated 7/19/2022, documented the resident had a history of several hospitalization s for mental illness. The care plan goal documented the resident would work with psychology and psychiatry services. The intervention dated 7/22/2022, documented the resident's stability and safety would be maintained. A Health Status Note dated 7/5/2022 at 3:24 AM, documented that at 2:15 AM, documented a Licensed Practical Nurse (LPN) observed blood on the resident's floor. On assessment by the RN, it was documented the resident was lying in their bed with a large amount of blood on the floor and a 5 cm laceration to their left ankle. The resident stated they had intentionally cut themselves with a piece of glass and wanted to die. They did not want to die a slow death in a nursing home and that they would do better next time. The resident was transported to the hospital via ambulance. A Physician's Progress Note dated 7/7/2022 at 10:50 AM, documented Resident #1 had returned to the facility after psychiatric clearance from the hospital following their suicide attempt. The resident stated they cut their left ankle with the intention that they did not want to live any longer. The MD documented the resident would need to be monitored very closely and a psychiatry consult should be obtained. During a subsequent interview on 8/17/2022 at 9:01 AM A psychological/psychiatric consult could have been done within the first couple of weeks of the resident's admission. RNM #1 stated Resident #1 was not put on any special precautions or observation and nothing official was done for resident supervision following their 7/5/2022 suicide attempt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/17/2022 at 1:14 PM, the Medical Director stated after Resident #1's 7/5/2022 suicide attempt they insisted on and received medical and psychiatric clearance before the would accept Resident #1 for readmission. The Medical Director stated they were told by the hospital the resident was not a suicide risk and the facility did not need to put any additional interventions in place for the resident. When discussing the 8/11/2022 suicide attempt, the Medical Director stated it was their third attempt. The first was the incident of self-harm the resident was admitted to the hospital for prior to admission to the facility, then the 7/5/2022 and 8/11/2022 suicide attempts. The Medical Director stated they would have expected the resident to be seen by a Psychologist following the 7/5/2022 incident. The Medical stated sometimes care plan interventions were risk mitigation (reducing the severity or seriousness of something). The Medical Director stated the facility could always learn and do better. They stated they did not like a bad outcome. The facility could make it part of the admission process for residents who have a history of suicidal ideation/attempts to have interventions in place in their care plan. During an interview on 8/17/2022 at 9:01 AM, #1 stated Resident #1 was not put on any special precautions or observation and nothing official was done for resident supervision following their 7/5/2022 suicide attempt, but they did implement plastic utensils and paper products and was not to have any glass or metal utensils. During an interview on 8/15/2022 on 12:00 PM, the Acting DON stated because the resident had a history of a recent suicide attempt, staff on the resident's unit should have been made aware of the resident's history of suicidal ideation so they could monitor the resident, interventions should be put in in place to keep the resident safe, such as nonmetal and paper products on their trays, and make sure there were no sharp objects in their room they could harm themselves with. The Acting DON stated the initial care plan should have documented the resident had a history of suicidal ideation and to prevent any further suicide attempts. During an interview on 8/18/2022 at 11:17 AM, the Acting Director of Social Work (DSW) stated it was confirmed by the Psychologist they had not met with Resident #1 following their 7/5/2022 suicide attempt and they received an email from the Psychiatrist that they had no record of having seen the resident. The Acting DSW stated in order for a resident to receive psychological/psychiatric services, they must be notified a request was being made, the resident must sign a consent form, the referral form filled out and then it was sent to both the Psychologist and Psychiatrist. The Acting DSW stated the referral paperwork had been completed for Resident #1 and there was a blank consent form for services with it. They stated they did not know why the consent form was blank or why the referral was never sent. The Social Workers were responsible for obtaining resident consent for services and sending the consent form and referral paperwork to the Psychologist and Psychiatrist. The Acting DSW stated Resident #1 should have been seen by the Psychologist/Psychiatrist following the first suicide attempt. The SW stated attempts/suicide ideations were urgent for psychiatry/psychology to see the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When discussing the 8/11/2022 suicide attempt, the Medical Director stated it was their third attempt. The first was the incident of self-harm the resident was admitted to the hospital for prior to admission to the facility, then the 7/5/2022 and 8/11/2022 suicide attempts. The Medical Director stated they would have expected the resident to be seen by a Psychologist following the 7/5/2022 incident. The Medical stated sometimes care plan interventions were risk mitigation (reducing the severity or seriousness of something). The Medical Director stated the facility could always learn and do better. They stated they did not like a bad outcome. The facility could make it part of the admission process for residents who have a history of suicidal ideation/attempts to have interventions in place in their care plan. During an interview on 8/17/2022 at 1:14 PM, the Medical Director stated after Resident #1's 7/5/2022 suicide attempt they insisted on and received medical and psychiatric clearance before the would accept Resident #1 for readmission. The Medical Director stated they were told by the hospital the resident was not a suicide risk and the facility did not need to put any additional interventions in place for the resident. The facility did not know whether the resident had been seen by psych and had to send an email to ask if the resident was s The resident told the Medical Director they had made the attempt because just prior, they had seen their daughter and son in bed together having sex. be a red flag to get her some psych help? 7/5 physician notet cleared psych in discharge document from Dr [NAME] .not a suicide risk, need to be monitored veryclosely, we should obtain psych eval 35228 Based on observation, record review, and interviews during an abbreviated survey (Case #NY00300510), the facility did not ensure that each resident received adequate supervision to prevent accidents for 1 (Resident #1) of 3 residents reviewed for accidents. Specifically, for Resident #1, who was admitted to the facility with a recent history of self-harm and hospitalization for mental health issues, the facility did not provide adequate supervision and did not put interventions in place to mitigate the risk of further self-harm and attempt of suicide after the resident was found lying in their bed with a large amount of blood on the floor and a cut to their left ankle on 7/5/2022. Resident #1 stated they had intentionally cut themselves, wanted to die, and stated they would do better next time. On 8/11/2022, the resident was found lying on the floor in a pool of blood, was vomiting and bleeding from both ankles and was sent to the hospital. This resulted in actual harm to Resident #1 that was not immediate jeopardy. This was evidenced by: The facility policy and procedure for Suicide Threats with the effective dates of 8/17, 10/18 and a revision date of 8/2022, documented that resident suicide threats shall be taken seriously and addressed appropriately. The policy interpretation and implementation documented that staff shall report any resident threats of immediately to the Nurse Supervisor/Charge Nurse/Social Services. Resident #1 was admitted to the facility with diagnoses of non-suicidal self-harm, suicidal ideations, and major depressive disorder. The Minimum Data Set (MDS-an assessment tool) dated 8/10/2022, documented the resident was cognitively intact, could be understood, and could understand others. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Hospital Discharge Summary dated 6/30/2022 at 9:12 AM, documented Resident #1 was admitted to the hospital on 6/6/2022 following an attempt to hurt themselves by cutting their arms with a plastic knife. The resident's family had a history of suicides and the resident stated they were afraid of doing the same. It documented Resident #1 needed the 1:1 sitter for 20 days until the 1:1 sitter was discontinued on 6/26/2022 when the resident was cleared psychologically. The Admission Note dated 6/30/2022 at 2:36 PM, documented the resident was admitted from the hospital for long term care. It documented the resident's mood/behavior concerns were sad/depression, anxiety, and potential for violence. The note did not document the resident had been admitted to the hospital because they harmed themselves by cutting themselves with a plastic knife. The initial Comprehensive Care Plan (CCP) dated 7/1/2022, did not include documentation of the resident's recent history of self-harm. A Physician's Progress Note dated 7/5/2022 at 2:25 AM, documented the Physician's Assistant was notified by nursing staff regarding a self-harm incident. Resident #1 stated that they wanted to hurt themselves and want to die. Staff found the resident with a lot of blood in their room. They had taken a piece of glass and cut their ankle. Pressure was applied to the wound, and it may require stitches. Emergency Medical Services (EMS) was called as the resident was openly expressing self-harm and would require 72-hour psychiatric hold at the hospital. The resident was being transferred to the closest emergency room for evaluation of their ankle wound as well as psychiatric evaluation. A Health Status Note dated 7/5/2022 at 3:24 AM, written by a Licensed Practical Nurse (LPN), documented that at 2:15 AM, blood was observed on the resident's floor. On assessment by the Registered Nurse (RN), it was documented the resident was lying in their bed with a large amount of blood on the floor and a 5 cm laceration to their left ankle. The resident stated they had intentionally cut themselves with a piece of glass and wanted to die. They did not want to die a slow death in a nursing home and that they would do better next time. The resident was transported to the hospital via ambulance. A Health Status Note dated 7/6/2022 at 6:12 AM, documented the resident returned to the facility at 4:14 AM with documentation the resident was medically and psychiatrically cleared to return to the facility. The resident was immediately placed on 1:1 supervision per the Supervisor's request. There was no further documentation in the medical record that 1:1 supervision was continued or discontinued. There was no further documentation in the medical record that 1:1 supervision was continued or discontinued. The CCP revised on 7/6/2022 for Behavior Symptoms/Provocative with Suicidal Ideation, documented that the resident was to receive paper products, plastic silverware, and no glass or metal utensils. The CCP did not include documentation of other interventions that addressed suicidal ideation. A Physician's Progress Note dated 7/7/2022 at 10:50 AM, documented Resident #1 had returned to the facility after psychiatric clearance from the hospital following their suicide attempt. The resident stated they cut their left ankle with the intention that they did not want to live any longer. The Medical Doctor (MD) documented the resident would need to be monitored very closely and a psychiatry consult should be obtained. (continued on next page)

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	335565	A. Building B. Wing	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A CCP with an initial date of 7/19/2022 and a revision date of 7/19/2022 for (Resident #1) has diagnosis of major depressive disorder and anxiety disorder with a history of several hospitalization s for Mental Illness documented a goal that the resident will work with psychology and psychiatry services with a date initiated of 7/19/2022 and a revision date of 7/22/2022. A facility document titled Medication Review Report (with a print date of 8/17/2022) under the section for order summary documented the following; -Psychiatry consult and treatment and follow-up per recommendation with an order date of 6/30/2022. -Psychology consult, treatment and follow-up per recommendation with an order date of 6/30/2022. A Health Status Note dated 8/11/2022 at 5:05 PM, documented the Registered Nurse Manager (RNM) was participating in a telehealth conference with the NP and another resident when they were interrupted by a commotion in Resident #1's room. As they started toward the resident's room, they were told it was urgent. Upon entering the room, the RNM observed the resident lying on the floor vomiting and surrounded by blood. There were also blood pools under the bed and on the window side of the room. After a quick assessment, it was determined there were lacerations of the resident's feet. A Code Blue was called, and staff responded. An LPN provided direct pressure on the wounds while other staff attempted to start intravenous fluid (an IV). The NP was still on the telehealth connection. 911 was called, responded, and th [TRUNCATED]

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35228 Based on interview and record review during a post survey revisit from 10/13/2022 to 10/17/2022, the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Specifically, for 4 (Unit 1, 3, 4, and 6) of 5 units reviewed, Administration did not ensure rounding sheets were completed daily on the evening and night shifts from 10/4/2022 to 10/12/2022 and did not ensure there was a system in place to confirm residents, including those with diagnoses of suicidal ideations and/or suicide attempts, were on the roster to be seen by psychological services after a referral was sent in accordance with the facility's plan of correction for accident hazards. The facility's alleged compliance date was 10/4/2022. This is evidenced by: Finding #1: Administration did not ensure, for 4 (Unit 1, 3, 4, and 6) of 5 units reviewed, rounding sheets were completed daily, on evening and night shifts, from 10/4/2022 to 10/12/2022 in accordance with the facility's plan of correction for accident hazards. The Plan of Correction (POC) submitted by the facility on 9/22/2022, documented rounding sheets would be utilized on all units on evenings and night shift to ensure resident safety. The Director of Nursing or designee would audit the rounding sheets for completion daily x 8 weeks and monthly x 6 months. The facility's alleged compliance date was 10/4/2022. The facility audit titled Nursing Rounding Sheets documented all rounding sheets have been collected and are complete. If not, corrective action has been initiated. The audit form was completed weekly (not daily) and documented for Week 2 (10/2-10/8) and Week 3 (10/9-10/14) the letter N, indicating all rounding sheets were not completed. A review of Rounding Sheets on Units 1, 3, 4, and 6 from 10/4/2022 to 10/12/2022 (9 days) documented: -Unit 1: 7 of 9 evening shifts and 8 of 9 night shifts did not have rounding sheets completed. -Unit 3: 9 of 9 evening shifts and 9 of 9 night shifts did not have rounding sheets completed. -Unit 4: 6 of 9 evening shifts and 7 of 9 night shifts did not have rounding sheets completed. -Unit 6: 3 of 9 evening shifts and 7 of 9 night shifts did not have rounding sheets completed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/2022 at 3:08 PM, the Assistant Administrator stated they were responsible for overseeing that the plan of correction was implemented and then they would update the Administrator. The Assistant Administrator stated based on the audit, the rounding sheets had not been completed on a weekly basis. Administration decided today, at the end of Week 3, 10/14/2022, that they would change the auditing process for the rounding sheets to ensure the sheets were being completed. The Assistant Administrator stated the Acting Director of Nursing (DON) was responsible for completing the rounding sheet audit, however the Acting ADON was out on leave at this time. It had not been brought to the Assistant Administrator's attention that the rounding sheets were not being completed. The Assistant Administrator stated they kept asking for the completed rounding sheets from each unit, but then they found out there were not any sheets completed, specifically for Unit 3. The Assistant Administrator stated they did not know if the Acting DON was looking at the rounding sheets daily or weekly, but hoped they were reviewing them frequently. Everyone was educated on the rounding sheets and now would be re-educated. The audit for the rounding sheets were talked about every morning and it was discussed they were not being done. The Assistant Administrator did not know why the rounding sheets were not being completed in accordance with the plan of correction. When the rounding sheets were not completed based on the weekly audit, the Assistant Administrator would remind staff about completing the rounding sheets, but corrective action was not implemented until the post survey revisit. The Assistant Administrator stated they had trouble getting feedback from nursing about whether the rounding sheets were being completed or not. During an interview on 10/14/2022 at 3:25 PM, the Administrator stated they would be stepping in more and overseeing the units more now that they were aware the rounding sheets were not being completed. The Administrator stated most of the plan of correction was implemented, and some of it was not. The Administrator stated they would make changes to it to the auditing process for the rounding sheets. Prior to yesterday, razors being in the resident rooms was not on the Administrator's radar, but now it was. The Administrator stated they would be going to the units on weekends and doing return demonstrations with staff to see how the staff were doing their safety checks. Finding #2: Administration did not ensure there was a system in place to confirm residents, including those with diagnoses of suicidal ideations and/or suicide attempts, were on the roster to be seen by psychological services after a referral was sent in accordance with the facility's plan of correction for accident hazards. The Plan of Correction (POC) submitted by the facility on 9/22/2022, documented Social Services would be educated to maintain a log that depicted when a psych referral was sent, and when the resident was seen by the provider. Social work would be given access to the consultant agency's portal for psychological services to ensure that residents were on the psych roster to be seen in house. The facility provided a list of 13 residents identified as having diagnoses of suicidal ideations and/or suicide attempts. The Plan of Correction documented a full house audit was conducted on all residents with a diagnosis of suicidal ideation or history of suicidal attempts to ensure that each resident had been referred to and was currently being seen by psych. Any one on the audit that had not been seen, a referral was sent. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon review of the Social Services log, referrals for psychological services were made for 11 of the 13 residents on 9/15/2022 and 9/16/2022. As of 10/13/2022, of the 11 residents referred, 7 residents did not have a date documented on the log to indicate if they were seen, or when the residents would be seen, by the provider for psychological services. During an interview on 10/13/2022 at 3:20 PM, the Director of Social Work (DSW) stated residents were usually seen within a week of a referral being sent for psychological services. The DSW stated the social workers were supposed to be getting access to the consultant agency's portal, but they did not have access yet. The social workers did not know which residents were seen by psychological services after a referral was sent. The DSW stated referrals were sent by fax and fax confirmation was received when the referral went through, but that was all the social workers knew; that the referral went through. The DSW stated right now there was not a follow up made with the consultant agency and the social workers did not know who was on the psychologist's list to be seen. The DSW stated if the social workers had access to the portal, they would be able to see when residents were seen and how often they were to be seen. The DSW stated they have asked the psychologist several times to leave a list of the residents they saw each day in order to track the residents being seen but the psychologist would not leave a list. The DSW stated if they had the portal, it would be easier to see who the psychologist has seen. The social workers could check the progress notes in the facility's electronic medical record system, but the notes were not always in there. Administration was working to get them access to the portal and were aware they did not have access. During an interview on 10/13/2022 at 3:55 PM, the Administrator stated the consultant agency for psychological services was an outside vendor and since it was still being worked on to get the social workers access to the portal, everything was done by phone. The Administrator stated the facility called the consultant agency and asked who was on the list to be seen and who was coming off the list for psychological services. The Director of Social Work was responsible to make those calls. There was not a date of when portal access was to be expected. The Administrator stated the facility manually confirmed that residents were being seen by making phone calls to the agency until the portal was in place and that was the only way to make sure the services were being provided. During an interview on 10/13/2022 at 5:10 PM, the Assistant Administrator stated they were aware the social workers did not have access to the consultant agency's psychological services portal. The Assistant Administrator and a representative from the agency were communicating via email regarding portal access for the social workers. There was not a timeframe in which access was to be expected. During a subsequent interview on 10/14/2022 at 1:31 PM, the DSW stated they called the consultant agency that provided psychological services in the facility maybe once a week to see if referrals were received. The DSW stated they asked if the referrals were received, not if the resident have been seen. The DSW stated they did not know who was being seen or what the psychologist's recommendations were after a resident was seen because the psychologist would not tell them who they saw. The DSW stated the residents should be seen within a week after the referral was made. During an interview on 10/14/2022 at 1:48 PM, the Psychologist stated when they saw a resident for psych services, they made recommendations for behavioral planning and those recommendations were always in their notes. The social workers needed to a run a report to see those notes. The Psychologist stated they did not give the social workers a list of the residents they were seeing for services. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/14/2022 at 3:08 PM, the Assistant Administrator stated they were responsible for overseeing that the plan of correction was implemented and then they would update the Administrator. During an interview on 10/14/2022 at 3:25 PM, the Administrator stated it was just expected that a resident was seen after a psychology referral was sent. The Administrator stated they were not aware prior to yesterday that residents referred to psych services had not been seen by psych services. The Administrator stated the social worker was new, and the Administrator should have been made aware. The Administrator stated there was a gap in communication and right now, there was no standard for when residents should be seen after a referral was sent. The Administrator stated the consultant agency needed to provide the psych services timely. The Administrator stated they would imagine the psychologist told the social workers their findings and that the social workers could see the psychologist's findings through their documentation. The Administrator stated they would be stepping up observations and involving psych services for anyone on that list (referring to the list of residents with diagnoses of suicidal ideations/suicide attempts). 10 NYCRR 415.26