STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335022	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sands Point Center for Health and Rehabilitation	1440 Port Washington Blvd Port Washington, NY 11050

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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 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. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 5/22/2024 and completed on 5/30/2024 the facility did not ensure that a comprehensive person-centered care plan was implemented for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This was identified for one (Resident #86) of three residents reviewed for Pressure Ulcers. Specifically, Resident #86, who was assessed to be at risk for developing pressure ulcers, was observed in bed on multiple occasions not wearing the physician-ordered protective heel boots. The finding is: The facility's undated policy titled Pressure Ulcer documented to always maintain the highest degree of skin and tissue integrity. It is the responsibility of facility staff via the interdisciplinary team to recognize any resident who is at risk for pressure ulcer development and initiate appropriate preventive measures. It is the goal of this facility to identify residents at risk, devise individualized care plans, promote involvement of the resident in the development of the plan of care, initiate preventative measures, and promote healing. Resident #86 was admitted with diagnoses including Diabetes Mellitus, Cerebrovascular Accident, and Hemiplegia (paralysis or weakness to one side of the body) following a Cerebrovascular Accident affecting the left non-dominant side. The 3/25/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact. The Minimum Data Set documented the resident had functional limitation in range of motion in both upper and lower extremities, was at risk for developing pressure ulcers, and had two venous/arterial ulcers. A Physician's order effective 9/18/2023 and renewed on 5/23/2024 documented to apply heel boots when in bed, remove for skin checks and hygiene, every day at 7:00 AM-3:00 PM; 3:00 PM-11:00 PM; 11:00 PM-7:00 AM. A physician's order dated 5/2/2024 documented to cleanse the right great toe with normal saline, pat dry, apply Betadine (antiseptic solution), and cover with a dry protective dressing daily. (continued on next page)

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nursing Assistant Resident Nursing Instructions for 5/1/2024-5/31/2024 did not include an intervention for offloading the heels with the use of heel boots or pillows as part of the resident's daily care. Resident #86 was observed in bed on 5/22/2024 at 10:59 AM. The resident not wearing the physician-ordered heel boots and the resident's heels were directly resting on the mattress. The resident stated they were not aware of having heel boots. On 5/23/2024 at 12:07 PM Resident #86 was observed in bed wearing a pair of diabetic shoes (specialized shoes to be worn out of bed, designed to protect feet from forces that can break down skin and develop sores and ulcers). The resident stated the shoes were just put on by the nursing staff because the resident would be getting out of bed soon. The resident stated prior to having the shoes put on, they were just wearing socks on their feet while in bed. Certified Nursing Assistant #4 was interviewed on 5/23/2024 at 12:09 PM and stated they did not know anything about the resident needing to wear heel boots in bed. Certified Nursing Assistant #4 then searched the resident's room and found the heel boots in the resident's closet. The resident was present in the room and stated they refused to wear the heel boots because the heel boots are cumbersome. The resident stated the last time they wore the heel boots was months ago. The resident stated, I have a dressing on my toe and socks, that is all I wore. On 5/24/2024 at 7:50 AM Resident #86 was observed in bed wearing socks. The heels were not offloaded from the mattress. Registered Nurse #5, the unit manager, was interviewed on 5/24/2024 at 7:55 AM and stated Certified Nursing Assistant #4 did not notify them that the resident was refusing to wear their heel boots. Registered Nurse #5 reviewed the resident's medical record and stated there was no documentation of the resident refusing to wear the heel boots. Registered Nurse #5 stated they would speak with the resident, update the care plan, and explore an alternative for offloading the heels that can be used. The Director of Nursing Services was interviewed on 5/24/2024 at 9:37 AM and stated if the resident was uncomfortable with using the heel boots and was refusing to wear them, the staff should have reached out to the Doctor and the Rehabilitation Department for an alternate means to offload the heels. A progress note written by the Director of Nursing Services on 5/25/2024 at 12:05 AM documented the resident continues to refuse heel boots despite encouragement. The Physician was notified with orders to discontinue the heel boots at this time. The Resident is to be offered pillows to offload the heels as needed. 10 NYCRR 415.11 (c)(1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 5/22/2024 and completed on 5/30/2024, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for two (Resident # 126 and Resident #124) of three residents reviewed for Pressure Ulcers. Specifically, 1) Resident #126 had a Physician's order for an alternating pressure relief air mattress secondary to a pressure ulcer of the sacral region. During multiple observations, the adjustable weight setting on the air mattress was not set accurately according to the resident's weight. 2) Resident #124, who had an unstageable right hip pressure ulcer, was utilizing an alternating pressure relief air mattress as per the physician's order. During observations, the air mattress weight setting was not accurately set to coincide with the resident's weight. The finding is: The facility's policy and procedure titled Pressure Ulcer Prevention-Support Surface Protocol last revised on 4/2024 documented that all residents will be assessed for the risk of skin breakdown. Choose an appropriate support surface according to the assessment findings. Usage of the air mattress will be based on an individual basis and approved by the wound care nurse or designee. Upon approval, the mattress will be ordered and placed on the bed by the Housekeeping/Maintenance department. The correct setting will be set by the nurse, per manufacturer instructions. Monitoring of the air mattress inflation will be done by the nurse every shift and documented on the treatment administration record. The Alternating Pressure with Low Air Loss System operation manual instructed to use the weight button on the control panel to adjust the weight from 100 pounds to 325 pounds according to the patient's weight. Resident #126 was admitted to the facility with diagnoses including Anorexic Brain Damage (damage caused by lack of oxygen to the brain), Type II Diabetes, and Respiratory failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented no Brief Interview for Mental Status (BIMS) score due to Resident #126's severe cognitive impairment. The Minimum Data Set assessment documented that Resident #126 had one Stage 4 (defined as full-thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer on the sacrum. A Physician's order dated 5/3/2024 renewed on 5/24/2024 documented Medihoney (a wound healing medication) 100 percent topical paste. Cleanse the sacrum with a quarter-strength Dakin's solution (a strong topical antiseptic) and pat dry. Apply Nystatin (an anti-fungal medication) cream to the peri-wound skin (the area around the wound). Apply Medihoney to the wound bed then pack with Calcium Alginate (an absorbent dressing) and cover with dry protective dressing daily and as needed. A Physician's order dated 5/3/2024 documented to utilize the Alternating Air Mattress. Monitor for placement and function every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) titled Skin Integrity: Pressure Ulcer renewed on 5/21/2024 documented interventions that included using the alternating air mattress and to monitor for placement and function. A Wound Care Physician Note dated 5/24/2024 documented that Resident #126 had a Stage 4 pressure ulcer to the sacrum. The wound measured 4 centimeters in length by 2 centimeters in width and 2.5 centimeters in depth. The wound bed has 60 % granulation (the appearance of red tissue in the wound bed as the wound heals), 20 % slough (dead cells in the wound bed), and 20 % epithelization (a process when layers of skin cover the surface of the wound for healing). No eschar (dead tissue) was present. A review of the electronic medical record indicated that Resident #126's most recent weight, dated 5/21/2024, was 157 pounds. On 5/22/2024 at 2:15 PM, Resident #126 was observed in bed. The alternating air mattress pump was set at 305 pounds. On 5/23/2024 at 7:50 AM, Resident #126 was observed in bed. The air mattress pump was set at 305 pounds. Licensed Practical Nurse #2 was interviewed on 5/23/2024 at 2:33 PM and stated they worked the 3:00 PM-11:00 shift on 5/22/2024 and the 7:00 AM-3:00 PM shift on 5/23/2024 as the medication nurse. Licensed Practical Nurse #2 stated they did not check the air mattress pump control panel and just signed the electronic medical record for both shifts. Licensed Practical Nurse #2 further stated the medication nurse on each shift is responsible for checking the functioning of the air mattress pump. Registered Nurse #2 (Unit Manager) was interviewed on 5/23/2024 at 2:49 PM. Registered Nurse #2 observed and acknowledged Resident #126's alternating air mattress pump was set at 305 pounds weight setting. Registered Nurse #2 stated that the medication nurses should have checked the alternating air mattress. Registered Nurse #2 stated that the correct weight of Resident #126 must be calibrated on the air mattress to ensure wound healing and offload pressure on the back. Licensed Practical Nurse #3 was interviewed on 5/23/2024 at 3:09 PM and stated they worked the 7:00 AM-3:00 PM shift as a medication nurse on 5/21/2024 and 5/22/2024. Licensed Practical Nurse #3 stated they did not check if the alternating air mattress was set according to Resident #126's weight. Licensed Practical Nurse #3 stated they only check if the mattress is moving and will sign off on the electronic medical record. Licensed Practical Nurse #3 stated they did not know that they had to ensure the resident's weight was accurately reflected on the air mattress control panel. The Director of Nursing Services was interviewed on 5/23/2024 at 3:26 PM and stated that the unit nurses are responsible for checking the alternating air mattress every shift as per the Physician's Order and ensuring that accurate resident's weight is reflected on the air mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Practitioner #1 was interviewed on 5/30/2024 at 12:02 PM and stated when the wound care nurse comes into the facility, they do not check the air mattress during their visit because it is the responsibility of the facility to assign who will monitor the air mattress. As a provider, they monitor the wound status, improvement, or deterioration and will make recommendations. The Nurse Practitioner stated they had spoken to the manufacturer of the air mattress. The Nurse Practitioner stated that the manufacturer is recommending that the weight-setting of the bed should be as close to the actual weight of the resident as possible. 10 NYCRR 415.12(c)(1) 17732 2) Resident #124 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy and Respiratory Failure. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 7 which indicated that the resident had moderately impaired cognitive skills for daily decision-making. The Minimum Data Set assessment documented that the resident had two Stage 2 pressure ulcers (defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising) and one unstageable pressure ulcer (defined as known, but not stageable due to coverage of wound bed by slough and/or eschar). A Physician's Order dated 4/19/2024 documented to cleanse the right hip with normal saline, pat dry, and apply MediHoney (a wound healing medication) to the wound bed and cover with a dry protective dressing daily and as needed for diagnosis of an unstageable pressure ulcer of the right hip. This order was discontinued on 5/2/2024. A Physician's Order dated 5/1/2024 and last renewed on 5/10/2024 documented Alternating Air Mattress: monitor for placement and function every shift. A Physician's Order dated 5/2/2024 last renewed on 5/10/2024 documented to cleanse the right hip with normal saline, pat dry, and apply Silvadene (a wound healing medication) to the wound bed and cover with a dry protective dressing daily and as needed for diagnosis of an unstageable pressure ulcer of the right hip. This order was discontinued on 5/16/2024. A Physician's Order dated 5/16/2024 documented to cleanse the right hip with normal saline, pat dry, and apply MediHoney to the wound bed and cover with a dry protective dressing daily and as needed for diagnosis of an unstageable pressure ulcer of the right hip. The Wound Care Physician Progress Note dated 5/16/2024 documented: The right hip is an unstageable/unclassified pressure ulcer measurements are 1.7 centimeters in length x 1.5 centimeters in width x 0.4 centimeters in depth with an area of 2.55 square centimeters and a volume of 1.02 cubic centimeters. There is a moderate amount of sero-sanguineous drainage noted which has no odor. The wound bed has 20% granulation, 70% slough, and 10% epithelialization; no eschar is present. There is no change in the wound progression. On 5/22/2024 at 12:20 PM Resident #124 was observed in bed. The air mattress pump weight setting was set at 325 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic medical record indicated Resident #124's most recent weight, dated 5/23/2024, was 166 pounds. On 5/23/2024 at 7:50 AM Resident #124 was observed in bed. The air mattress pump weight setting was set at 325 pounds. A review of the May 2024 Treatment Administration Record revealed that Nurses had been documenting every shift that the resident's air mattress was functioning properly as per the Physician's Order. Registered Nurse #2, the Registered Nurse Unit Manager who had signed for the functioning of the resident's air mattress on 5/23/2024 on the 7:00 AM-3:00 PM shift, was interviewed on 5/23/2024 at 2:35 PM. Registered Nurse #2 stated that they signed for the functioning of the resident's mattress on 5/23/2024 but did not check the resident's weight to ensure the air mattress pump was set at the appropriate weight setting, and they should have. Licensed Practical Nurse #3, who had signed for the functioning of the resident's air mattress on 5/22/2024 on the 7:00 AM-3:00 PM shift, was interviewed on 5/23/2024 at 3:05 PM. Licensed Practical Nurse #3 stated when they checked for the functioning of the air mattress, they were only making sure there was air moving in the mattress. Licensed Practical Nurse #3 stated that they had never touched the settings on the machine (pump) on the air mattress at the foot of the resident's bed. The Director of Nursing Services was interviewed on 5/23/24 at 3:25 PM and stated that if the weight setting is set higher than what it needs to be, the mattress could be too firm and the resident may not be getting the full effect of what the mattress is supposed to do and that is to relieve pressure. The Director of Nursing Services further stated they would have to re-educate staff regarding the functioning of the air mattress. 10 NYCRR 415.12(c)(2)

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F 0689 Level of Harm - Minimal harm or potential for 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** 40696 Based on observations, record review, and interviews during the Recertification Survey initiated on 5/22/2024 and completed on 5/30/2024, the facility did not ensure that the resident environment remained as free of accident hazards as is possible. This was identified for three (Resident #58, #91, and #140) of five residents reviewed for Accidents. Specifically, 1) Resident #140 was observed with a Symbicort inhaler medication at the bedside; however, the resident was not assessed to self-administer their medications 2) Resident #58 was observed on two occasions with air freshener spray and a bottle of multi-surface disinfectant cleaner spray at the bedside table; and 3) Resident #91 had an oxygen E-Cylinder oxygen tank freely standing next to the bed with no metal rack or movable caddy to secure the tank. The findings are: 1) The undated facility Safety and Supervision of Residents policy documented the facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. The undated facility Self Medication policy documented upon admission and periodically, each resident is assessed by the interdisciplinary team for capacity to participate in the self-medication program. If the resident is deemed a candidate for self-medication, a Physician order for self-medication will be maintained and include the drug name, dose, frequency, route, and self-medication approval. Resident #140 was admitted to the facility with the diagnoses of Chronic Obstructive Pulmonary Disease, Pneumonia, and Dysphagia. The Admission Minimum Data Set assessment dated [DATE] documented Resident #140 had a brief interview for mental status assessment score of 12, indicating the resident had moderately impaired cognition. The Minimum Data Set assessment also documented that Resident #140 experienced shortness of breath while lying flat and received oxygen therapy while at the facility. Resident #140's Alteration in Respiratory Status Care Plan dated 3/14/2024 documented Resident #140 had Chronic Obstructive Pulmonary Disease and shortness of breath. The interventions documented to administer medication as ordered, assess respirations for rate and quality, and monitor for respiratory distress. Resident #140's Physician's Orders dated 5/16/2024 documented Symbicort 160 micrograms to 4.5 micrograms per actuation Hydrofluoroalkane aerosol inhaler to be administered every 12 hours: 2 puffs by inhalation route. The order directed to keep Resident #140's medication supply locked up in the medication cart, and a nurse was to administer the inhaler. A review of Resident #140's medical record revealed that Resident #140 was not assessed, or care planned to self-administer medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/2024 at 10:50 AM, Resident #140 was observed approaching the nurse's station asking Licensed Practical Nurse #6 for a rescue inhaler (used to relieve the symptoms of an asthma attack quickly) to use it in the rehabilitation gym if they felt out of breath. Licensed Practical Nurse #6 told Resident #140 that only the staff could provide the inhaler treatment to the resident. On 5/22/2024 at 11:55 AM, Resident #140 was observed lying in bed while receiving oxygen via a nasal cannula. A Symbicort 160 micrograms to 4.5 micrograms per actuation Hydrofluoroalkane aerosol inhaler was observed at the resident's bedside. Resident #140 stated they self-administer the inhaler and inform the Licensed Practical Nurse when they (Resident #140) self-administer. Resident #140 stated they typically self-administer the Symbicort inhaler at 8:30 AM and 8:30 PM. An observation of Resident #140's room was made with Licensed Practical Nurse #7 on 5/22/2024 at 3:00 PM. Licensed Practical Nurse #7 observed the Symbicort inhaler at Resident #140's overbed table at the bedside. Licensed Practical Nurse #7 stated that they were the medication nurse for Resident #140 during the day shift today, 5/22/2024. Licensed Practical Nurse #7 stated they supervise Resident #140 while the resident self-administers the Symbicort. Licensed Practical Nurse #7 stated they last observed Resident #140 self-administering the inhaler medication this morning. Licensed Practical Nurse #7 stated that the Symbicort inhaler should have been stored in the medication cart and should not be left at the resident's bedside table. Licensed Practical Nurse #6, who was the Charge Nurse for Resident #140's unit, was interviewed on 5/22/2024 at 3:03 PM. Licensed Practical Nurse #6 reviewed Resident #140's medical record and stated there was no care plan or assessment about Resident #140 self-administering the Symbicort inhaler. Licensed Practical Nurse #6 stated Resident #140's physician's order documented that the nursing staff should administer the Symbicort inhaler to Resident #140 and that the inhaler medication should be stored in the medication cart. Licensed Practical Nurse #6 stated that the Symbicort inhaler should not have been left at the resident's bedside. Resident #140 requires monitored use of the inhaler because there is a risk that Resident #140 could over-administer the medication when they feel out of breath. The Director of Nursing Services was interviewed on 5/23/2024 at 3:36 PM and stated Resident #140 should not have the Symbicort inhaler at their bedside and it should have been stored in the medication cart. The Director of Nursing Services stated that there is a potential that the resident may self-administer the inhaler while unsupervised when the inhaler is left at the bedside. 49245 2) An undated facility's policy and procedure titled Safety Management: Chemicals documented that all chemicals are evaluated and labeled. Safety data sheets are provided [to employees] and employees are trained. The facility will designate a person to oversee the hazard communication program and have Safety Data Sheets (SDS) for all hazardous chemicals in the facility. The Policy indicated that no staff or family members/residents can bring in or have any outside chemicals or cleaning agents brought in for any use. Resident #58 was admitted with diagnoses of Multiple Sclerosis, Major Depressive Disorder, and Arthropathy (joint disease). A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #58 was cognitively intact. The resident had no impairment to their upper extremities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/22/2024 at 10:45 AM, Resident #58 was in bed. An air freshener spray bottle and a half-filled transparent bottle of Multi-Surface Disinfectant cleaner spray were on the bedside table. Registered Nurse #1, Unit Manager, was interviewed on 5/22/2024 at 11:00 AM and stated that Resident #58's family member brought the cleaning supplies. Resident #58 prefers to keep the cleaning supplies in their room. Registered Nurse #1 stated they had spoken to the resident and the family member numerous times about not bringing the cleaning supplies from home. Registered Nurse #1 stated the staff should have reported to Registered Nurse #1 and removed the cleaning supplies from Resident #58's room. During an observation on 5/23/2024 at 7:50 AM, Resident #58 was in bed. A bottle of Multi-Surface Disinfectant cleaner spray was observed on the bedside table next to Resident #58. Housekeeper #1 was interviewed on 5/29/2024 at 10:07 AM and stated they regularly clean Resident #58's room and knew that the resident has cleaning products. Housekeeper #1 stated they had tried helping Resident #58 put the products away but Resident #58 got upset. Licensed Practical Nurse #1 was interviewed on 5/29/2024 at 10:23 AM and stated they told Resident #58 that cleaning supplies were not allowed in the room. Licensed Practical Nurse #1 stated that they (Licensed Practical Nurse #1) had not seen the cleaning supplies in the resident's room for a while; they must have overlooked that Resident #58 still had the cleaning supplies. Licensed Practical Nurse #1 stated that the staff should have been aware and observant of Resident #58's non-compliance with keeping cleaning products. The Material Safety Data Sheet (MSDS) was reviewed with the Director of Maintenance on 5/29/2024 at 12:11 PM. There was no Safety Data Sheet (SDS) documented for the Multi-Surface Disinfectant cleaner spray that was found in the resident's room. The Director of Maintenance was interviewed on 5/29/2024 at 12:11 PM and stated that residents are encouraged not to bring any cleaning products from home. The facility can supply the cleaning products to the residents. There was no Safety Data Sheet (SDS) for the products found in Resident #58's room because the products were brought in by the resident's family member. Certified Nursing Assistant #1 was interviewed on 5/29/2024 at 2:08 PM and stated Resident #58's family member keeps on bringing the cleaning supplies and the resident wanted to keep the supplies in their room. Certified Nursing Assistant #1 stated Resident #58 would use the air freshener if they had a bowel movement. Certified Nursing Assistant #1 stated they had never seen the multi-surface cleaner spray in the resident's room. Certified Nursing Assistant #1 stated they reported that the resident had an air freshener spray in their room (could not recall when) and the nurse spoke to the resident and their family to not bring in the cleaning products. A subsequent interview with Registered Nurse #1 was completed on 5/29/20204 at 2:08 PM. Registered Nurse #1 stated they took out most of the cleaning supplies from Resident # 58's room on 5/22/2024 after the surveyor made the observation. Registered Nurse #1 did not know how Resident #58 acquired another Multi-Surface Disinfectant cleaner spray the following morning, on 5/23/2024. (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 - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 5/30/2024 at 10:41 AM and stated that Resident #58 should not have any cleaning supplies in the room. The Director of Nursing Services stated the staff should have told them (Director of Nursing Services) about the family's noncompliance with the facility policy regarding bringing the cleaning supplies. The Director of Nursing Services stated they would have met with the family member and discussed the facility's Policy with them. The staff are expected to report any chemical products that they see in the resident's room. 3) The facility policy and procedure titled Oxygen Tank Storage last revised on 2/27/2022 documented that oxygen shall be stored in the facility following all federal, state, and local guidelines. Oxygen rooms and closets are appropriately signed and meet all the applicable fire codes. Tanks have rolling safety stands to secure the tank when transporting in the facility and when placed in residents' rooms. Under no circumstances shall tanks be left free-standing, regardless of if they are full or empty. Nursing staff will obtain full tanks from the oxygen rooms or closets and return tanks to the same using the appropriate rolling safety stand. Resident #91 was admitted with Diagnoses of Chronic Obstructive Pulmonary Disease, Dementia, and Osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3 which indicated Resident #91 had severe cognitive impairment. The Minimum Data Set (MDS) documented Resident #91 had shortness of breath or trouble breathing when lying flat. Resident #91's Physician's Order dated 4/7/2024 documented DuoNeb (medication used to treat shortness of breath) 2.5 milligrams-0.5 milligrams per 3 milliliters for nebulization. Inhale 3 milliliters by nebulization route every 6 hours as needed for Chronic Obstructive Pulmonary Disease. The order was discontinued on 4/15/2024. There were no documented Physician's orders for the oxygen use for Resident #91. Resident #91's Alteration in Respiratory Status Comprehensive Care Plan (CCP) dated 1/5/2024 documented interventions that included administering medications as ordered, to monitor effectiveness and for side effects, to elevate the head of the bed while in bed, and to assess respirations for rate and quality. During an observation on 5/22/2024 at 10:00 AM and 3:25 PM, a free-standing, unsecured oxygen E-Cylinder tank was observed next to Resident #91's bed. An oxygen sign was posted outside Resident #91 room. Registered Nurse #1, Unit Manager, was interviewed on 5/22/2024 at 3:35 PM and stated that the resident no longer received oxygen treatment. Registered Nurse #1 stated that the medication nurses are responsible for providing oxygen therapy and storing the oxygen tanks on the Unit. The oxygen tanks should be secured in a rolling safety stand. Registered Nurse #1 did not know why there was an unsecured empty tank in Resident #91's room. Certified Nursing Assistant #2 was interviewed on 5/23/2024 at 2:06 PM and stated they take care of Resident #91 during the dayshift. Certified Nursing Assistant #2 stated they must have overlooked and did not see the unsecured oxygen E-Cylinder tank next to Resident #91's bed. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeper #1 was interviewed on 5/29/2024 at 10:02 AM and stated they had seen the oxygen E-Cylinder tank in Resident #91's room and had spoken to the Certified Nursing Assistants about the tank. Housekeeper #1 did not recall who they had spoken to. Housekeeper #1 stated they continued to clean Resident #91's room as per schedule and thought that it was acceptable to have the oxygen E-Cylinder tank next to Resident #91's bed as it had been there for a while even after they had reported it. Licensed Practical Nurse #1 was interviewed on 5/29/2024 at 12:15 PM and stated that Resident #91 did not have any order for oxygen use. Licensed Practical Nurse #1 stated that instead of using a regular nebulizer machine, the Nurses used the oxygen E-Cylinder tank for nebulization. The order for nebulizer treatment was discontinued as of 4/15/2024. Licensed Practical Nurse #1 stated they should have taken the tank out of the resident's room and ensured that a secured rolling safety stand was provided when in use. Licensed Practical Nurse #1 stated they had overlooked and did not see that the unsecured oxygen E-Cylinder tank was still in Resident #91's room. Respiratory Therapist #1 was interviewed on 5/29/2024 at 1:00 PM and stated the oxygen E-Cylinder tank must be secured in either a metal rack or rolling safety stand due to the risk of falling and the tank exploding if it's full. If it was not full, there would be a risk of the metal tank falling on someone and causing an injury. The Director of Nursing Services was interviewed on 5/30/2024 at 10:27 AM and stated they did not know the nursing staff was using an oxygen E-Cylinder tank for nebulization purposes. The Director of Nursing Services stated they have plenty of nebulizer machines in the facility to use. The Director of Nursing Services further stated that the oxygen tank must always be secured by using a rolling safety stand. 10 NYCRR 415.12(h)(1)

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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** 40696 Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00329525) initiated on 5/22/2024 and completed on 5/30/2024, the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the Payroll-Based Journal Staffing Data Report indicated that the facility had a 1-star staffing rating; Ten (Resident #8, #20, #55, #59, #66, #72, #99, #113, #117, and #119) out of Ten residents in the Resident Council Task reported complaints about short staffing; and a random sampling of facility nursing staffing assignments did not reflect the staffing ratio as indicated in the facility assessment for the Certified Nurse Aides. The findings are but not limited to: The facility assessment dated [DATE] documented that the facility had a 180-bed capacity with an average daily census of 161.77 based on the last 10 months' facility census. The nursing staff assignments are assessed by the Director of Nursing/designee at least monthly to determine that the heaviness of assignments is distributed equally (i.e., # of Hoyer list residents). The facility assessment documented the following staffing plan: -During the Day shift (7:00 AM-3:00 PM) a ratio of one Certified Nurse Aide for eight residents -During the Evening shift (3:00 PM-11:00 PM) a ratio of one Certified Nurse Aide for eight residents -During the Night shift (11:00 PM-7:00 AM) a ratio of one Certified Nurse Aide for 13 residents The staffing plan did not specify the number of Licensed Practical Nurses and Registered Nurses needed on the units during the day shift, evening shift, and night shift. The Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter One 2024 (October 1st-December 31st) documented the facility triggered for the Metric of One Star Staffing Rating and Excessively low weekend staffing based on facility submitted staffing data. A review of the Facility Unit Census log from 12/31/2024 to 4/28/2024 revealed that in Unit 1 Center the resident census was between 30 and 34. A review of the 11:00 PM-7:00 AM shift schedule dated 3/30/2024 and 3/31/2024 on Unit 1 Center indicated there was one Certified Nurse Aide assigned to 25 residents on 3/30/2024 and one Certified Nurse Aide was assigned to 28 residents on 3/31/2024. The facility did not maintain a ratio of one Certified Nurse Aide to 13 residents as indicated in the facility assessment. A review of the 7:00 AM-3:00 PM shift schedule on Unit 1 Center from 12/31/2023 to 4/28/2024 indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/20/2024 there were two Certified Nurse Aides on the schedule indicating the ratio of one Certified Nurse Aide to 16 residents. - On 1/7/2024 there were two Certified Nurse Aides on the schedule indicating the ratio of one Certified Nurse Aide to 17 residents. - On 1/10/2024, 1/14/2024, 1/15/2024, 1/21/2024, 2/10/2024, 2/11/2024, 2/14/2024, 2/26/2024, 3/9/2024, 3/16/2024, 4/14/2024, 4/21/2024, and 4/28/2024 there were three Certified Nurse Aides on the schedule indicating the ratio of one Certified Nurse Aide to ten residents. -On 12/31/23, 1/1/2024, 1/6/2024, 2/12/2024, 2/13/2024, 2/18/2024, 2/19/2024, 3/1/2024, 3/2/2024, 3/3/2024, and 4/27/2024 there were three Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to eleven residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the 3:00 PM-11:00 PM shift schedule on Unit 1 Center from 12/31/2023 to 4/28/2024 indicated the following: -On 12/31/2023 there were three Certified Nurse Aides on the schedule indicating one Certified Nurse Aide to 11 residents - On 1/1/2024 there were two Certified Nurse Aides on the schedule indicating one Certified Nurse Aide for 16.5 residents. -On 1/15/2024 there were two Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 15 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the Facility Unit Census log revealed Unit 1 North maintained a census between 26 to 35 on dates identified with short staffing from 12/31/23 to 4/7/24. A review of the 3:00 PM-11:00 PM shift schedule on Unit 1 North from 12/31/2023 to 4/28/2024 indicated the following: -On 12/31/2023 there were two Certified Nurse Aides on the schedule indicating one Certified Nurse Aide to 13 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the 7:00 AM-3:00 PM shift schedule on Unit 1 North from 12/31/2023 to 4/28/2024 indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 2/26/2024 and 3/2/2024 there were three Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 12 residents. -On 3/24/2024 and 4/7/2024 there were three Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 11 residents -On 1/10/2024, 1/20/2024, 1/21/2024, 2/11/2024, 2/14/2024, 3/16/2024, and 3/17/2024 there were three Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 10 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the Facility Unit Census log revealed Unit 1 [NAME] maintained a census between 30 to 35 residents from 12/31/2023 to 4/28/2024. A review of the 11:00 PM-7:00 AM shift schedule on Unit 1 [NAME] from 12/31/2023 to 4/28/2024 indicated the following: -On 1/1/2024 there was only one Certified Nurse Aide on the schedule indicating a staffing ratio of one Certified Nurse Aide to 32 residents. -On 1/6/2024 there was only one Certified Nurse Aide on the schedule indicating a staffing ratio of one Certified Nurse Aide to 31 residents. The facility did not maintain a ratio of one Certified Nurse Aide to 13 residents as indicated in the facility assessment. A review of the 7:00 AM-3:00 PM shift schedule on Unit 1 [NAME] from 12/31/2023 to 4/28/2024 indicated the following: -On 1/7/2024 there were two Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 15 residents. -On 2/14/2024, 2/18/2024, 4/6/2024, 4/7/2024, 4/13/2024, 4/20/2024, 4/21/2024, 4/27/2024, and 4/28/2024 there were three Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 11 residents. -On 12/31/2023, 1/1/2024, 1/20/2024, 1/21/2024, 2/13/2024, 2/26/2024, 3/1/2024, 3/2/2024, 3/3/2024, 3/16/2024, 3/24/2024, and 3/31/2024 there were three Certified Nurse Aides on the schedule indicating a ratio of one Certified Nurse Aide to 10 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the 3:00 PM-11:00 PM shift schedule on Unit 1 [NAME] from 12/31/2023 to 4/28/2024 indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/31/2023 and 3/1/2024 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 10 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the Facility Unit Census log revealed Unit 2 Center maintained a census between 32 and 36 on dates identified with short staffing from 12/31/2023 to 4/28/2024. A review of the 11:00 PM- 7:00 AM shift schedule on Unit 2 Center from 12/31/2023 to 4/28/2024 indicated the following: -On 1/6/2024 there was only one Certified Nurse Aide assigned on the schedule indicating a staffing ratio of one Certified Nurse Aide to 33 residents. -On 3/9/2024 there was only one Certified Nurse Aide assigned to the schedule indicating a staffing ratio of one Certified Nurse Aide to 36 residents. -On 3/31/2024 and 4/28/2024 there was only one Certified Nurse Aide assigned on the schedule indicating a staffing ratio of one Certified Nurse Aide to 32 residents. The facility did not maintain a ratio of one Certified Nurse Aide to thirteen residents as indicated in the facility assessment. A review of the 7:00 AM-3:00 PM shift schedule on Unit 2 Center from 12/31/2023 to 4/28/2024 indicated the following: -On 3/16/2024 and 3/17/2024 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 12 residents. -On 12/31/2023, 1/1/2024, 1/6/2024, 1/7/2024, 1/10/2024, 1/14/2024, 1/15/2024, 2/11/2024, 2/12/2024, 2/13/2024, 2/14/2024, 2/19/2024, 2/26/2024, 3/1/2024, 3/2/2024, 3/24/2024, 4/6/2024, 4/7/2024, and 4/21/2024 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 11 residents. -On 3/31/2024, 4/13/2024, 4/20/2024, 4/27/2024, and 4/28/2024 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 10 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the 3:00 PM-11:00 PM shift schedule on Unit 2 Center from 12/31/2023 to 4/28/2024 indicated the following: -On 12/31/2023 there were two Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 17.5 residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/1/2024 and 3/10/2024 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 12 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the Facility Unit Census log revealed Unit 2 [NAME] maintained a census between 30 and 33 on dates identified with short staffing from 12/31/2023 to 4/28/2024. A review of the 11:00 PM-7:00 AM shift schedule on Unit 2 [NAME] from 12/31/2023 to 4/28/2024 indicated the following: -On 1/1/2024 there was only one Certified Nurse Aide on the schedule indicating a ratio of one Certified Nurse Aide to 33 residents. -On 2/26/2024 there was only one Certified Nurse Aide on the schedule indicating a ratio of one Certified Nurse Aide to 26 residents. -On 3/1/2024 and 3/2/2024 there was only one Certified Nurse Aide on the schedule indicating a ratio of one Certified Nurse Aide to 28 residents. The facility did not maintain a ratio of one Certified Nurse Aide to thirteen residents as indicated in the facility assessment. A review of the 7:00 AM-3:00 PM shift schedule on Unit 2 [NAME] from 12/31/2023 to 4/28/2024 indicated the following: On 12/31/2023 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 11 residents. -On 1/1/2024 there were two Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 16.5 residents. -On 1/6/2024 there were two Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 15 residents. -On 1/7/2024, 1/14/2024, 1/10/2024, 1/20/2024, 2/10/2024, 2/11/2024, 3/24/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/27/2024, and 4/28/2024 there were three Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 10 residents. - On 3/16/2024 and 3/17/2024 there were two Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 14.5 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. A review of the 3:00 PM-11:00 PM shift schedule on Unit 2 [NAME] from 12/31/2023 to 4/28/2024 indicated the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/31/2023 and 1/1/2024 there were two Certified Nurse Aides on the schedule indicating a staffing ratio of one Certified Nurse Aide to 16.5 residents. The facility did not maintain a ratio of one Certified Nurse Aide to eight residents as indicated in the facility assessment. The Resident Council task was completed on 5/23/2024 at 10:15 AM. During the meeting, 10 out of 10 residents stated the facility is very short-staffed. Resident #66 stated they missed two showers in the same week and received bed baths due to short staffing. Resident #20 stated that weekends have fewer nursing staff than during the weekdays. Resident # 72 stated they had been told by Certified Nurse Aides I am here alone, and you can't get your shower today. Certified Nurse Aide #11 was interviewed on 5/22/2024 at 2:19 PM and stated that they are not assigned to a specific unit and provide Certified Nurse Aide coverage on the day shift. Certified Nurse Aide #11 stated that the facility is chronically understaffed due to callouts and the facility's inability to get staff to cover the callouts. The Certified Nurse Aides are overworked as there have been several occasions when there were only two aides providing care for an entire unit. One Certified Nurse Aide is assigned to care for 13 to 16 residents on the day shift. Certified Nurse Aide #11 stated when there are too many residents to care for, they have to give a bed bath instead of a shower. Certified Nurse Aide #11 stated sometimes they have many residents on their assignments who require assistance with meals and have to wait to be fed due to short staffing. Certified Nurse Aide #12 was interviewed on 5/23/2024 at 12:01 PM and stated they usually work on different units throughout the facility to provide Certified Nurse Aide coverage on the day shift. Certified Nurse Aide #12 stated there are usually two Certified Nurse Aides for 35-36 residents on Unit 1 West. Certified Nurse Aide #12 stated when they are assigned to care for 13 residents, they have to provide bed baths instead of showers. Certified Nurse Aide #12 stated residents complain about food being cold because there are not enough staff to serve their meals on time. Certified Nurse Aide #12 stated that after finishing morning care for their assigned residents, they were told to go to other units to start care for residents who had been waiting because the units were understaffed. Certified Nurse Aide #10 was interviewed on 5/28/2024 at 9:24 AM and stated the dayshift frequently has 2-3 aides per unit. Previously there used to be five aides per unit. When there are only 2-3 aides on the day shift, the residents receive bed baths instead of showers because there is not enough time to provide showers. The Staffing Coordinator was interviewed on 5/30/2024 at 12:22 PM and stated they have worked as a Staffing Coordinator for six years at the facility. In the past, they used to schedule five Certified Nurse Aides per unit on the dayshift but now they schedule four Certified Nurse Aides instead. The Staffing Coordinator stated that based on the par levels there should be no more than eight residents assigned to each Certified Nurse Aide on the rehabilitation units and nine residents per Certified Nurse Aide on the long-term care units during the day shift and evening shift. There should be two Certified Nurse Aides on each unit for the night shift. The Administrator and the Director of Nursing directed them to continue using the same par level when the new ownership took over. The Staffing Coordinator reviewed the staffing sheets from December 2023 to April 2024 and stated that the facility is understaffed, has trouble recruiting new staff, and there is a lot of staff turnover. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing Services was interviewed on 5/30/2024 at 12:47 PM and stated that all units should have four Certified Nurse Aides on the day shift, 3-4 Certified Nurse Aides on the evening, and two Certified Nurse Aides on the night shift. The Director of Nursing Services stated that the facility is short-staffed due to a lot of callouts. The Director of Nursing Services stated that at times they had to come into the facility to assist the direct care staff because there were not enough Certified Nurse Aides to tend to the residents. The Director of Nursing Services further stated that the facility has trouble retaining new nursing staff. The Administrator was interviewed on 5/30/2024 at 2:18 PM and stated the facility is struggling with nursing staff calling out. The Administrator acknowledged that the facility is short-staffed, especially with Certified Nurse Aides. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40696 Based on observation, record review, and interviews during the Recertification Survey initiated on 5/22/2024 and completed on 5/30/2024, the facility did not ensure that all drugs and biologicals were stored in locked compartments. This was identified for one (Resident #140) of five residents reviewed for Accidents. Specifically, on 5/22/2024 at 11:55 AM and 3:00 PM, Resident #140 was observed with a Symbicort 160 micrograms to 4.5 micrograms per actuation Hydrofluoroalkane aerosol inhaler stored at the bedside and there was no staff in the vicinity. Additionally, Resident #140 was not assessed to self-administer their medications. The finding is: The undated facility's Medication Storage policy documented that medications must be stored and secured in locked storage areas in compliance with State and Federal requirements and professional standards of practice. Access to medications is limited to authorized personnel only. Resident #140 was admitted to the facility with the diagnoses of Chronic Obstructive Pulmonary Disease, Pneumonia, and Dysphagia. The Admission Minimum Data Set assessment dated [DATE] documented Resident #140 had a brief interview for mental status assessment score of 12, indicating the resident had moderately impaired cognition. The Minimum Data Set assessment also documented that Resident #140 experienced shortness of breath while lying flat and received oxygen therapy while at the facility. Resident #140's Alteration in Respiratory Status Care Plan dated 3/14/2024 documented Resident #140 had Chronic Obstructive Pulmonary Disease and shortness of breath. The interventions documented to administer medication as ordered, assess respirations for rate and quality, and monitor for respiratory distress. Resident #140's Physician's Orders dated 5/16/2024 documented Symbicort 160 micrograms to 4.5 micrograms per actuation Hydrofluoroalkane aerosol inhaler to be administered every 12 hours: 2 puffs by inhalation route. The order directed to keep Resident #140's medication supply locked up in the medication cart, and a nurse was to administer the inhaler. Resident #140 was observed lying in bed and was receiving oxygen via a nasal cannula on 5/22/2024 at 11:55 AM. A Symbicort inhaler was observed at the overbed table at the resident's bedside. Resident #140 stated they self-administer the Symbicort inhaler and inform the Licensed Practical Nurse when they (Resident #140) self-administer. Resident #140 stated they typically self-administer the Symbicort inhaler at 8:30 AM and 8:30 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335022	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sands Point Center for Health and Rehabilitation	1440 Port Washington Blvd Port Washington, NY 11050

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #140's room was made with Licensed Practical Nurse #7 on 5/22/2024 at 3:00 PM. Licensed Practical Nurse #7 observed the Symbicort inhaler at Resident #140's overbed table at the bedside. Licensed Practical Nurse #7 stated they were the medication nurse for Resident #140 during the day shift today, 5/22/2024. Licensed Practical Nurse #7 stated they last observed Resident #140 self-administering the inhaler medication this morning. Licensed Practical Nurse #7 stated they had signed that the inhaler medication was administered. Licensed Practical Nurse #7 stated the Symbicort inhaler should have been stored in the medication cart and should not be left at the resident's bedside table. Licensed Practical Nurse #6, who was the Charge Nurse for Resident #140's unit, was interviewed on 5/22/2024 at 3:03 PM. Licensed Practical Nurse #6 stated Resident #140's physician's order documented that the nursing staff should administer the Symbicort inhaler for Resident #140 and the inhaler medication should be stored in the medication cart. Licensed Practical Nurse #6 stated that the Symbicort inhaler should not have been left at the resident's bedside. The Director of Nursing Services was interviewed on 5/23/2024 at 3:36 PM and stated Resident #140 should not have the Symbicort inhaler at their bedside because there is a potential that the resident may self-administer the inhaler while unsupervised when the inhaler is left at the bedside. The Director of Nursing Services further stated the Symbicort inhaler should have been stored in the medication cart. 10 NYCRR 415.18(e)(1-4)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on record review and interview during the Recertification Survey initiated on 5/22/2024 and completed on 5/30/2024, the facility did not ensure that the facility assessment included what resources were necessary to care for its residents competently during day-to-day operations. Specifically, the facility assessment did not include the overall number of qualified nursing staff to meet each resident's needs. The finding is: The facility assessment dated [DATE] documented the following staffing plan: -One Director of Nursing Services full-time days -Assistant Director of Nursing Services full-time days -Registered Nurse Minimum Data Set full-time days -Registered Nurse Supervisor full-time days -Registered Nurse Charge -Registered Nurse Charge Supervisor -Registered Nurse Supervisor full-time evenings -Registered Nurse Supervisor full-time nights -Licensed Practical Nurse 7 full-time -15 Day shift Certified Nurse Aides, for a ratio of one Certified Nurse Aide to eight Residents -15 Evening shift Certified Nurse Aides, for a ratio of one Certified Nurse Aide to eight Residents -Seven Night shift Certified Nurse Aides, for a ratio of one Certified Nurse Aide to 13 Residents The staffing plan did not specify the number of Licensed Practical Nurses and Registered Nurses on the units on the day shift, evening shift, and night shift. (continued on next page)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	The Administrator was interviewed on 5/30/2024 at 2:06 PM and stated they reviewed the facility assessment on 3/6/2024 but did not notice that the number of licensed nurses per shift was missing. The Administrator stated that the facility assessment staffing plan for Certified Nurse Aides was incorrect. The Administrator stated that the overall number of Certified Nursing Aides should be higher to maintain the ratio of 1:8 residents. The Administrator stated the facility has 180 certified beds, and the number of Certified Nurse Aides listed on the staffing plan may be based on the 120 beds instead of the 180 beds. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34798 Based on observation, record review, and staff interviews during the Recertification Survey initiated on 5/22/2024 and completed on 5/30/2024 the facility did not ensure that it maintained an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections for one (Resident #81) of one resident reviewed for skin conditions. Specifically, during the wound care observation of Resident #81's left heel ulcer, performed by Registered Nurse #5, the nurse did not perform hand hygiene after cleaning the wound and allowed the cleansed heel wound to come in direct contact with a dirty surface (the bed sheet). The finding is: The facility policy titled Clean Dressing, revised 12/2023, documented to ensure that procedures are followed to prevent the wound from becoming worse and to promote healing. Procedures include to position resident appropriately (get assistance if needed), remove gloves and perform hand hygiene after removing the dirty dressing, don (put on) gloves and clean wound starting from center to outwards, remove gloves and perform hand hygiene, put on clean pair of gloves and perform treatment as ordered. The facility's undated clean dressing technique competency documented to ensure the resident is positioned appropriately; the nurse should remove gloves, cleanse hands, and reapply clean gloves after cleaning the wound. This competency was signed by Registered Nurse #5 on 1/30/2024. Resident #81 was admitted with diagnoses including Diabetes Mellitus, Peripheral Vascular Disease, and Non-Pressure Chronic Ulcer of the Heel. The 5/10/2024 Annual Minimum Data Set assessment documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. A physician's order dated 5/9/2024 and renewed on 5/27/2024 documented MediHoney (a wound medication) 100% topical paste, to the left heel, cleanse with normal saline, pat dry, apply MediHoney to the wound bed and cover with dry protective dressing daily for non-pressure chronic ulcer of the heel. A wound care consultant note dated 5/16/2024 documented left heel wound is a Diabetic ulcer measuring 3 centimeters in length by 2 centimeters in width by 0.2 centimeters in depth. There is a moderate amount of serosanguinous (blood-tinged) drainage. The resident reports pain of 0 out of a scale of 10. The wound is deteriorating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/2024 at 10:36 AM Resident #81 was observed in bed and received wound care performed by Registered Nurse #5. The wound care supplies were set up on an overbed table and were brought into the resident's room. The left heel had eschar (dead tissue) with some redness around the wound and there was minimal drainage observed on the soiled dressing. The resident winced and grimaced when the nurse cleansed the wound. Registered Nurse #5 was holding the resident's leg off the mattress with one hand while cleansing the wound. There was no protective barrier placed on the mattress. When Registered Nurse #5 completed cleaning the wound, they allowed the cleansed wound to come to rest directly on the dirty mattress sheet. This was brought to Registered Nurse #5's attention by the surveyor. The nurse asked the resident to provide a pillow that the resident was using to rest their head on. Registered Nurse #5 placed the pillow under the resident's lower left leg, thereby elevating the left heel off the mattress. Registered Nurse #5 did not re-cleanse the heel wound or wash or sanitize their hands. Registered Nurse #5 reached for the Medihoney treatment, which was already applied to a tongue depressor. This was brought to Registered Nurse #5's attention. The nurse then washed their hands. Registered Nurse #5 was interviewed on 5/28/2024 at 12:48 PM and stated they were nervous during the wound care treatment and should have sanitized their hands after cleansing the wound. Registered Nurse #5 also stated they did not have anyone to help them with the wound care and they should not have let the heel ulcer come in direct contact with the bed or the mattress after the wound was cleansed. The Registered Nurse Infection Preventionist was interviewed on 5/28/2024 at 3:39 PM and stated the nurse should have asked for staff assistance to hold the resident's leg up or find some way to support the resident's leg before starting the wound care. The Infection Preventionist stated after cleaning the wound, the nurse should have sanitized their hands before attempting to apply the clean treatment. The Director of Nursing Services was interviewed on 5/29/2024 at 8:59 AM and stated the nurse should have sanitized their hands after cleaning the wound and should not have allowed the cleaned wound to come in direct contact with the bed or the mattress. If the resident could not hold their leg up, the nurse should have asked for help with the wound care. 10 NYCRR 415.19 (a)(1-3)