STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335044	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Far Rockaway Center for Rehabilitation and Nursing	13 11 Virgina St Far Rockaway, NY 11691

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44864 Based on interviews and record review conducted during the Recertification survey from 07/21/2024 to 07/25/2024, the facility did not ensure a resident, or their designated representative was provided appropriate notification at the termination of Medicare Part A benefits. This was evident for 1 (Resident #73) of 3 residents reviewed for Beneficiary Notification out of 28 total sampled residents. Specifically, the Notice of Medicare Non-Coverage were not mailed out to Resident #73's designated representatives on the same day as telephone notification. The findings are: Resident #73 was discharged from skilled services on 1/24/24. The Notice of Medicare Non-coverage documented that on 1/22/24, Resident #73's Representative was made aware that their last coverage date would be 1/24/24 and that a message was left by the Minimum Data Set Director, regarding content of the letter. The Notice of Medicare Non-coverage form also documented that the facility was waiting for a return call from the Resident #73's Representative. On 07/24/24 at 1:30 PM, the Minimum Data Set Director provided a Certified Mail Receipt addressed to Resident #73's Representative. The Certified Mail Receipt contained a signature but no date of delivery. The United States Postal Service Tracking number on the Certified Mail Receipt addressed to Resident #73's Representative indicated that there was no status update on when the mail was sent or arrived. On 07/25/24 at 02:18 PM, the Resident #73's Representative was contacted and stated that they did not receive a letter from the facility after 1/22/24 regarding any notices from the facility. Resident #73's Representative also stated that they did not know if maybe a letter was sent out and the facility had the wrong address, however the Administrator called them on 07/24/24 to verify their address. On 07/25/24 at 02:46 PM, the Administrator was interviewed and stated that they did not know if Resident #73's Representative received the Notice of Medicare Non-Coverage and that they are reviewing their systems on sending out the letters. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 03:01 PM, the Minimum Data Set Director was interviewed and stated that they are responsible for giving the letters for Notice of Medicare Non-Coverage. The letters are given out 2 days prior to the resident's last covered day. The Minimum Data Set Director also stated that they provide the letter to the residents who are cognitively intact, and for residents who are not cognitively intact the family is called. The Minimum Data Set Director further stated that if they cannot reach the representative after several calls, they would notify the Administrator who oversees sending out the letters. The Minimum Data Set Director stated that they did not know if the Resident #73's Representative had received the Notice of Medicare Non-Coverage. 10 NYCRR 415.3(g)(2)(i)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 50894 Based on observation, interviews, and record review conducted during the Recertification Survey from 07/21/2024 through 07/25/2024, the facility did not ensure that residents' privacy was maintained. This was evident for 2 of 2 residents (#23 & #27) reviewed for Privacy out of 28 sampled residents. Specifically, Licensed Practical Nurses were observed performing blood glucose monitoring and insulin administration in the hallway. The findings are: The facility policy and procedure titled Quality of Life/Dignity revised 10/2023, documented that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1. On 07/22/2024 at 04:06 PM, Licensed Practical Nurse #1 was observed in the North Unit hallway with Resident #23. Resident #23 was standing beside the medication cart while Licensed Practical Nurse #1 conducted blood glucose testing and then administered insulin to Resident #23. Other residents and staff members were present in the hallway while the testing was done and insulin was given. 2. On 07/22/24 at 04:51 PM, Licensed Practical Nurse #4 was observed in the South Unit hallway with Resident #27. Resident #27 was standing beside the medication cart while Licensed Practical Nurse #4 conducted blood glucose testing. Other residents and staff members were present in the hallway while the testing was done. On 07/24/2024 at 03:31 PM, Licensed Practical Nurse #4 was interviewed and stated that they do not perform blood glucose monitoring on residents in their rooms but instead try to isolate them as much as possible in the hallway. Licensed Practical Nurse #4 also stated that there was no particular reason why they do not perform blood glucose monitoring in resident rooms, and that doing it in the resident's room would be the most private place to do it in. Licensed Practical Nurse #4 further stated that they were unfamiliar with any facility policy related to maintaining resident privacy during treatments. On 07/24/2024 at 03:45 PM, Licensed Practical Nurse #1 was interviewed and stated that to maintain resident's privacy during treatments, the nurse will take the resident to their room and close the door or curtain. Licensed Practical Nurse #1 stated that they are supposed to do blood glucose monitoring and insulin administration in the resident's room, but they did it in the hallway with Resident #23 because they were nervous. On 07/25/24 at 12:25 PM, the Assistant Director of Nursing was interviewed and stated that finger sticks for blood glucose monitoring should be completed in resident rooms. The Assistant Director of Nursing also stated that performing treatments in the hallway does not follow best practices. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 03:52 PM, the Director of Nursing was interviewed and stated that blood glucose monitoring and insulin administration should be conducted in private, which involves closing the door, pulling the curtain, and ensuring that medical information is not discussed in an area where other residents can hear it. The Director of Nursing also stated that the hallways are not considered a private area to perform blood glucose monitoring or insulin administration. 10 NYCRR 415.3(e)(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44472 Based on observations and interviews conducted during a Recertification survey from 07/21/24 to 07/25/24, the facility did not ensure that housekeeping and maintenance services were provided to maintain a safe, clean, comfortable, and homelike environment. Specifically multiple areas were observed to have broken blinds, mishung privacy curtains, furniture which was soiled and in disrepair, warped and loose floor tiles, resident equipment in disrepair, room sinks not firmly affixed to wall and torn, and frayed and stained clean linen cart covers. This was evident in 2 of 3 Units. (Units South and North) The findings include but are not limited to: 1.During observations made from 07/21/24 at 9:22 AM through 07/25/24 at 11:24 AM the following were observed on the South Unit. 1.) Room # 13 with multiple broken blinds 2.) Dining room with multiple broken and missing window slats 3.) Room # 16 with curtain off the hook 4.) room [ROOM NUMBER] with curtain off the hook On 07/25/24 at 12:18 PM, an interview was conducted with the Director of Maintenance and Housekeeping who stated that they are aware that they have to replace broken window blinds and missing slats on the window blinds. The Director of Maintenance also stated that they currently have no replacements for the broken window blinds and missing slats. On 07/25/24 at 01:20 PM, the Administrator was interviewed and stated new blinds are on order now and will soon be delivered. Once delivered they will immediately replace all broken blinds and missing window slats. Observations made from 07/21/24 beginning at 9:22 AM through 07/25/24 at 11:24 AM the following were observed on the South Unit. 19546 2. During observations made from 07/21/24 at 10:21 AM through 07/25/24 at 10:40 AM, the following was observed on the North Unit. 1.) Outside room [ROOM NUMBER]: a.) wheelchair with torn bilateral arm rests, and metal frame below seat encrusted with dirt and debris. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) room [ROOM NUMBER]: a.) wheelchair with rusty metal frame, torn arm rest. 3.) Corridor bathroom across from room [ROOM NUMBER]: a.) metal frame chair inside the bathroom with torn armrest, tattered, and in disrepair. b.) rusty wall mounted paper towel dispenser. 4.) Corridor Area: a.) Two (2) blue mesh clean linen cart covers stained, torn, and frayed. 5.) room [ROOM NUMBER]a: a.) Torn privacy curtains b.) window curtains torn, hanging off window hooks 6.) Main Dining Room Area: a.) wobbly dining room tables b.) 3 half-moon shaped dining tables with rough bottom edges, rusty nails on top side of tables c.) window shade near exit door missing slat. d.) peeled, cracked paint surrounding air conditioner. e.) opened space surrounding the air conditioner. f.) radiators rusty and dusty. g.) dusty, sticky floors. 6a: Small TV area: a.) small television room area adjacent to the main dining room observed with wall mounted fan layered with dirt and dust. 7.) room [ROOM NUMBER]c: a.) torn back side of wheelchair with torn bilateral arm rests, metal frame layered with dirt and debris. 8.) room [ROOM NUMBER]a: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.) room sink with faulty handles, leaky faucet. b.) dresser drawer missing two of three drawer handles. c.) closet door unable to properly latch, uneven door closet, not firmly affixed to back hooks. 9.) room [ROOM NUMBER]b: a.) missing nail that secures the room number to the door. room [ROOM NUMBER] sticking out. b.) top closet drawer broken, off hinge, in disrepair. c.) bottom closet drawer unable to fully close. d.) room tray tables on a slant, wobbly, peeled, chipped table tops. 9.) room [ROOM NUMBER]a: a.) torn privacy curtains. b.) torn bilateral arm rest to wheelchair. 10.) room [ROOM NUMBER]: a.) bubbled up flooring, loose flooring in places, multiple flies in room. 11.) room [ROOM NUMBER]: a.) wheelchair with torn bilateral arm rests. 12.) room [ROOM NUMBER]: a.) multiple flies in room. b.) sticky floors. c.) torn, dusty window curtains hanging off hook. d.) room sink with cracked caulking, not firmly affixed to wall. Rusty streaks beneath sink wall. 13.) Corridor bathroom across from room [ROOM NUMBER] a.) metal frame chair with torn arm rest, rusty metal frame, in disrepair. On 07/24/24 the North Unit Maintenance Work Book was reviewed from dates 01/02/24 to 06/28/24 and revealed that there was no documented evidence the above concerns had been logged in. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/25/24 at 10:49 AM, Certified Nurse Aide #1 stated that when environmental concerns are identified, they can either verbally notify the Environmental Department or they can write concerns in the log book. On 07/25/24 at 10:50 AM, the North Unit Licensed Practical Nurse #1 was interviewed and stated that environmental issues are communicated either verbally or are noted in the log book located on the unit. Housekeeper #1 was interviewed on 07/25/24 at 10:55 AM and stated that they are responsible for cleaning all resident rooms from top to bottom. Housekeeper #1 also stated that when they come across issues that need repair or replacement, they verbally notify their supervisor, and staff can also make a written request in the log book for issues that they might identify. Housekeeper #1 further stated that there is an exterminator who comes in on a regular basis to address rodents, flies and other vermin. Housekeeper #1 stated they verbally report furniture and floor issues to maintenance and recently verbally reported the bubbled-up flooring but could not recall how long ago this was done. The Director of Housekeeping/Maintenance was interviewed on 07/25/24 at 11:223 AM and stated that the exterminator comes in 2 times a week, has targeted areas that they look at, and the fly situation has gotten a whole lot better. The Director of Housekeeping/Maintenance also stated that on each unit there is a Maintenance Work Book in which any staff can make a written report regarding environmental concerns, which is reviewed by maintenance staff at least twice a day. The Director of Housekeeping/Maintenance further stated their role is to try to maintain and provide a safe and comfortable environment for all of the residents, and they make multiple environmental observations to identify safety hazards, which they would address first. The Director of Housekeeping/Maintenance stated that there are some challenging residents, and they try to keep up to prevent a worse situation from occurring. The Director of Housekeeping/Maintenance stated that there is no set schedule for power washing the residents equipment. 10 NYCRR 415.5(h)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18881 Based on record review and interviews conducted during the Recertification Survey from 07/21/2024 to 07/26/2024, the facility did not ensure a person-centered comprehensive care plan was developed and implemented to meet a resident's needs. This was evident for 1 (Resident #87) of 1 resident reviewed for Communication/Sensory out of 28 sampled residents. Specifically, there was no care plan created for Resident #87 who had concerns with vision. The findings include: The facility policy titled Care Plan-Comprehensive created 10/2015 and revised 10/2023 stated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care planning process will facilitate resident and or representative involvement, include an assessment of the resident's strength and needs and incorporate the resident's personal and cultural preferences in developing the goals of care. The Comprehensive Care person centered care plan will incorporate identified problem areas and areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Will aid in preventing or reducing decline in the resident's functional status or functional levels and enhance the optimal functioning of the resident by focusing on a rehabilitative program. Resident #87 was admitted to the facility with diagnoses that included Anemia, Malnutrition, and Dry Eye Syndrome. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #87 had impaired vision and used corrective lenses. On 07/24/2024 at 1:01 PM, Resident #87 was observed in their room wearing a pair of eyeglasses and writing in a book. The Consult Form dated 12/1/2023 documented that Resident #87 was seen by the Optometrist for Dry Eye Syndrome in both eyes. No new recommendations were made, and resident was scheduled for follow-up in December 2024. bilateral eyes. The Report of Consultation dated 12/12/23 documented that Resident #87 was seen by Ophthalmologist for left eye pain and was to be seen for follow-up in three months. There was no documented evidence that a Comprehensive Care Plan for vision was initiated for Resident #87. On 07/25/2024 at 10:01AM, the Director of Nursing was interviewed and stated that resident's care plans are done by the Unit Managers and Registered Nurse Supervisor on admission, significant change, quarterly and as needed if there are new care areas that needed to be addressed and care planned for. The Director of Nursing also stated that upon doing a quality review on care plans, they found out that there was no care plan for vision for Resident # 87 and that was an oversight on their part. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.3(h)(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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50894 Based on observations, record review, and interviews conducted during the Recertification and survey from 07/21/2024 to 07/25/2024, the facility did not ensure services provided met professional standards. This was evident for 1 (Resident #27) out of 29 total sampled residents. Specifically, Licensed Practical Nurse #4 was observed conducting blood glucose monitoring and then failing to administer insulin as per the doctor's order. The facility policy and procedure titled Blood Glucose Testing, Meter/Device Use revised 02/01/2024 states that the first step of blood glucose testing using the meter is to verify a healthcare provider's order for the procedure. After testing the blood glucose level, the procedure states to record the results of the blood glucose test on the resident's medication administration record and follow appropriate interventions regarding blood glucose testing results. Resident #27 was admitted to the facility with diagnoses that included Parkinson's Disease and Diabetes Mellitus. The Physician's Order for Resident #27 with start date 2/13/24 documented inject 19 units of Novolog Solution 100 unit/ml (Insulin Aspart) subcutaneously before meals for Diabetes Mellitus, hold if blood glucose is less than 100 mg/dl. On 07/22/2024 at 04:51 PM, Licensed Practical Nurse #4 was observed conducting blood glucose monitoring for Resident #27 in the South Unit hallway. Licensed Practical Nurse #4 stated that the resident's glucose was reading 114 mg/dL so the resident did not need to receive insulin. Resident #27 was escorted to the South Unit dining room where a Certified Nursing Assistant brought them a tray consisting of pureed split pea soup, pureed baked filet of fish, pureed spinach, pureed peaches, and skimmed milk. Resident #27 was observed feeding themself mashed potatoes and split pea soup. The Medication Administration Record dated July 2024 documented that Resident #27 had blood glucose levels above 100 mg/dL on 9 of 22 occasions and documentation entered on the Medication Administration Record was 12. The Medication Administration Record Chart Codes indicated that 12=No Insulin Required. There was no documented evidence that Novolog 19 units was administered by Licensed Practical Nurse #4 as ordered. The Medication Administration Record dated June 2024 documented that Resident #27 had blood glucose levels above 100 mg/dL on 10 of 30 occasions and documentation entered on the Medication Administration Record was 12. The Medication Administration Record Chart Codes indicated that 12=No Insulin Required. There was no documented evidence that Novolog 19 units was administered by Licensed Practical Nurse #4 as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/2024 at 03:31 PM, Licensed Practical Nurse #4 was interviewed and stated that they do not provide insulin coverage to Resident #27 if the blood glucose reading is less than 200 mg/dL. Licensed Practical Nurse #4 then looked at the order and read that Resident #27 was supposed to receive 19 units of Novolog before meals unless their blood glucose was under 100 mg/dL. Licensed Practical Nurse #4 stated that they believed that Resident #27 was on a sliding scale for insulin. Licensed Practical Nurse #4 also stated that they were not sure how many times they had made this error. Licensed Practical Nurse #4 further stated that they do not read orders before conducting blood glucose testing or administering insulin. On 07/25/2024 at 12:25 PM, the Assistant Director of Nursing was interviewed and stated that orders should be checked every time a medication is being administered, or a treatment is being conducted. The Assistant Director of Nursing also stated that Licensed Practical Nurse #4 should have checked the order prior to conducting blood glucose testing on Resident #27 and that if Licensed Practical Nurse #4 had any concerns about administering the insulin, they should have notified the Nurse Practitioner on call to be instructed on what to do. On 07/25/24 at 03:52 PM, the Director of Nursing was interviewed and was unable to provide a reason for why Licensed Practical Nurse #4 did not follow the orders for Resident #27's insulin administration. The Director of Nursing stated that staff education is needed to prevent medication errors from occurring in the future. On 07/25/2024 at 3:36 PM, Physician #1 was interviewed and stated that it was unacceptable for Licensed Practical Nurse #4 to fail to read the order and administer insulin as per the order's directions. Physician #1 also stated that if the nurse had concerns about providing insulin based on the order's parameters, they would be required to inform the provider who would determine if changes needed to be made to the order. Physician #1 further stated that they had not been contacted to change insulin orders or been informed that Resident #27 was not reciving insulin as ordered. 10 NYCRR 415.11(c)(3)(i)

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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** 50894 Based on observations, record reviews, and interviews, conducted during the Recertification survey from 07/21/2024 to 07/25/2024, the facility did not ensure that a resident received care consistent with professional standards of practice to prevent infection and promote healing. This was evident for 1 of 2 residents (Resident #7) reviewed for Pressure Ulcer Injury out of a total of 28 sampled residents. Specifically, during wound care observation, Resident #7 did not receive the physician ordered pressure ulcer treatment and Licensed Practical Nurse #1 failed to maintain infection prevention standards. The findings are: The facility policy titled Skin and Pressure Injury Prevention revised 6/27/2024 documented that the facility will assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice. Resident #7 was admitted with diagnoses that included Peripheral Vascular Disease, wound infection, and malnutrition. The Minimum Data Set Quarterly assessment dated [DATE] documented that Resident #7 was frequently incontinent of bowel and frequently incontinent of bladder and had 1 Stage 3 pressure ulcer that was present upon admission. The Comprehensive Care plan with a focus of Alteration in skin integrity-resident has an actual presence of injury related to sacrum stage 4 created 05/07/2024 documented a goal of the wound will show improvement appropriately for wound size/type through the review date. Interventions included evaluate wound weekly and as needed, document wound measurements, wound bed appearance, odor, draining, and surrounding tissue, and monitor dressing daily for signs and symptoms of infection. The Wound Evaluation & Management Summary dated 07/19/2024 documented that Resident #7 had a Stage 4 sacral pressure wound, and the dressing treatment plan was to add Isodosorb gel, cover with gauze island with border, and apply Zinc ointment to the peri wound once daily. The Order Audit Report documented an order dated 07/19/2024 for Iodosorb External Gel 0.9% (Cadexomer Iodine)-apply to sacrum topically every day shift for wound care. Cleanse with normal saline, apply Iodosorb Gel to wound bed, cover with dry gauze and bordered gauze island dressing daily and as needed. Apply zinc to peri wound with every dressing change and as needed. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/2024 at 10:47 AM, Licensed Practical Nurse #1 was observed performing wound care for Resident #7. Licensed Practical Nurse #1 laid a drape sheet on the bedside table and placed a box of 25 individually packaged abdominal pads, a package of 200 gauze sponges, a bottle of normal saline solution, Iodosorb Gel, and a box of gloves on top of the drape sheet. Licensed Practical Nurse #1 performed hand hygiene and donned a gown and gloves. With the assistance of a Certified Nursing Assistant, Resident #7 was rolled onto their side and their incontinence brief was removed. The sacral wound was visible with no dressing covering it. Licensed Practical Nurse #1 then removed a few gauze sponges from the package, wet the gauze sponges with normal saline solution, and pushed the wet gauze sponges into the wound two times to clean the wound. Licensed Practical Nurse #1 then disposed of the gauze sponges and performed hand hygiene before donning clean gloves. Licensed Practical Nurse #1 applied treatment to a dry gauze sponge and placed the gauze sponge with treatment on top of an abdominal pad. The abdominal pad with gauze sponge and treatment were then placed on Resident #7's sacral region. The ordered bordered gauze was not applied to secure the dressing, and a clean incontinence brief was placed on Resident #7. Licensed Practical Nurse #1 was not observed applying zinc ointment to the peri wound. Licensed Practical Nurse #1 then returned the box of abdominal pads and the package of gauze sponges to the treatment cart. On 07/24/2024 at 03:45 PM, Licensed Practical Nurse #1 was interviewed and stated that prior to the wound care observation, they had removed the sacral dressing while assisting Resident #7 with personal hygiene care. Licensed Practical Nurse #1 stated that they should have put another dressing on the wound immediately. Licensed Practical Nurse #1 also stated that they are supposed to clean the wound by going in a circular motion from clean to dirty, and they believed they did that while being observed, but were nervous during the observation. Licensed Practical Nurse #1 further stated that they did not use bordered gauze on the wound because they had noticed that Resident #7 was having skin breakdown from the bordered gauze's adhesive. Licensed Practical Nurse #1 stated that they did not notify the ordering physician of this to request a new order. Licensed Practical Nurse #1 stated that the gauze and abdominal pads that were brought into the room but were not used were returned to the treatment cart after Resident #7's wound care was completed. On 07/25/2024 at 12:13 PM, the Assistant Director of Nursing was interviewed and stated that their job responsibilities include making observations of nurses doing wound care weekly. The Assistant Director of Nursing stated that they do not observe every nurse every week but observe a sample of nurses each week. The Assistant Director of Nursing stated that the wound should always be covered with the ordered treatment and should not be left uncovered. The Assistant Director of Nursing stated that nurses performing wound care must follow the doctor's order and should report any concerns with the ordered treatment to the provider, and the supervisor or the Director of Nursing. The Assistant Director of Nursing stated that nurses cannot change the wound care treatment without a new order issued by a physician. The Assistant Director of Nursing also stated that nurses should only take as many supplies as they need for the treatment into the room, and that any supplies that enter a resident's room should stay in the resident's room or be discarded. On 07/25/24 at 03:59 PM, an interview was conducted with the Director of Nursing who stated that they had been informed about Licensed Practical Nurse #1 practices during the wound care observation. The Director of Nursing also stated that nurses should always follow the doctor's order and should know that any stock supplies being taken into a resident's room belong to that resident and should not be taken out. 10 NYCRR 415.12(c)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50894 Based on observation, record review, and interviews conducted during the Recertification survey from 07/21/2024 to 07/25/2024, the facility did not ensure timely identification and removal of expired medications. Specifically, a bag containing 8 syringes of Lorazepam gel with an expiration date of 12/29/2021 and 44 capsules of Dronabinol with an expiration date of 01/26/2024 were located in the refrigerator narcotics box in the South Unit medication room. Additionally, narcotics were not being stored in permanently affixed cabinets in the facility. The findings are: The facility policy titled Medication - Storage revised 1/2019 documented that the center will store medications in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance with Department of Health guidelines. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. The facility policy titled Controlled Substance Management created 8/2022 documented that the medication nurse is responsible for proper storage of controlled drugs in a double door, double locked, double keyed, steel, wall mounted, controlled drug cabinet during non-medication pass times and in locked controlled drug compartment of medication cart during medication pass times. The Director of Nursing Services is responsible for the secure storage of the controlled drugs and records, and for the proper destruction of controlled drugs in accordance with regulations. On 07/25/2024 at 11:40 AM, Licensed Practical Nurse #5 was observed in the medication storage room. Licensed Practical Nurse #2 open the narcotics lock box in the refrigerator. A bag with an expiration date of 12/29/2021 containing eight syringes of Lorazepam gel, and 44 capsules of Dronabinol with an expiration date of 01/26/2024 were located inside of the refrigerator lock box. On 07/25/2024 at 11:53 AM, Licensed Practical Nurse #5 was interviewed and stated that nurses in the facility do not use the narcotics cabinets located in the medication storage room. Licensed Practical Nurse #5 also stated that all narcotics being used for residents are stored in the medication carts. On 07/25/2024 at 12:45 PM, Licensed Practical Nurse #6 stated that the facility used to store narcotics in the medication room but changed the procedure about a year ago, and narcotics are now stored in the medication carts. On 07/25/2024 at 12:51 PM, Licensed Practical Nurse #1 was interviewed and stated that a supervisor directed the staff to stop using the narcotics box in the medication room and instead store the narcotics in the medication cart approximately one year ago. They stated that this supervisor is no longer employed by the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 01:59 PM, the Assistant Director of Nursing was interviewed and stated that all expired or discontinued narcotics should be given to the Director of Nursing to be returned to the pharmacy. The Assistant Director of Nursing also stated that the facility previously disposed of medications through a destruction day program, but the facility now ships the medications to the pharmacy or has the pharmacy pick them up. The Assistant Director of Nursing further stated that they were not aware that narcotics were being stored in medication carts only. On 07/25/2024 at 03:52 PM, the Director of Nursing was interviewed and stated that if a resident is discharged , expires, or a narcotic is discontinued, the nurse is supposed to give the Director of Nursing the medication. The medication will be signed off in the narcotics book if it is a narcotic, and the Director of Nursing will place the medication in a lockbox that will be shipped back to the pharmacy to be disposed of. The Director of Nursing also stated that the nurse should bring the discontinued medication to the Director of Nursing immediately or by the next business day if the Director of Nursing is not in the building at the time the medication is discontinued. The Director of Nursing further stated that the nurses should be using the narcotics cabinets in the medication rooms, and that they provided an in-service to the nurses informing them that narcotics being used on their shift can be stored in the medication cart, and that all narcotics not being used on that shift must be stored in the medication cabinet. The Director of Nursing stated that they were not aware that nurses were not using the narcotic cabinets. 10 NYCRR 415.18(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50894 Based on record reviews and interviews conducted during the Recertification survey from 07/21/2024 to 07/25/2024, the facility did not ensure that all residents were free of significant medication errors. Specifically, Resident #27 did not receive insulin in accordance with Physician's Orders. The findings are: The facility policy and procedure titled Blood Glucose Testing, Meter/Device Use revised 02/01/2024 states that the first step of blood glucose testing using the meter is to verify a healthcare provider's order for the procedure. After testing the blood glucose level, the procedure states to record the results of the blood glucose test on the resident's medication administration record and follow appropriate interventions regarding blood glucose testing results. On 07/22/2024 at 04:51 PM, Licensed Practical Nurse #4 was observed conducting blood glucose monitoring for Resident #27 in the South Unit hallway. Licensed Practical Nurse #4 stated that the resident's glucose was reading 114 mg/dL so Resident #27 did not need to receive 19 units of Novolog. Resident #27 was escorted to the South Unit dining room where a Certified Nursing Assistant brought Resident #27 a tray consisting of puree split pea soup, puree baked filet of fish, puree spinach, puree peaches, and skimmed milk. Resident #27 was observed feeding themself mashed potatoes and split pea soup. The Medication Administration Record dated July 2024 documented that Resident #27 had blood glucose levels above 100 mg/dL on 9 of 22 occasions and documentation entered on the Medication Administration Record was 12. The Medication Administration Record Chart Codes indicated that 12=No Insulin Required. There was no documented evidence that Novolog 19 units was administered by Licensed Practical Nurse #4 as ordered. The Medication Administration Record dated June 2024 documented that Resident #27 had blood glucose levels above 100 mg/dL on 10 of 30 occasions and documentation entered on the Medication Administration Record was 12. The Medication Administration Record Chart Codes indicated that 12=No Insulin Required. There was no documented evidence that Novolog 19 units was administered by Licensed Practical Nurse #4 as ordered. On 07/24/2024 at 03:31 PM, Licensed Practical Nurse #4 was interviewed and stated that they do not provide insulin coverage to Resident #27 if the blood glucose reading is less than 200 mg/dL. Licensed Practical Nurse #4 then reviewed the order and stated based on the order Resident #27 was supposed to have received 19 units of Novolog before meals unless their blood glucose was under 100 mg/dL. Licensed Practical Nurse #4 also stated that they believed that Resident #27 was on a sliding scale for insulin, and that they were not sure how many times they had made this error. Licensed Practical Nurse #4 further stated that they do not read orders before conducting blood glucose testing or giving insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 at 12:25 PM, the Assistant Director of Nursing was interviewed and stated that orders should be checked every time a medication is being administered, or a treatment is being conducted. The Assistant Director of Nursing also stated that Licensed Practical Nurse #4 should have checked the order prior to conducting blood glucose testing on Resident #27 and that if Licensed Practical Nurse #4 had any concerns about administering the insulin, they should have notified the Nurse Practitioner on call to be instructed on what to do. On 07/25/24 at 03:52 PM, the Director of Nursing was interviewed and was unable to provide a reason for why Licensed Practical Nurse #4 did not follow the orders for Resident #27's insulin administration. The Director of Nursing stated that staff education is needed to prevent medication errors from occurring in the future. On 07/25/2024 at 03:20 PM, Nurse Practitioner #1 was interviewed and stated that it is important that nurses follow medication administration orders. Nurse Practitioner #1 stated that failing to give ordered insulin prior to a meal can be significant due to the risk of the resident's blood sugar level increasing after eating. Nurse Practitioner #1 stated that they were not aware that the insulin was not being given to Resident #27 as per the order and that they were not contacted regarding any changes in insulin coverage for this resident. On 07/25/2024 at 3:36 PM, Physician #1 was interviewed and stated that it was unacceptable for Licensed Practical Nurse #4 to fail to read the order and administer insulin as per the order's directions. Physician #1 also stated that this would constitute a significant medication administration error. Physician #1 further stated that if the nurse had concerns about providing insulin based on the order's parameters, they would be required to inform the provider who would determine if changes needed to be made to the order. Physician #1 stated that they had not been contacted to change insulin orders or been informed that Resident #27 was not receiving insulin as ordered. 10 NYCRR 415.12(m)(2)

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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. 50894 Based on observation, record review, and interviews conducted during the Recertification survey from 07/21/2024 to 07/25/2024, the facility did not ensure medications and biologicals were stored in accordance with currently accepted professional principles. This was evident for 1 of 3 medication storage carts (South Unit medication cart) observed. Specifically, 3 open insulin vials did not contain the date opened on the vials, 1 opened vial of insulin did not contain a resident's name on the box or vial, and 3 inhalers did not contain the date opened or the resident's name on the inhaler devices. The findings are: The facility policy titled Medication-Storage revised 1/2019 documented the facility will store medications in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance Department of Health guidelines. Medications will be stored in the original, labeled containers received from the pharmacy. On 07/25/2024 at 11:13 AM, Licensed Practical Nurse #1 was observed at the medication cart on the South Unit. An open vial of Levemir for Resident #23, an open vial of Novolog for Resident #88, and an open vial of Lispro for Resident #9 was not labeled with the date opened or the resident's name on the vial. In addition, an open Breyna inhaler for Resident #15, an open Symbicort inhaler for Resident #96 and an open Dulera inhaler for Resident #83 did not have the date opened or the resident's name on the inhaler. On 07/25/24 at 11:26 AM, Licensed Practical Nurse #1 was interviewed and stated that the nurse opening a medication would be responsible for labeling. Licensed Practical Nurse #1 also stated that they label the medication box with the open date. Licensed Practical Nurse #1 stated that the facility policy does not specify where to label each medication. Licensed Practical Nurse #1 further stated that all nurses are responsible for ensuring that all medications are labeled but did not specify how or when this should be done. On 07/25/24 at 12:31 PM, the Assistant Director of Nursing was interviewed and stated that insulin should be labeled with the resident's name and the date opened should be placed on the vial and the box. The Assistant Director of Nursing also stated that inhalers should be labeled with a sharpie listing the first administration date on the inhaler and the resident's name. The Assistant Director of Nursing further stated that the nurse assigned to the cart for that shift is responsible for labeling medications, disposing of expired medications, and ensuring medications are stored properly. The Assistant Director of Nursing stated that the unit manager or the Registered Nurse Supervisor does sporadic checks of the medication carts and audits to ensure medications are labeled appropriately. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 at 03:52 PM, the Director of Nursing was interviewed and stated that the date a medication was opened should be listed on the box and on the vial of insulin. The Director of Nursing also stated that inhalers come in a bag that is labeled with the resident's name and open date, and that the inhaler device should also be labeled with a sticker that lists the resident's name and the date the medication was opened. The Director of Nursing stated that this is what nurses in the facility have been in-serviced on and should be doing. 10 NYCRR 415.18(e)(1-4)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894 Based on observations, record review and interviews during the Recertification survey from 07/21/2024 to 07/25/2024, the facility did not ensure each resident received food that accommodated their allergies, intolerances, and preferences. This was evident for 1 (Resident #80) of 2 residents reviewed for food out of a sampe of 28 residents. Specifically, Resident #80 received lunch trays that included foods that did not accommodate their documented preferences. The findings include: The facility policy and procedure titled Honoring Preferences, Making Substitutions reviewed 02/2023 documented that food preferences are obtained as part of the admission process by a member of the food and nutrition department. Preferences and dislikes obtained are then transferred to the electronic meal program. Meal tickets should be reviewed carefully at all meals and a substitute of equal nutritive value should be substituted. If resident has numerous dislikes, the registered dietician is to meet with resident and discuss proper nutrition, substitutes, and make recommendations accordingly. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #80 was cognitively intact and had diagnoses which included Hypertension, Malnutrition, and Gout. The Quarterly Nutritional assessment dated [DATE] documented that Resident #80 was on a Heart Healthy diet. The assessment also documented that diet preferences and dislikes were reviewed and updated, and that the resident's preferences were listed on the ticket. The Physician order dated 01/18/2024 documented that Resident #80 was on a heart healthy diet, regular texture, regular consistency. On 07/21/2024 at 11:54 AM, Resident #80 was observed in the dining room. Resident #80 was asked about their meal and stated that they were served pineapple juice when they were not supposed to receive pineapples. Orange-pineapple juice was observed on the Resident #80's tray. Resident #80's ticket also stated, no mashed potatoes, no pasta, no beans, no read meat, no pineapple. Resident #80 informed Certified Nursing Assistant #7 that pineapple juice was served, and the pineapple juice remained on Resident #80's tray with no substitution provided. On 07/23/2024 at 12:07 PM, Resident #80 was observed in the dining room with a lunch tray that included tuna fish, white rice, a cookie, orange-pineapple juice. Resident #80's ticket read that the tray should have included eggplant parmesan, chef choice starch, zucchini, sugar cookie, 4 fluid ounces of assorted juice. Resident #80's ticket also stated, no mashed potatoes, no pasta, no beans, no read meat, no pineapple. Resident #80 was served pineapple juice when the ticket indicated pineapples were not supposed to be served to the resident. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/2024 at 11:49 AM, Resident #80 was observed in the dining room being served lunch. The tray included corn, mashed potatoes, beef stew, cranberry cocktail juice, mandarin oranges. The tray ticket dated 7/24/24 stated that the tray should have included baked chicken with jerk sauce, rice, corn, mandarin oranges, 4 fluid ounces of assorted juice. Resident #80's ticket also stated, no mashed potatoes, no pasta, no beans, no read meat, no pineapple. Resident #80 was served mashed potatoes when the ticket indicated mashed potatoes were not supposed to be served. On 07/24/2024 at 02:10 PM, Certified Nursing Assistant #8 was interviewed and stated that they have worked with Resident #80 since 07/01/2024. Certified Nursing Assistant #8 stated that Resident #80 is independent in most aspects of care and that the only concern they can recall the resident ever having raised was related to meal trays not matching the tray tickets. Certified Nursing Assistant #8 was unable to recall how frequently this occurred, but stated that when it happens, Resident #80 notifies them of the issue, and they will then request the correct item for the resident from the kitchen. Certified Nursing Assistant #8 stated that sometimes the dietician will be in the dining room while meals are being served, will notice the discrepancy, and will go to the kitchen to get what is needed for Resident #80. On 07/25/2024 at 10:31 AM, the Director of Food Services was interviewed and stated that trays are assembled through the tray line process. The caller receives a tray that contains a meal ticket, condiments, and juice on it, and then calls out the instructions listed on the meal ticket related to the resident's diet and preferences. On the other side of the line, a person plates the ordered food according to what the caller reads out. The Director of Food Services also stated that there is a second checker who will randomly go through trays to ensure trays are correct as per the meal ticket and make corrections if necessary. The Director of Food Services further stated that substitutions should always be reflected on the ticket if the resident cannot have any of the items being served. The Director of Food Services stated that it is the responsibility of the callers to ensure that trays include the correct items before leaving the kitchen and that the Director of Food Services oversees the callers. The Director of Food Services stated that they do not know why Resident #80 received incorrect food items on multiple occasions and on occasion they review trays for accuracy. On 07/25/2024 at 11:00 AM, the Registered Dietician was interviewed and stated that their job responsibilities include overseeing resident diets, following weights, following appetite changes, and working to accommodate resident dietary needs. The Registered Dietician also stated that it is also their responsibility, shared with the Director of Food Services, to edit meal preferences and substitutions in the electronic meal ticket system. The Registered Dietician stated that Resident #80 was admitted to the facility with dietary restrictions that Resident #80 stated were recommended by a dietician during a prior hospitalization due to the diagnosis of gout. The Registered Dietician stated that they did not see any clinical basis for these restrictions and stated that they have not yet discussed this with the resident to determine if the restrictions or preferences should remain active. The Registered Dietician also stated that the meals served should always meet Resident #80's preferences. 10 NYCRR 415.14(d)(4)

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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. 19546 Based on observations and interviews conducted during a Recertification survey from 07/21/24 to 07/25/24, the facility did not ensure that infection control practices were maintained during multiple lunch meal observations. Specifically, during two lunch meal observations in the Main Dining Room, Certified Nurse Assistants (Certified Nurse Assistant # 6 & Certified Nurse Assistant #1) were observed assisting multiple residents in the dining room with hand hygiene. The Certified Nurse Assistants did not wear gloves, provided residents with hand sanitizing wipes, collected used hand sanitizing wipes, and assisted other residents without performing hand hygiene between resident contact. The findings are: On 07/21/24 at 11:37 AM, during a lunch meal observation, Certified Nurse Assistant #6 was observed handed out sanitizing wipes to residents with bare hands. Certified Nurse Assistant #6 assisted residents in hand hygiene with bare hands. Certified Nurse Assistant #6 then collected the used hand wipes with their left hand and continued from resident to resident handing out wipes with the right hand and performing hand hygiene with both hands for some residents. Certified Nurse Assistant #6 did not perform hand hygiene between residents. On 07/21/24 at 11:45 AM, Certified Nurse Assistant #1 was observed going from resident to resident and assisting residents with hand hygiene. Certified Nurse Assistant #1 was not wearing gloves during this task. Certified Nurse Assistant #1 was observed collecting the used hand wipes in one hand while going from resident to resident to assist residents and provide hand wipes. Certified Nurse Assistant #1 did not perform hand hygiene between residents. On 07/23/24 at 11:40 AM, during a lunch meal observation Certified Nurse Assistant #1 was observed going from resident to resident to hand out sanitizing hand wipes. Certified Nurse Assistant #1 was not wearing gloves. Certified Nurse Assistant #1 was observed assisting residents to clean their hands. Certified Nurse Assistant #1 continued to go from resident to resident and provided hand sanitizing wipes. Certified Nurse Assistant #1 did not perform hand hygiene between residents. On 07/23/24 at 11:48 AM, Certified Nurse Assistant #1 was interviewed and stated that they were trained to clean their hands before and after resident contact. Certified Nurse Assistant #1 further stated that they had used the wall mounted hand sanitizer before handing out the resident wipes. Certified Nurse Assistant #1 stated that if they had had skin contact with a resident, they would have to stop and clean their hands. Certified Nurse Assistant #1 could not recall having had assisted residents in performing hand hygiene or having had skin to skin contact with any resident while in the process of handing out sanitizing wipes. Certified Nurse Assistant #1 stated that after completing their task of providing hand wipes to the residents, they are to perform hand hygiene. The Director of Nursing was interviewed on 07/24/24 at 11:34 AM and stated that the staff were trained to first perform hand hygiene before and after resident contact and care. The Director of Nursing also stated that when providing sanitizing wipes to the residents before meals the staff should have gloves and carry a receptacle for collecting the used wipes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 8:30 AM, the Infection Control Preventionist was interviewed and stated that the process for providing hand hygiene to residents before meals is as that staff are to first perform hand hygiene and then have a barrier between them and residents to prevent cross contamination and skin contact. A bag is to be used to collect the used hand wipes. The Infection Control Preventionist also stated that there is not a specific in service provided to staff or specific policy on the task of how to distribute hand wipes to residents before meals. The Infection Control Preventionist further stated that they want to provide a barrier between resident and staff when providing hand wipes to avoid cross contamination, to maintain best infection control practices. 10 NYCRR 415.19(b)(4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335044	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Far Rockaway Center for Rehabilitation and Nursing	13 11 Virgina St Far Rockaway, NY 11691

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19546 Based on observations and interviews conducted during a Recertification survey from 07/21/24 to 07/25/24, the facility did not ensure that a safe, functional, sanitary, and comfortable environment was provided for staff and the public Specifically, furniture in the nursing station was soiled, dirty, and in disrepair, visitor and staff bathrooms were in disrepair. The findings are: During multiple observations conducted between 07/21/24 and 07/25/24, the following was observed: 1.) In the North Unit Nurses Station there were chairs that were soiled, dirty, and in disrepair. 2.) In the Visitor Bathrooms across from the Dietician Office, both bathrooms had rusted radiators and in one of the two bathrooms there was a broken toilet paper dispenser, missing wall light cover and a rusted wall light cover. 3.) in the Staff Bathroom across from room [ROOM NUMBER] there were missing and broken wall tiles behind the sink area. During a tour on 07/25/24 at 10:30 AM, the Director of Housekeeping stated that the building is old, and their role is to try to maintain and provide a safe and comfortable environment for all of the residents, and they make multiple environmental observations to identify safety hazards, which they would address first. On 07/25/24 at 12:45 PM, the Administrator was interviewed and stated they would order new furniture for the nurse station, but that none was on order at this time. The Administrator also stated that money had been spent to improve the lobby area, the visitor bathroom and the staff bathroom, but additional areas of concern identified would be addressed. 10 NYCRR 415.29

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	335044	A. Building B. Wing	07/26/2024

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19546 Based on observations, interviews, and record reviews during the recertification survey, the facility did not ensure that an effective pest control program was in place. Specifically, multiple flies were observed during the initial and subsequent tours of the North/South/Hallway Units, Nurse Station. The finding is: The policy and procedure titled Pest Control revised 11/2023, documented that the facility would maintain an ongoing pest control program to ensure the building is kept free of pests and rodents. The policy also documented that Pest Control service visit documentation will be kept on file in the facility, and screens would be maintained for facility windows. During multiple observations conducted from 07/21/24 to 07/25/24 the following was observed: 1.) Multiple flies were observed during initial and subsequent tours of resident rooms, nurse station, dining room area. 2.) In the North Unit Nurse Station there were multiple flies. 3.) In room [ROOM NUMBER] there were multiple flies on the privacy curtains and outside room walls. 4.) In room [ROOM NUMBER] there were multiple flies in the room. 5.) In the Dining Room area multiple flies. 6.) in the hallway there were multiple flies. The Pest Control Log Book were reviewed for North areas from January 2024 to July 2024. The Pest Control Log Sheet documented weekly or twice weekly exterminator visits from 03/21/24 to 07/18/24 which documented that staff observations was there were no reports on the North Unit. The Director of Housekeeping/Maintenance was interviewed on 07/25/24 at 11:223 AM and stated that the exterminator comes in 2 times a week, has targeted areas that they look at, and the fly situation has gotten a whole lot better. The Director of Housekeeping/Maintenance also stated that on each unit there is a Maintenance Work Book in which any staff can make a written report regarding environmental concerns, which is reviewed by maintenance staff at least twice a day. The Director of Housekeeping/Maintenance further stated that there are some challenging residents, and they try to keep up to prevent a worse situation from occurring. The Director of Housekeeping/Maintenance stated that they recently replaced or fixed all window screens to mitigate flies from coming in, and they have monthly window rounds to ensure that window screens are intact and not torn. The Director of Housekeeping/Maintenance also stated that the facility has been using ultraviolet lights that attract the flies and become stuck on glue trap within these ultraviolet lights and the exterminator replaces these glue traps often. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.29(j)(5)