

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER Apex Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Birchwood Dr Huntington Station, NY 11746	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</p> <p>Based on observations, records review, and interviews during Recertification Survey and Abbreviated Survey (NY 00319371) initiated on 2/6/2024 and completed on 2/14/2024, the facility did not ensure that a clean, comfortable, and homelike environment was maintained for each resident. This was identified for four (Resident #146, Resident #85, Resident #104, and Resident #93) of four residents reviewed for Environment. Specifically, 1) Resident #146's room was observed on 2/6/2024 and 2/7/2024; the room furniture and the sink vanity were not in good repair with detached base molding, missing drawers, and rusty exposed metal parts. 2) Resident #85's room was observed on 2/6/2024 and 2/7/2024. The room furniture and the sink vanity were not in good repair with missing drawers and a nonfunctioning bureau. 3) Resident #104's room was observed on 2/6/2024 and 2/7/2024. The furniture in the room was not in good repair as evidenced by drawers without a handle, drawers that could not be opened, and missing drawers. 4) Resident #93's room was observed on 2/6/2024 and 2/7/2024; the sink vanity was observed to be missing the middle drawer and a piece of wood was nailed in the place of the drawer front.</p> <p>The findings include but are not limited to:</p> <p>The facility's policy titled Routine Maintenance dated 2/2022 and last reviewed 5/2023 documented that the facility will ensure the provision of a safe, functional, sanitary, and comfortable environment for residents. The maintenance department will ensure that the physical environment, furniture, and equipment are maintained in good repair throughout the facility.</p> <p>1) Resident #146 was admitted with diagnoses that include Dementia, Depression, and Chronic Obstructive Pulmonary Disease. The Annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was four, which indicated the resident's cognition was severely impaired.</p> <p>During an environmental tour of Resident #146's room on 2/6/2024 at 10:54 AM, the bottom drawer of the nightstand, located next to the bed, was open and could not be shut. The corner base molding to the left of the sink vanity was detached. To the right of the sink vanity, the drywall was missing from the corner of the wall and the metal corner bead was exposed and rusted. The middle sink vanity drawer was missing and a piece of wood was nailed in the place of the drawer front. The sink vanity's bottom drawer was missing the handle.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an environmental tour of Resident #146's room on 2/7/2024 at 8:42 AM the bottom drawer of the nightstand next to the bed was open and could not be shut. The corner base molding to the left of the sink vanity was detached. To the right of the sink vanity, the drywall was missing from the corner of the wall and the metal corner bead was exposed and rusted. The middle sink vanity drawer was missing and a piece of wood was nailed in the place of the drawer front. The sink vanity's bottom drawer was missing the handle.</p> <p>Certified Nursing Assistant #6 was interviewed on 2/9/2024 at 9:45 AM and stated they are regularly assigned to work with Resident #146. Certified Nursing Assistant #6 stated they did not report the issues with the vanity, wall, or nightstand in Resident #146's room. Certified Nursing Assistant #6 stated if they saw maintenance concerns, they reported them to the charge nurse and the charge nurse would submit a maintenance request.</p> <p>Housekeeper #1 was interviewed on 2/9/2024 at 10:31 AM and stated they are the regularly assigned housekeeper on the unit. Housekeeper #1 stated they cleaned each room on the unit every day. Housekeeper #1 stated they did not observe maintenance problems in Resident #146's room. Housekeeper #1 stated they have not observed any broken furniture or things in disrepair. Housekeeper #1 stated if they see an issue that required maintenance they would report the problem to the charge nurse.</p> <p>Registered Nurse #9 was interviewed on 2/9/2024 at 10:43 AM and stated they had not observed anything in need of maintenance in Resident #146's room. Registered Nurse #9 stated they reported maintenance concerns to the charge nurse on the unit.</p> <p>Licensed Practical Nurse #1 was interviewed on 2/9/2024 at 10:50 AM and stated they were the charge nurse on the unit. Licensed Practical Nurse #1 stated they completed a tour of the unit and went into each room daily. Licensed Practical Nurse #1 stated Resident #146 did not report any environmental concerns with their room. Licensed Practical Nurse #1 stated they complete a maintenance request in the computer system if they saw a problem or if a problem was reported to them. Licensed Practical Nurse #1 stated they have not submitted any maintenance requests for Resident #146's room recently.</p> <p>Maintenance Worker #1 was interviewed on 2/9/2024 at 10:59 AM and stated they toured the unit daily and they asked the unit charge nurse if they had maintenance concerns. Maintenance Worker #1 stated they check the computer system daily for new requests. Maintenance Worker #1 stated they had fixed broken furniture and placed wooden planks in place of new drawers on the vanity. Maintenance Worker #1 stated the furniture broke frequently and they have repaired a few pieces on the unit more than once. Maintenance Worker #1 stated the sink vanities on the unit are old and replacement drawers are no longer available. Maintenance Worker #1 stated the wood planks were placed on the vanity to protect the residents from hurting themselves.</p> <p>The Director of Maintenance was interviewed on 2/9/2024 at 4:06 PM. The Director of Maintenance stated they tour the building once a week. The Director of Maintenance stated the facility used a computer system to report maintenance concerns to the maintenance department. The Director of Maintenance stated they have not received any complaints from the residents on the unit that Resident #146 resided on. The Director of Maintenance reported they replaced furniture if it could no longer be fixed. The Director of Maintenance stated any furniture needs were brought to the attention of the Administrator. The Director of Maintenance stated the drawer replacements for the sink vanities on the unit were no longer available and the wood planks were placed to cover up the holes left by the missing drawers.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #146 was interviewed on 2/12/2024 at 11:46 AM. Resident #146 stated they were not sure how long the nightstand and vanity were in disrepair. Resident #146 stated they could not remember if they reported the vanity and broken nightstand drawer to the nurse.</p> <p>The Administrator was interviewed on 2/14/2024 at 10:11 AM and stated they were not aware of the environmental concerns on the unit where Resident #146 resided. The Administrator stated the facility always tried to provide a home-like environment for the residents. The Administrator stated were not aware of the concerns in Resident #146's room.</p> <p>A second interview was conducted with the Director of Maintenance on 2/14/2024 at 1:18 PM. The Director of Maintenance stated they reviewed the computer maintenance request logs from 7/1/2023 through 2/14/2024 and there were no repairs requested for Resident #146's bureau or sink vanity.</p> <p>2) Resident #85 was admitted with diagnoses that include Vascular Dementia, Schizophrenia, and Chronic Obstructive Pulmonary Disease. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was ten, which indicated the resident's cognition was moderately impaired.</p> <p>During an environmental tour of Resident #85's room on 2/6/2024 at 11:01 AM the second drawer of their bureau was open and would not stay shut. The sink vanity was observed with a missing middle drawer and a plank of wood was nailed in place of the drawer front.</p> <p>During an observation of Resident #85's room on 2/7/2024 at 8:30 AM, the sink vanity was observed with a missing middle drawer, and a plank of wood was nailed in place of the drawer front.</p> <p>Certified Nursing Assistant #6 was interviewed on 2/9/2024 at 9:45 AM and stated they are regularly assigned to work with Resident # 85. Certified Nursing Assistant #6 stated they did not report the issues with the vanity or nightstand in Resident #85's room. Certified Nursing Assistant #6 stated if they saw maintenance concerns, they reported them to the charge nurse and the charge nurse would submit a maintenance request.</p> <p>Housekeeper #1 was interviewed on 2/9/2024 at 10:31 AM and stated they are the regularly assigned housekeeper on the unit. Housekeeper #1 stated they cleaned each room on the unit daily. Housekeeper #1 stated they did not observe maintenance problems in Resident #85's room. Housekeeper #1 stated they have not observed any broken furniture or things in disrepair. Housekeeper #1 stated if they see an issue that required maintenance they would report the problem to the charge nurse.</p> <p>Licensed Practical Nurse #1 was interviewed on 2/9/2024 at 10:50 AM and stated Resident #85 has not reported any environmental concerns with their room. Licensed Practical Nurse #1 stated they have not submitted any maintenance requests for Resident #85's room recently.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Maintenance Worker #1 was interviewed on 2/9/2024 at 10:59 AM and stated they toured the unit daily and asked the unit charge nurse if they had maintenance concerns. Maintenance Worker #1 stated they check the computer system daily for new requests. Maintenance Worker #1 stated they had fixed broken furniture and placed wooden planks in place of new drawers on the vanity. Maintenance Worker #1 stated the furniture broke frequently and they have repaired a few pieces on the unit more than once. Maintenance Worker #1 stated the sink vanities on the unit are old and replacement drawers are no longer available. Maintenance Worker #1 stated the wood planks were placed on the vanity to protect the residents from hurting themselves.</p> <p>The Director of Maintenance was interviewed on 2/9/2024 at 4:06 PM. The Director of Maintenance stated they tour the building once a week. The Director of Maintenance stated the facility used a computer system to report maintenance concerns to the maintenance department. The Director of Maintenance stated they had not received any complaints from the residents on the unit that Resident #85 resided on. The Director of Maintenance reported they replaced furniture if it could no longer be fixed. The Director of Maintenance stated any furniture needs were brought to the attention of the Administrator. The Director of Maintenance stated the drawer replacements for the sink vanities on the unit were no longer available and the wood planks were placed to cover up the holes left by the missing drawers.</p> <p>The Administrator was interviewed on 2/14/2024 at 10:11 AM and stated they were not aware of the environmental concerns on the unit where Resident #85 resided. The Administrator stated the facility always tried to provide a home-like environment for the residents. The Administrator stated, if there were needs they were aware of, they would address them but they were not aware of the concerns in Resident #85's room.</p> <p>A second interview was conducted with the Director of Maintenance on 2/14/2024 at 1:18 PM. The Director of Maintenance stated they reviewed the computer maintenance request logs from 7/1/2023 through 2/14/2024 and there were no repairs requested for Resident #85's bureau or sink vanity.</p> <p>3) Resident #104 was admitted to the facility with diagnoses that include Dementia, Type 2 Diabetes, and Chronic Obstructive Pulmonary Disease. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was ten, which indicated the resident's cognition was moderately impaired.</p> <p>During an environmental tour of Resident #104's room on 2/6/2024 at 10:39 AM the top drawer of their bureau was open and could not be shut and the second drawer handle was missing.</p> <p>A second observation of Resident #104's room was completed on 2/7/2024 at 8:51 AM and the bureau drawer was shut and functional and the second drawer was missing a handle.</p> <p>Resident #104 was interviewed on 2/6/2024 at 10:39 AM and stated the top bureau drawer had been broken and the second drawer's handle had been missing for a while but could not say for how long. Resident #104 stated they reported the problems with the bureau but could not recall when or to whom.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Certified Nursing Assistant #7 was interviewed on 2/9/2024 at 10:23 AM and stated they are regularly assigned to work with Resident #104. Certified Nursing Assistant #7 stated they did not report the issues with the bureau in Resident #104's room. Certified Nursing Assistant #7 stated if they saw maintenance concerns, they reported them to the charge nurse and the charge nurse would submit a maintenance request.</p> <p>Housekeeper #1 was interviewed on 2/9/2024 at 10:31 AM and stated they are the regularly assigned housekeeper on the unit. Housekeeper #1 stated they cleaned each room on the unit daily. Housekeeper #1 stated they did not observe maintenance problems in Resident #104's room. Housekeeper #1 stated they have not observed any broken furniture or things in disrepair. Housekeeper #1 stated if they see an issue that required maintenance they would report the problem to the charge nurse.</p> <p>Licensed Practical Nurse #1 was interviewed on 2/9/2024 at 10:50 AM and stated they were the charge nurse on the unit. Licensed Practical Nurse #1 stated they completed a tour of the unit and went into each room daily. Licensed Practical Nurse #1 stated Resident #104 had not reported any environmental concerns with their room. Licensed Practical Nurse #1 stated they completed a maintenance request in the computer system if they saw a problem or if a problem was reported to them. Licensed Practical Nurse #1 stated they have not submitted any maintenance requests for Resident #104's room recently.</p> <p>Maintenance Worker #1 was interviewed on 2/9/2024 at 10:59 AM and stated they toured the unit daily and asked the unit charge nurse if they had maintenance concerns. Maintenance Worker #1 stated they check the computer system daily for new requests. Maintenance Worker #1 stated they have fixed broken furniture. Maintenance Worker #1 stated the furniture broke frequently and they have repaired a few pieces on the unit more than once.</p> <p>The Director of Maintenance was interviewed on 2/9/2024 at 4:06 PM. The Director of Maintenance stated they tour the building once a week. The Director of Maintenance stated the facility used a computer system to report maintenance concerns to the maintenance department. The Director of Maintenance stated they had not received any complaints from the residents on the unit where Resident #104 resided. The Director of Maintenance reported they replaced furniture if it could no longer be fixed. The Director of Maintenance stated any furniture needs were brought to the attention of the Administrator.</p> <p>The Administrator was interviewed on 2/14/2024 at 10:11 AM and stated they were not aware of the environmental concerns on the unit where Resident #104 resided. The Administrator stated the facility always tried to provide a home-like environment for the residents. The Administrator stated if there were needs they were aware of they would address them but they were not aware of the concerns in Resident #104's room.</p> <p>A second interview was conducted with the Director of Maintenance on 2/14/2024 at 1:18 PM. The Director of Maintenance stated they reviewed the computer maintenance request logs from 7/1/2023 through 2/14/2024 and there were no repairs requested for Resident #104's bureau.</p> <p>10 NYCRR 415.5(h)(2)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</p> <p>Based on record review and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately to the New York State Department of Health, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This was identified for one (Resident #98) of 11 residents reviewed for Accidents. Specifically, on 11/24/2023 Resident #98 was identified with an injury of unknown origin. There was no documented evidence that the injury was reported to the New York State Department of Health as required.</p> <p>The facility's policy titled, Abuse Prevention effective 11/2/2022 and last revised 6/1/2023 documented that an injury of unknown origin is to be reported to the New York State Department of Health.</p> <p>Resident #98 was admitted with diagnoses that included Cerebral Vascular Accident (Stroke), Dementia, and Bipolar Disorder. The Annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was not conducted because the resident is rarely/never understood. The Minimum Data Set documented Resident #98 required supervision/touch assistance for lying to sitting on the side of the bed, transfers, and walking.</p> <p>A Progress Note dated 11/24/2023 at 10:39 AM documented Resident #98 was observed with a small hematoma (bruise) on the right side of their forehead with no known origin.</p> <p>An Accident/Incident Report dated 11/24/2023 at 8:00 AM documented Resident #98 was noted with a hematoma (bruise) to the forehead with no known origin. The resident walked ad-lib (as desired) and was combative and aphasic (a speech disorder). The Accident/Incident Report documented Resident #98 was nonverbal and cognitively impaired. The Accident/Incident report concluded that there was no cause to believe that resident abuse, neglect, or mistreatment had occurred.</p> <p>A Comprehensive Care Plan dated 11/24/2023 for Skin Integrity documented the resident had a hematoma on the forehead. Interventions included to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bath or daily care.</p> <p>Certified Nursing Assistant #6 was interviewed on 2/9/2024 at 2:29 PM and stated they were the regularly assigned Certified Nursing Assistant for Resident #98. Certified Nursing Assistant #6 stated they worked 7:00 AM - 3:00 PM on 11/24/2023. Certified Nursing Assistant #6 stated when they arrived on the unit Resident #98 was sleeping. Certified Nursing Assistant #6 stated they provided care to two other residents and returned to Resident #98's room to provide care and they observed a bump on the resident's right forehead. Certified Nursing Assistant #6 stated they reported the bump to Licensed Practical Nurse #1, who was the unit charge nurse.</p> <p>Licensed Practical Nurse #1, the unit charge nurse, was interviewed on 2/9/2024 at 2:38 PM and stated they could not recall the event that occurred on 11/24/2023 related to Resident #98.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Assistant Director of Nursing Services was interviewed on 2/14/2024 at 8:50 AM and stated they were responsible for completing the Accident and Incident reports. The Assistant Director of Nursing Services stated they should have completed an investigation that went back three shifts to rule of abuse because no one witnessed how Resident #98 sustained the bump on their right forehead. The Assistant Director of Nursing stated Resident #98 used the handrails in the hallway to ambulate and if they turned a corner, they could have hit their head on the corner of the wall therefore they did not think that the resident's injury (hematoma) was as a result of abuse.</p> <p>An interview was conducted with the Director of Nursing Services on 2/14/2024 at 9:02 AM. The Director of Nursing Services stated the incident should have been investigated by interviewing staff on all shifts for the seventy-two hours prior to the observation of the bump on Resident #98's forehead. The Director of Nursing Services stated they should have reported the injury of unknown origin to the New York State Department of Health within twenty-four hours and it was an oversight.</p> <p>10 NYCRR 415.4(b)(2)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</p> <p>Based on record review and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024 the facility did not ensure that all incidents including the injury of unknown origin were thoroughly investigated . This was identified for one (Resident #98) of 11 residents reviewed for Accidents. Specifically, on 11/24/2023 at 8:00 AM Resident #98 was observed with an injury of unknown origin and the facility did not thoroughly investigate the incident to identify the root cause of the injury and to rule of Abuse, Neglect, and Mistreatment.</p> <p>The finding is:</p> <p>The facility's policy titled, Accident/Incident last revised December 2023, documented that all injuries of unknown sources will be investigated.</p> <p>The facility's policy titled, Abuse Prevention effective 11/2/2022 and last revised 6/2023 documented the facility will investigate all incidents of alleged and actual abuse, complaints/grievances, misappropriation, and injuries of unknown origin. The investigative process will include statements from staff, witnesses, and residents, interviews with staff witnesses, and residents, medical record review if applicable, and review of employee records. All findings of investigations will be documented.</p> <p>Resident #98 was admitted with diagnoses that included Cerebral Vascular Accident (stroke), Dementia, and Bipolar Disorder. The Annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was not conducted because the resident is rarely/never understood. The Minimum Data Set documented Resident #98 required supervision/touch assistance for lying to sitting on the side of the bed, transfers, and walking.</p> <p>A Progress Note dated 11/24/2023 at 10:39 AM documented Resident #98 was observed with a small hematoma (bruise) on the right side of their forehead with no known origin.</p> <p>A Comprehensive Care Plan dated 11/24/2023 for Skin Integrity documented Resident #98 had a hematoma on their forehead. Interventions included to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bath or daily care.</p> <p>An Accident/Incident Report dated 11/24/2023 at 8:00 AM documented Resident #98 was noted with a hematoma (bruise) on their forehead with no known origin, walks ad-lib (as desired) and was combative and aphasic (a language disorder). The Accident/Incident Reported documented Resident #98 was nonverbal and cognitively impaired.</p> <p>An undated written statement from Certified Nursing Assistant #6 documented Certified Nursing Assistant #6 was assigned to Resident #98 on 11/24/2023 during the 7:00 AM - 3:00 PM shift. Certified Nursing Assistant #6 noted a bump on Resident #98's right forehead when they provided care to the resident. Certified Nursing Assistant #6 documented that they notified their observation to the charge nurse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An undated written statement from the charge nurse, Licensed Practical Nurse #1, documented they (Licensed Practical Nurse #1) were called to Resident #98's room and observed a bump on the right side of Resident #98's forehead and they (Licensed Practical Nurse #1) informed their observation to their supervisor, the Assistant Director of Nursing Services.</p> <p>The Accident/Incident Report did not have statements from the previous shift staff to identify the root cause of the resident's hematoma, an injury of unknown origin.</p> <p>Certified Nursing Assistant #6 was interviewed on 2/9/2024 at 2:29 PM and stated they were the regularly assigned Certified Nursing Assistant for Resident #98. Certified Nursing Assistant #6 stated they worked 7:00 AM - 3:00 PM on 11/24/2023. Certified Nursing Assistant #6 stated when they arrived at the unit Resident #98 was sleeping. Certified Nursing Assistant #6 stated they provided care to two other residents and returned to Resident #98's room to provide care and they observed a bump on the resident's right forehead. Certified Nursing Assistant #6 stated they reported the bump to the charge nurse.</p> <p>The Assistant Director of Nursing Services was interviewed on 2/14/2024 at 8:50 AM and stated that no one witnessed how Resident #98 received the bump on their right forehead. The Assistant Director of Nursing Services stated they should have completed an investigation that went back three shifts to rule out abuse. The Assistant Director of Nursing stated Resident #98 used the handrails in the hallway to ambulate and if they turned a corner, they could have hit their head on the corner of the wall; however, acknowledged that no one witnessed the incident and therefore they did not know the origin of the injury.</p> <p>The Director of Nursing Services was interviewed on 2/14/2024 at 9:02 AM and stated the incident should have been investigated by interviewing staff on all shifts for the seventy-two hours prior to the observation of the injury of unknown origin. The Director of Nursing Services stated because the investigation was not thorough, the root cause of the injury could not be determined to rule out abuse, neglect, or mistreatment.</p> <p>10 NYCRR415.4(b)(3)</p>		

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NAME OF PROVIDER OR SUPPLIER Apex Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Birchwood Dr Huntington Station, NY 11746	

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349</p> <p>Based on record review and interview during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024, the facility did not ensure that the Minimum Data Set (MDS) assessment accurately reflects the resident's status. This was identified for one (Resident #61) of one resident reviewed for Dialysis. Specifically, the Minimum Data Set assessment for Resident #61 did not accurately capture that the resident was receiving dialysis treatment.</p> <p>The finding is:</p> <p>The facility policy and procedure titled, MDS 3.0, last reviewed 10/2023, documented that residents are assessed, using a comprehensive assessment process, to identify care needs and to develop an interdisciplinary care plan.</p> <p>Resident #61 was admitted with diagnoses including Cancer, End-Stage Renal Disease (ESRD), and Dependence on Renal Dialysis. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Section O of the Minimum Data Set for Special Treatments, Procedures, and Programs was blank for dialysis. A quarterly Minimum Data Set assessment dated [DATE] documented under Section O: Special Treatments, Procedures, and Programs triggered dialysis.</p> <p>A Physician's order dated 12/19/2023 documented to provide Hemodialysis at an outside Dialysis Center facility every day shift every Tuesday, Thursday, and Saturday.</p> <p>Registered Nurse (RN) #5, the Minimum Data Set Coordinator, was interviewed on 2/9/2024 at 2:44 PM and stated they are responsible to check for accuracy of the Minimum Data Set assessment. Registered Nurse #5 stated that it was an oversight that the Minimum Data Set was not coded correctly.</p> <p>10 NYCCR 415.11(b)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024 the facility did not ensure a person-centered comprehensive care plan was reviewed and revised to address each resident's needs. This was identified for one (Resident #152) of 35 sampled residents. Specifically, a quarterly Minimum Data Set assessment was completed on 12/20/2023 for Resident #152. There was no documented evidence that a care plan meeting was held after each assessment including both the comprehensive and quarterly review assessments. The resident or their representative were not provided notice of a care plan meeting for an opportunity to attend and participate. In addition, Resident #152's comprehensive care plan related to Resident/Family participation in assessment and care planning and Satisfaction with the current plan of care were not reviewed and revised upon the quarterly Minimum Data Set assessment dated [DATE].</p> <p>The finding is:</p> <p>The facility's policy and procedure titled, Care Planning last reviewed October 2023, documented to provide each resident with an individualized interdisciplinary plan of care. The initial comprehensive care plan meeting is conducted no later than 21 days after admission. The facilitator for the meetings is the Minimum Data Set Coordinator or designee. The facilitator/clinical nurse manager will ensure that a record of team meetings is initiated and that all participating members are present and sign the Comprehensive Care Plan meeting attendance sheet. The Comprehensive care plan is reviewed/revised in conjunction with the Minimum Data Set assessment schedule to include annual reviews, quarterly reviews, and in response to a significant change and all episodic events. The policy and procedure do not address when the resident and/or their representative is invited to participate in the care plan meeting.</p> <p>Resident #152 was admitted with diagnoses including Depression, and Anxiety Disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12 indicating the resident had moderately impaired cognition. The resident had adequate hearing with clear speech; was understood and understood others.</p> <p>A social services progress note dated 3/28/2023 documented that the initial care plan meeting was held today and was attended by the resident's family member. The progress documented that it was not beneficial for the resident to attend meetings due to the resident's cognitive status.</p> <p>The nursing and social work progress notes from 10/1/2023 to 2/7/2024 did not reveal any documentation that a care plan meeting was held or that the resident or the resident's representative was invited to attend and or that a care plan meeting was held.</p> <p>A record review was completed on 2/8/2024 at 9:14 AM and revealed multiple Comprehensive Care Plans (example: Cognition created 3/14/23 revision 12/26/23) were reviewed and/or revised in accordance with the Minimum Data Set assessment schedule. There was no evidence documenting that the Resident/ Family participation in assessment and care planning or the Satisfaction with the current plan of care was reviewed and/or revised in accordance with the Minimum Data Set assessment schedule.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Registered Nurse Minimum Data Set Coordinator #1 was interviewed on 2/9/2024 at 2:53 PM and stated that they are responsible for generating the care planning schedule and the Social Worker is responsible for inviting the resident and or the resident's representative. Registered Nurse Minimum Data Set Coordinator #1 further stated that care plan meetings are held upon admission, annually, and with significant change in condition. Registered Nurse Minimum Data Set Coordinator #1 stated that the team does not invite the resident and or their representative for quarterly assessment meetings.</p> <p>The Director of Social Work was interviewed on 2/9/2024 at 3:25 PM and stated that care plan meetings are held when a new admission, quarterly, and significant change assessments are completed. The Director of Social Work stated that ideally if the resident is capable of attending, or their designated representative attend the initial, annual, discharge, or significant change care plan meetings. The Social Work department gets a list from the Minimum Data Set Coordinator and then the Social Worker calls the resident's representative about the meeting and asks if they can attend. The facility accommodates the resident representative's schedule. The resident is also notified. The Director of Social Work stated they only invite the resident and the resident representative to initial, annual, and significant change meetings. The resident and the resident representative are not invited to a quarterly meeting; however, a call is the representative to provide updates. The Director of Social Work reviewed Resident #152's Electronic Medical Record and confirmed that there was no documentation of a care plan meeting held for Resident #152 other than the initial meeting dated 3/28/2023. The Director of Social Work also reviewed the care plans in the Electronic Medical Record and stated that the Comprehensive Care Plans titled, Resident/ Family Participation in Assessment and Care Planning and Satisfaction with the current Plan of Care were not reviewed in conjunction with the Minimum Data Set assessments.</p> <p>10 NYCCR 415.11</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>34798</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024 the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain personal hygiene. This was identified for one (Resident #122) of two residents reviewed for Activities of Daily Living. Specifically, on 2/6/2024 Resident #122 was observed with long, dirty, and jagged fingernails with a brown substance under the nails on both hands.</p> <p>The finding is:</p> <p>The facility's policy titled, Job Description-Certified Nursing Assistant, dated January 2015, documented the primary purpose of the Certified Nursing Assistant is to provide each of your residents with routine daily nursing care and services in accordance with the resident's assessment and care plan including assisting with nail care (clipping, trimming, and cleaning the finger/toenails). Note: does not include diabetic residents.</p> <p>Resident #122 was admitted with diagnoses including Diabetes Mellitus, Schizophrenia, and Depression. The 1/5/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 12, indicating the resident was cognitively intact. The Minimum Data Set documented that the resident needed set-up or clean-up assistance for Personal Hygiene.</p> <p>A Comprehensive Care Plan titled, Activities of Daily Living effective 5/28/2021 and last updated on 1/17/2024, documented that the resident required supervision for personal hygiene tasks. Interventions included but were not limited to provide assistance with grooming as needed. The Comprehensive Care Plan did not include specific care instructions or interventions regarding nail care.</p> <p>A Comprehensive Care Plan titled, Visual Function initiated on 7/7/2021 and last updated on 8/18/2023, documented the resident is at risk of impaired visual function related to presbyopia (normal age-related changes), retinal detachment, and Diabetes Mellitus; moderately impaired vision and is unable to see small print but can see larger print.</p> <p>The Kardex (resident care instructions provided to the Certified Nursing Assistants) documented that Resident #122 required supervision for personal hygiene. The Kardex did not document specific instructions regarding nail care.</p> <p>On 2/6/2024 at 10:05 AM during an interview with Licensed Practical Nurse #2, the charge nurse on Unit 1A, Resident #122 approached the nurse's station and stated that they needed their fingernails trimmed. Resident #122 resided on another unit (Unit C). The surveyor observed the resident's fingernails to be long and dirty. There was a brown color substance under the resident's fingernails and the nails were broken with jagged edges on both hands. Registered Nurse #1, the Minimum Data Set nurse, was present at the nurse's station at the time of the observation and escorted the resident back to their unit (Unit C). Registered Nurse #1 stated they would return Resident #122 to their unit to have the fingernails taken care of.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Registered Nurse #2, the Unit C charge nurse, was interviewed on 2/8/2024 at 2:07 PM and stated Resident #122 has been on Unit C for approximately two months and the Certified Nursing Assistants are responsible for fingernail care and keeping the resident's nails clean. Registered Nurse #2 stated if a resident refuses to have their nails trimmed, the Certified Nursing Assistant is supposed to let the nurse know. Registered Nurse #2 stated the first time they were alerted about the issue with Resident #122's fingernails was on 2/6/2024 after the observation by the surveyor. Registered Nurse #2 stated as soon as they were made aware, they cut the resident's nails and the resident offered no resistance.</p> <p>The Registered Nurse Inservice Coordinator was interviewed on 2/9/2024 at 8:51 AM and stated that the Certified Nursing Assistants are supposed to provide nail care on shower days at least two times a week as per the facility policy. The Registered Nurse Inservice Coordinator stated that the Certified Nursing Assistants sign the skin monitoring sheet every shower day to indicate the resident received the shower and any refusals regarding shower or nail care should be reported to the nurse. The skin monitoring sheet is also signed by the floor nurse. The Registered Nurse Inservice Coordinator stated if a resident is Diabetic, the floor nurse should cut the fingernails.</p> <p>A review of the Skin Monitoring: Comprehensive Certified Nursing Assistant Shower Review sheet dated 2/3/2024 indicated Resident #122 received a shower on 2/3/2024. The sheet was signed by Certified Nursing Assistant #2 and Registered Nurse #3 and documented no concerns.</p> <p>Certified Nursing Assistant #2 was interviewed on 2/9/2024 at 2:18 PM and stated the skin monitoring sheets are filled out for every shower and signed by the Certified Nursing Assistants and the Nurse to confirm that the skin checks were performed, including checking fingernails and toenails. Certified Nursing Assistant #2 stated they would cut the residents' nails if the nails were long, and if the resident is a diabetic, they would tell the nurse. Certified Nursing Assistant #2 stated they did not see any concerns with Resident #122's nails during the 2/3/2024 shower and there was nothing to report.</p> <p>Registered Nurse #3 was interviewed on 2/9/2024 at 3:35 PM. Registered Nurse #3 stated even though the Certified Nursing Assistant fills out and signs the skin monitoring sheets that there are no concerns, they (Registered Nurse #3) still must go and check the resident. Registered Nurse #3 stated they could not remember if there was any problem with Resident #122's fingernails on 2/3/2024.</p> <p>The Director of Nursing Services was interviewed on 2/12/2024 at 10:01 AM and stated the residents' fingernails are trimmed and cleaned on shower days and as needed. The staff do not have to wait for a shower day to cut or trim resident's nails. The Director of Nursing Services stated that Resident #122 refused to get their nails cut and the Certified Nursing Assistant did not inform the nurse. The Director of Nursing Services further stated the nurse should also have checked the resident's nails.</p> <p>10 NYCRR 415.12(a)(3)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28173</p> <p>Based on observations, record review and interviews conducted during a Recertification and abbreviated Survey (NY 00318188) initiated on 2/6/2024 and completed on 2/14/2024, the facility did not ensure that the residents' environment remained as free from accident hazards as possible, and each resident receives adequate supervision to prevent accidents. This was identified for one (Resident #146) of 11 residents reviewed for Accidents/elopement, 2) for six (Resident #93, Resident #104, Resident #146, Resident #103, Resident #112, and Resident #85) of eleven residents reviewed for Accidents hazards; and 3) for one Unit 1A of four units observed during the Medication Storage Task. Specifically, 1) Resident #146, who had a diagnosis of Dementia and was identified by the facility as an elopement risk/wanderer, wandered outside of the facility on 6/11/2023 after being directed to an outdoor area by the receptionist. The resident left the facility without staff knowledge and was brought back by the local police after the resident was found knocking at the door of a private home looking for their parents. 2) On multiple observations of Resident's, #93's, #104's, #146, #103's, #112's, and #85's bathrooms, the handrails on each side of the toilet were observed loose and unsteady; 3) During the Medication Storage Task on Unit 1A, the medication storage closet was observed with no lock. The medication storage contained over the counter medications along with other medical supplies such as syringes and intravenous fluid bags.</p> <p>The findings include but are not limited to:</p> <p>1) The facility's policy titled, Elopement and Unsafe Wandering dated 2/2022 documented staff education regarding the responsibility to identify, report, and intervene in wandering/elopement risk; such as but not limited to anticipating resident needs based upon wandering triggers and patterns, acknowledging resident's behavior as an attempt to communicate needs and encourage verbalization, identifying etiology, and recognizing feelings.</p> <p>Resident #146 was admitted with diagnoses that included Dementia, Chronic Obstructive Pulmonary Disease, and Emphysema. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 4 which indicated severe cognitive impairment. The Minimum Data Set documented the resident needed extensive assistance from one staff for locomotion off the unit. The resident utilized a walker and a wheelchair as per the Minimum Data Set.</p> <p>A Comprehensive Care Plan for Wandering dated 12/20/2022 and last revised on 1/3/2024 documented that the resident is an elopement risk/wanderer as the resident moves about aimlessly. Interventions included to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The investigation report dated 6/11/2023 documented that at approximately 7:55 PM the resident was speaking to the receptionist while sitting in the lobby, which is their usual behavior, and verbalized they wanted to get some fresh air. The receptionist reported they directed the resident towards the patio to accommodate their request. The surveillance camera revealed that at approximately 8:12 PM Resident #146 was observed walking back towards their unit and the patio. At 8:18 PM the resident was noted walking through the dining room, entering the hub, pushing on the alarmed exterior door, and exiting the facility. At 9:15 PM the resident returned to the facility accompanied by the police department after they were found knocking on a neighbor's door looking for their parents. The investigation summary concluded that the receptionist/security did not follow policy & procedure regarding facility alarms as they did not utilize the proper notification to the Registered Nurse Supervisor with regards to Resident #146's request to leave, nor did they provide an escort.</p> <p>A written statement from the receptionist dated 6/11/2023 documented that they did not hear the sounding of an alarm or have any awareness of the resident exiting the building until the resident's family called asking for the resident and then entered the building accompanied by the resident and the police.</p> <p>The Director of Maintenance Services was interviewed on 2/7/2024 at 2:42 PM. The Director of Maintenance Services stated that the Hub (an area described as a rarely used recreation room adjacent to the first-floor dining room) is inspected by staff every Friday. They stated that the area was alarmed remotely at the front desk, and they expected that the front desk staff would notify the nursing supervisor if the alarm sounded. The Director of Maintenance Services stated that the fence enclosing the outdoor area exiting the Hub was broken. The fence may have come down because of the landscaper's equipment moving.</p> <p>The Director of Nursing Services (DNS) was interviewed on 2/7/2024 at 2:47 PM. The Direction of Nursing Services stated Resident #146 expressed a desire for fresh air to the front desk receptionist on 6/11/2023 and the receptionist directed the resident to the patio without conveying the request to the nursing supervisor. The resident however wandered to another area of the building referred to as the Hub and exited a remotely alarmed exit door to the outside of the building. This area outside of the building was fenced in; however, a section of the fence had collapsed and Resident #146 wandered through this breached area to a neighbor's home at which point the police were called by the neighbors. The resident was escorted back to the facility by the police. The Director of Nursing Services stated that the receptionist alleged that the alarmed door did not sound at the front desk; however, an examination of the door alarm in question was checked and was found to be operational. The receptionist was later terminated for failing to alert the nursing supervisor of the resident's intent.</p> <p>Resident #146 was observed in their bed on 2/9/2024 at 11:27 AM. Resident #146 was alert. Resident #146 was communicative; however, did present with impaired memory and had no recollection of the incident on 6/11/2023.</p> <p>Licensed Practical Nurse #1 was interviewed on 2/9/2024 at 11:41 AM. Licensed Practical Nurse #1 stated that Resident #146 is a known wanderer with periods of confusion. Licensed Practical Nurse #1 stated that Resident #146 was moved to the Dementia Unit on the second floor following the incident on 6/11/2023. Licensed Practical Nurse #1 stated that Resident #146 now wears a wander guard and is in a secured unit requiring staff assistance to exit the unit. Licensed Practical Nurse #1 stated that Resident #146 was not a known wanderer before the incident on 6/11/2023.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>41051</p> <p>2) The facility's policy titled Routine Maintenance dated 2/2022 and last reviewed 5/2023 documented the facility will ensure the provision of a safe, functional, sanitary, and comfortable environment for the resident. The maintenance department will ensure that the physical environment, furniture, and equipment are maintained in good repair throughout the facility.</p> <p>2a) Resident #93 was admitted with diagnoses that included Bilateral Osteoarthritis of the hips, Dementia, and Anxiety Disorder. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status was not completed because the resident is rarely/never understood. The Minimum Data Set documented the resident used a wheelchair and needed supervision or touch assistance for mobility. The Minimum Data Set documented Resident #93 was always continent of bowel and bladder and required partial/moderate assistance during toilet transfer.</p> <p>During an environmental tour of Resident #93's bathroom on 2/6/2024 at 11:01 AM the handrails on both sides of the toilet were loose and unsteady.</p> <p>Resident #93 was observed in their room on 2/6/2024 at 11:01 AM. Resident #93 was in bed and stated they preferred to rest and chose to be in bed. Resident #93 stated they did not want to talk further.</p> <p>A second observation was completed on 2/7/2024 at 8:30 AM and the handrails on both sides of the toilet were loose and unsteady.</p> <p>Certified Nursing Assistant #6 was interviewed on 2/9/2024 at 9:45 AM and stated they are regularly assigned to work with Resident #93. Certified Nursing Assistant #6 stated they did not notice the loose handrails in Resident #93's bathroom. Certified Nursing Assistant #6 stated Resident #93 required the assistance of two people to transfer from their wheelchair to the toilet and from the toilet to the wheelchair. Certified Nursing Assistant #6 stated if they saw maintenance concerns, they reported them to the charge nurse and the charge nurse submitted a maintenance request.</p> <p>Housekeeper #1 was interviewed on 2/9/2024 at 10:31 AM and stated they are the regularly assigned housekeeper on the unit. Housekeeper #1 stated they cleaned each bathroom on the unit daily. Housekeeper #1 stated they had not observed loose handrails in Resident #93's bathroom. Housekeeper #1 stated if they saw an issue that required maintenance, they would report the problem to the charge nurse.</p> <p>Licensed Practical Nurse #1 was interviewed on 2/9/2024 at 10:50 AM and stated they were the charge nurse on the unit. Licensed Practical Nurse #1 stated they completed a tour of the unit and went into each room daily. Licensed Practical Nurse #1 stated Resident #93 has not reported any environmental concerns with their bathroom. Licensed Practical Nurse #1 stated they have not observed loose toilet handrails in any of the resident's bathrooms on the unit. Licensed Practical Nurse #1 stated they have not submitted any maintenance requests for Resident #93's bathroom recently.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Maintenance Worker #1 was interviewed on 2/9/2024 at 10:59 AM and stated they toured the unit daily and they asked the unit charge nurse if they had maintenance concerns. Maintenance Worker #1 stated they checked the computer system daily for new requests. Maintenance Worker #1 stated they replaced the screws on the toilet handrails a couple of months ago but were unable to state exactly when. Maintenance Worker #1 stated the toilet handrails on the unit were loose and they frequently tightened them.</p> <p>The Director of Maintenance was interviewed on 2/9/2024 at 4:06 PM. The Director of Maintenance stated the toilet handrails should be secure and sturdy for resident safety. The Director of Maintenance stated they toured the building once a week to see if any environmental concerns needed to be addressed. The Director of Maintenance stated the facility used a computer system to report maintenance concerns to the maintenance department. The Director of Maintenance stated they had not received any complaints from the residents on the unit that Resident #93 resided on.</p> <p>The Administrator was interviewed on 2/14/2024 at 10:11 AM and stated they were not aware of the concerns with the toilet handrails on the unit where Resident #93 resided. The Administrator stated they were not aware of the concerns in Resident #93's bathroom.</p> <p>A second interview was conducted with the Director of Maintenance on 2/14/2024 at 1:18 PM. The Director of Maintenance stated they reviewed the computer maintenance request logs from 7/1/2023 through 2/14/2024 and there were no repairs requested for Resident #93's toilet handrails.</p> <p>2 b) Resident #104 was admitted to the facility with diagnoses that included Dementia, Type 2 Diabetes, and Chronic Obstructive Pulmonary Disease. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was ten, which indicated the resident's cognition was moderately impaired. The Minimum Data Set documented Resident #104 used a walker and wheelchair for mobility. The Minimum Data Set documented Resident #104 was occasionally incontinent of bowel and bladder and required supervision or touch assistance with toilet transfer.</p> <p>During an environmental tour of Resident #104's room on 2/6/2024 at 10:39 AM the toilet handrails in Resident #104's bathroom were observed to be loose and unsteady.</p> <p>Resident #104 was interviewed on 2/6/2024 at 10:39 AM and stated they used the toilet in their bathroom on their own and used the toilet handrails to steady themselves. Resident #104 stated they knew the handrails were loose, but they were not sure if they reported it to anyone.</p> <p>During an environmental tour of Resident #104's room on 2/7/2024 at 8:51 AM the toilet handrails in Resident #104's bathroom were observed to be loose and unsteady.</p> <p>Certified Nursing Assistant #7 was interviewed on 2/9/2024 at 10:23 AM and stated they are regularly assigned to work with Resident #104. Certified Nursing Assistant #7 stated Resident #104 was usually independent in the bathroom and had not reported loose toilet handrails. Certified Nursing Assistant #7 stated Resident #104 was sometimes unsteady on their feet and used a walker. Certified Nursing Assistant #7 stated if they saw maintenance concerns, they reported them to the charge nurse and the charge nurse submitted a maintenance request.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Housekeeper #1 was interviewed on 2/9/2024 at 10:31 AM and stated they are the regularly assigned housekeeper on the unit. Housekeeper #1 stated they cleaned each room on the unit. Housekeeper #1 stated they had not observed loose handrails in Resident #104's bathroom.</p> <p>Maintenance Worker #1 was interviewed on 2/9/2024 at 10:59 AM and stated they toured the unit daily and asked the unit charge nurse if they had maintenance concerns. Maintenance Worker #1 stated they checked the computer system daily for new requests. Maintenance Worker #1 stated they replaced the screws on the toilet handrails a couple of months ago, but they were unable to state exactly when. Maintenance Worker #1 stated the toilet handrails on the unit were loose and they frequently tighten them.</p> <p>The Director of Maintenance was interviewed on 2/9/2024 at 4:06 PM. The Director of Maintenance stated the toilet handrails should be secure and sturdy for resident safety. The Director of Maintenance stated they toured the building once a week to see if any environmental concerns needed to be addressed. The Director of Maintenance stated the facility used a computer system to report maintenance concerns to the maintenance department. The Director of Maintenance stated they have not received any complaints from the residents on the unit Resident #104 resided on.</p> <p>The Administrator was interviewed on 2/14/2024 at 10:11 AM and stated they were not aware of the concerns with the toilet handrails on the unit where Resident #104 resided.</p> <p>A second interview was conducted with the Director of Maintenance on 2/14/2024 at 1:18 PM. The Director of Maintenance stated they reviewed the computer maintenance request logs from 7/1/2023 through 2/14/2024 and there were no repairs requested for Resident #104's toilet handrails.</p> <p>2 c) Resident #146 was admitted to the facility with diagnoses that included Dementia, Depression, and Chronic Obstructive Pulmonary Disease. The Annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was four, which indicated the resident's cognition was severely impaired. The Minimum Data Set documented Resident #146 was always continent of bowel and bladder and used a walker and wheelchair for mobility. The Annual Minimum Data Set documented that Resident #146 required partial/moderate assistance during toilet transfer.</p> <p>During an environmental tour of Resident #146's room on 2/6/2024 at 10:54 AM the toilet handrails in Resident #146's bathroom were loose and unsteady.</p> <p>During an environmental tour of Resident #146's room on 2/6/2024 at 10:54 AM and 2/7/2024 at 8:42 AM the toilet handrails in Resident #146's bathroom were loose and unsteady.</p> <p>Certified Nursing Assistant #6 was interviewed on 2/9/2024 at 9:45 AM and stated they are regularly assigned to work with Resident #146. Certified Nursing Assistant #6 stated they did not notice the loose handrails in Resident #146's bathroom. Certified Nursing Assistant #6 stated Resident #146 used the bathroom independently. Certified Nursing Assistant #6 stated Resident #146 used a walker and was unsteady on their feet. Certified Nursing Assistant #6 stated if they saw maintenance concerns, they reported them to the charge nurse and the charge nurse submitted a maintenance request.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Housekeeper #1 was interviewed on 2/9/2024 at 10:31 AM and stated they are the regularly assigned housekeeper on the unit. Housekeeper #1 stated they clean each bathroom on the unit daily and have not observed loose handrails in Resident #146's bathroom. Housekeeper #1 stated if they saw an issue that required maintenance, they would report the problem to the charge nurse.</p> <p>Licensed Practical Nurse #1 was interviewed on 2/9/2024 at 10:50 AM and stated they were the charge nurse on the unit. Licensed Practical Nurse #1 stated they completed a tour of the unit and went into each room daily. Licensed Practical Nurse #1 stated they have not observed loose toilet handrails in any of the resident's bathrooms on the unit and have not submitted any maintenance requests for Resident #146's bathroom recently.</p> <p>Maintenance Worker #1 was interviewed on 2/9/2024 at 10:59 AM and stated they toured the unit daily and asked the unit charge nurse if they had maintenance concerns. Maintenance Worker #1 stated they check the computer system daily for new requests. Maintenance Worker #1 stated they replaced the screws on the toilet handrails a couple of months ago but were unable to state exactly when. Maintenance Worker #1 stated the toilet handrails on the unit were loose and they frequently tightened them.</p> <p>The Director of Maintenance was interviewed on 2/9/2024 at 4:06 PM. The Director of Maintenance stated the toilet handrails should be secure and sturdy for resident safety. The Director of Maintenance stated they toured the building once a week to see if any environmental concerns needed to be addressed. The Director of Maintenance stated the facility used a computer system to report maintenance concerns to the maintenance department. The Director of Maintenance stated they have not received any complaints from the residents on the unit that Resident #146 resided on.</p> <p>The Administrator was interviewed on 2/14/2024 at 10:11 AM and stated they were not aware of the concerns with the toilet handrails on the unit where Resident #146 resided. The Administrator stated they were not aware of the concerns in Resident #146's bathroom.</p> <p>A second interview was conducted with the Director of Maintenance on 2/14/2024 at 1:18 PM. The Director of Maintenance stated they reviewed the computer maintenance request logs from 7/1/2023 through 2/14/2024 and there were no repairs requested for Resident #146's toilet handrails.</p> <p>3) The facility's policy titled Medication Storage last reviewed in October 2023, documented all drugs and biologicals would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms). Only authorized personnel would have access to the keys to locked compartments.</p> <p>During a tour of the facility's medication storage on Unit 1A on 2/14/2024 at 2:21 PM, the medication closet was observed to not have a lock. The closet was located behind the unit's nurse's station. The items in the unlocked closet included but were not limited to insulin syringes, Tuberculin syringes, razors for shaving, Pepcid tablets (for gastroesophageal reflux disease), Loratadine tablets (an antihistamine) bottles, Acetaminophen tablets (used to relieve pain and reduce fever) bottles, Hydrogen Peroxide (an antiseptic) bottles, Geri-Tussin liquid (used to relieve cough), Zinc tablets (a nutritional supplement), Povidone Iodine (a disinfectant) bottles, Lidocaine pain relief patches, intravenous fluids (liquids injected into a person's veins through an intravenous tube) and, Antacid tablets (used to treat heartburn) bottles etc.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Licensed Practical Nurse #2, who was the unit charge nurse, was interviewed on 2/14/2024 at 2:21 PM and stated the nurse's station was under renovation and the facility had stored medication in the unlocked closet behind the nurse's station for about two or three months. Licensed Practical Nurse #2 stated there was usually a nurse seated at the station but if the nurse was called away the closet was unsupervised and accessible to the other staff, residents, or visitors.</p> <p>The Director of Maintenance was interviewed on 2/14/2024 at 2:48 PM and stated the closet doors have not had locks for about two to three months. The Director of Maintenance stated the area was recently renovated and the previous doors did not have locks so they did not think they needed a lock on the medication storage area.</p> <p>The Director of Nursing Services was interviewed on 2/24/2024 at 3:02 PM and stated the nurse's station was recently renovated. The Director of Nursing Services stated the medicine closet is behind the nurse's station and residents do not go behind there, but the closet should be locked.</p> <p>10 NYCRR 415.12(h)(1)(2)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>28670</p> <p>Based on record review and staff interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024, the facility did not ensure sufficient nursing staff were available to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. This was identified for three (Unit 1A, Unit 2A, and Unit C) of four Units during the Sufficient Staffing Task review. Specifically, a review of the Payroll Based Journal (PBJ) Staffing Data Report, the Facility Assessment, review of weekend staffing and staffing during the Recertification Survey revealed the facility had insufficient nursing staff on numerous occasions.</p> <p>The finding is:</p> <p>The Facility's Staffing Policy and Procedure dated October 2023 documented the facility will maintain safe staffing levels and that the nursing department will schedule and arrange staff according to the acuity and census of each unit to ensure quality of care is maintained. The employees who call out sick will always be replaced at the time of incident to the highest degree possible and practical. Overtime will be used when necessary to ensure staffing levels. Additionally, the nursing department will ensure each unit is maintained at a safe staffing level. This may require nursing to shift assignments to the unit with the highest acuity and/or highest census. Licensed nurses may be assigned to complete Certified Nursing Assistant (CNA) responsibility and administrative nurses may be assigned to administer medications and treatments.</p> <p>The Payroll-Based Journal (PBJ) Staffing Data Report dated for Fiscal Year (FY) Quarter four 2023 (July 1-September 30) documented the facility triggered for the Metric of Excessively low weekend staffing: July 1, 2023, July 16, 2023, August 5, 2023, September 9, 2023, and September 24, 2023</p> <p>The Facility Assessment for 2024 documented the facility does not take a census-based approach to staffing but looks at the acuity levels of the residents in order to provide the best staffing possible. Organizational staffing is monitored and evaluated daily for changes and required adjustments. The Facility Assessment indicated the facility would need 58 Certified Nursing Assistants on a daily (24-hour) basis and 18-24 Licensed nurses for providing direct care. The Facility Assessment did not identify the required staffing needs for each nursing shift (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM).</p> <p>A review of the weekend staffing from 7/1/2023 to 9/30/2023 revealed there was insufficient nursing staff than indicated on the Facility Assessment. Examples include but are not limited to:</p> <ul style="list-style-type: none"> -On July 1, 2023 (Saturday), the facility had 49 Certified Nursing Assistants on duty instead of 58 Certified Nursing Assistants. -On July 16, 2023 (Sunday), the facility had 46 Certified Nursing Assistants on duty instead of 58 Certified Nursing Assistants. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On August 5, 2023 (Saturday), the facility had 48 Certified Nursing Assistants on duty instead of 58 Certified Nursing Assistants.</p> <p>-On September 9, 2023 (Saturday), the facility had 48 Certified Nursing Assistants on duty instead of 58 Certified Nursing Assistants.</p> <p>-On September 24, 2023 (Sunday), the facility had 52 Certified Nursing Assistants on duty instead of 58 Certified Nursing Assistants.</p> <p>Additionally, a review of the actual Daily Staffing Assignments revealed:</p> <p>-On 7/1/2023 and 7/16/2023, during the 11:00 PM-7:00 AM shift Unit 1A had only one Certified Nursing Assistant on duty with a Census of 44 residents.</p> <p>-On 8/5/2023 during the 11:00 PM-7:00 AM shift Unit 1A and Unit C had only one Certified Nursing Assistant on duty with a census of 46 residents on Unit 1A and 57 residents on Unit C.</p> <p>-On 9/9/2023 during the 11:00 PM-7:00 AM shift Unit 1A and Unit 2A had only one Certified Nursing Assistant on duty with a census of 44 residents on Unit 1A and 29 residents on Unit 2A.</p> <p>-On 9/24/2023 during the 11:00 PM-7:00 AM shift Unit 1A had only one Certified Nursing Assistant on duty with a full census of 46 residents.</p> <p>The Staffing Coordinator #1 was interviewed on 2/12/2024 at 4:25 PM and stated that the staffing par level (minimum and maximum staff numbers set by the facility) for each unit was in place prior to them starting in this position. Staffing Coordinator #1 stated when there are call-outs certain staff are willing to pick up extra shifts; the facility also offers overtime to replace the call-outs. Staffing Coordinator #1 stated that, particularly on the weekends, it is difficult to get both licensed and non-licensed nursing staff to replace the staff who called in sick. Staffing Coordinator #1 stated the par levels are as follows:</p> <p>-On Day Shift: 7:00 AM - 3:00 PM</p> <p>-Unit 1A should have five Certified Nursing Assistants, one Charge Licensed Practical Nurse, and two Registered Nurses (medication nurse).</p> <p>-Unit 2A should have four Certified Nursing Assistants, one Charge Licensed Practical Nurse, one Licensed Practical Nurse or Registered Nurse (medication nurse).</p> <p>-Unit B should have seven Certified Nursing assistants, two Charge Registered Nurses, and two medication nurses.</p> <p>- Unit C should have seven Certified Nursing Assistants, one Charge Registered Nurse, and two Registered Nurses (medication nurses).</p> <p>On the Evening Shift: 3:00 PM - 11:00 PM</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Unit 1A should have five Certified Nursing Assistants, one Charge Registered Nurse, and one Licensed Practical Nurse (medication nurse).</p> <p>-Unit 2A should have four Certified Nursing assistants, and two Licensed Practical Nurses (medication nurses).</p> <p>-Unit B should have five Certified Nursing Assistants, two Charge Registered Nurses</p> <p>-Unit C should have six Certified Nursing Assistants and two Charge Registered Nurses and there should be two Registered Nurse Supervisors on duty for the entire building.</p> <p>On the Night Shift: 11:00 PM - 7:00 AM</p> <p>-Unit 1A should have three Certified Nursing Assistants and one Registered Nurse.</p> <p>-Unit 2A should have two Certified Nursing Assistants and one Registered Nurse or Licensed Practical Nurse.</p> <p>-Unit B should have three Certified Nursing Assistants and two Registered Nurses</p> <p>-Unit C should have three Certified Nursing Assistants and one Registered Nurse and there should be one Registered Nurse Supervisor for the entire building.</p> <p>The Director of Nursing Services was interviewed on 2/24/2024 at 2:12 PM. The Director of Nursing Services stated that the par-levels for the weekends are the same as the weekdays, except, on the weekends there are no charge nurses. The Director of Nursing Services stated that if there were call-outs on the weekend the Registered Nurse Supervisors would get someone to stay or call other staff to replace the call-out. The Director of Nursing Services stated that they would expect the Staffing Coordinator to notify them if the staffing par levels are not met. The Daily Staffing Assignments for 7/1/2023, 7/16/2023, 8/5/2023, 9/6/2023, and 9/24/2024 were reviewed with the Director of Nursing Services. The Director of Nursing Services confirmed the staffing levels and stated that they were not informed by anyone that sufficient staff were not available to care for the residents on the weekends in July, August, and September 2023. The Director of Nursing Services stated that if they had been made aware the units were working with only one Certified Nursing Assistant, they would have instructed the Staffing Coordinator or the Nursing Supervisor to ensure that the staff were replaced.</p> <p>The Administrator was interviewed on 2/14/2024 at 3:22 PM. The Administrator stated that they were not directly involved with staffing. The Administrator stated that they did not recall anyone complaining about short staffing and that currently there have been no concerns about short staffing. The Administrator stated that the par-levels are census-based and were set up prior to them being hired at the facility. The Administrator stated that if the census was low there might not be a need for extra staff; however, if the units fell below their par levels, they expected the other staff to be called.</p> <p>10 NYCRR 415.13(a)(1)(i-iii)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024 the facility did not ensure that nurse's aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This was identified for one (Resident #48) of two residents reviewed for Choices. Specifically, Certified Nursing Assistant #8 was observed utilizing a sink as a basin to store the water for providing care to Resident #48 in a semi-private room. The sink is also utilized by other residents for handwashing and other hygiene tasks.</p> <p>The finding is:</p> <p>The facility Activity of Daily Living (ADL) Policy dated 6/2023 documented to perform a bed bath, the nursing assistant will secure the bath supplies and clean bed linens as needed and bring them to the resident/patient's bedside.</p> <p>Resident #48 was admitted with diagnoses that included Vascular Dementia, Adult Failure to Thrive, and Liver Cell Carcinoma. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident had short and long term memory problems. The resident had no behavior problems and required total staff assistance for bathing and personal hygiene.</p> <p>The Activities of Living Care Plan dated 3/24/2022 and last updated on 11/10/2023 documented that the resident was totally dependent on staff for bathing and personal hygiene.</p> <p>During an observation on 2/9/2024 at 12:00 PM, Certified Nursing Assistant #8 was observed in Resident #48's room. Certified Nursing Assistant #8 was standing by the sink. The water faucet was on, and a towel was placed in the water that was being collected in the sink. Certified Nursing Assistant #8 stated that they were assigned to Resident #48 and were in the process of administering a bed bath to the resident. Certified Nursing Assistant #8 stated that they were using the towel and the water in the sink to administer care to Resident #48. Certified Nursing Assistant #8 stated that they always provide hygiene care for the resident using the sink as the basin. Licensed Practical Nurse #2, the nurse in charge, then came to the resident's room and instructed Certified Nursing Assistant #8 to use the wash basin to administer care.</p> <p>Licensed Practical Nurse #2 was interviewed on 2/9/2024 at 3:24 PM and stated that Certified Nursing Assistant #8 should never wash residents from the sink as it is a break in infection control. Licensed Practical Nurse #2 stated that each resident has a designated wash basin and Certified Nursing Assistant #8 should have used Resident #48's basin to administer care.</p> <p>The Staff Educator, who was also the Infection Preventionist, was interviewed on 2/9/2024 at 3:59 PM and stated that under no circumstances should the sink be used to collect water to wash the resident. The Staff Educator stated that Certified Nursing Assistant #8 should have used a wash basin that was designated for Resident #48 to administer care. The Staff Educator further stated that the sink was a mode of transmission of infection.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing Services was interviewed on 2/14/2024 at 12:29 PM and stated that the Certified Nursing Assistants are educated on proper procedures for providing morning care. The Director of Nursing Services stated that Certified Nursing Assistant #8 was expected to clean the resident's wash basin with soap and water and then administer morning care by using the wash basin filled with water. The Director of Nursing Services stated that the sink in the resident's room should not be used as a mode for collecting water to administer care.</p> <p>10 NYCRR 415.26(c)(1)(iv)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>41051</p> <p>Based on observations, records review, and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024 the facility did not ensure all drugs and biologicals were stored in locked compartments and permitted only authorized personnel to have access to the keys. This was identified for one unit (Unit 1A) of four units observed during the Medication Storage Task. Specifically, during an observation of the medication storage on 2/14/2024, the medication closet on Unit 1A was observed without a lock. The medication closet door had no locking mechanism installed on the door. The storage closet had multiple medications, syringes, and intravenous medication bags stored.</p> <p>The finding is:</p> <p>The facility's policy titled, Medication Storage last reviewed October 2023, documented all drugs and biologicals would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms). Only authorized personnel would have access to the keys to locked compartments.</p> <p>During a tour of the facility's medication storage on Unit 1A on 2/14/2024 at 2:21 PM, the medication closet was observed to not have a lock or a locking mechanism installed. The closet was located behind the unit's nurse's station. The medication closet had items that included but were not limited to Pepcid tablets (for gastroesophageal reflux disease), Loratadine tablets (an antihistamine), Acetaminophen tablets (used to relieve pain and reduce fever), Hydrogen Peroxide (an antiseptic), Geri-Tussin liquid (used to relieve cough), Zinc tablets (a nutritional supplement), Povidone Iodine (a disinfectant), Lidocaine pain relief patches, intravenous fluids (liquids injected into a person's veins through an intravenous tube) and, Antacid tablet bottles (used to treat heartburn). There were no staff members present in the vicinity.</p> <p>Licensed Practical Nurse #2 was interviewed on 2/14/2024 at 2:21 PM and stated the nurse's station was under renovation and the facility had stored medication in the unlocked closet behind the nurse's station for about two or three months. Licensed Practical Nurse #2 stated there was usually a nurse seated at the station but if the nurse was called away the closet was not supervised and was accessible to anyone.</p> <p>The Director of Maintenance was interviewed on 2/14/2024 at 2:48 PM and stated the closet doors have not had locks for about two to three months. The Director of Maintenance stated the area was recently renovated and the previous doors also did not have locks so they did not think the locks were needed for the medication closet.</p> <p>The Director of Nursing Services was interviewed on 2/24/2024 at 3:02 PM and stated the nurse's station was recently renovated. The Director of Nursing Services stated the medication storage closet is behind the nurse's station and residents do not go behind there; however, the closet should be locked.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Apex Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Birchwood Dr Huntington Station, NY 11746	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.18(e)(1-4)

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670</p> <p>Based on record review and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024 the facility did not ensure each resident received radiology services in a timely manner. This was identified for one (Resident #48) of two residents reviewed for Choices. Specifically, Resident #48 had a Physician's order for pacemaker checks every three months and there was no documented evidence that the pacemaker checks were completed as per the Physician's order since 10/4/2023.</p> <p>The finding is:</p> <p>The facility Pacemaker Policy, last reviewed on 6/2023, documented the charge nurse was responsible for ensuring that pacemaker/automated implantable defibrillator (AICD-a device inserted into the chest to help fix fast, abnormal heart rhythms) checks are conducted and reported in compliance with Physician's orders every 3 to 6 months.</p> <p>Resident #48 was admitted with diagnoses that included Atrial Fibrillation, Hypertension, and Presence of a Cardiac Pacemaker. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident had short and long term memory problems. The Minimum Data Set assessment did not document the use of the Pacemaker in section 18000.</p> <p>The Comprehensive Care Plan dated 9/29/2023 and updated 11/14/2023 documented the resident had a pacemaker to the left upper chest due to diagnoses of Atrial Fibrillation. Interventions included to observe, document, and report any signs and symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope (fainting), difficulty breathing, pulse rate lower than programmed rate, and lower than baseline blood pressure to the Physician as needed</p> <p>A Physician's order dated 9/29/2023 and last reviewed 1/14/2024 documented to have the resident's pacemaker checked every 3 months.</p> <p>A review of the Radiology Results Report documented Resident #48's pacemaker monitoring was completed on 10/4/2023 and was reported to the facility on [DATE].</p> <p>A review of the medical record lacked documented evidence that Resident #48's pacemaker monitoring was conducted after 10/4/2023.</p> <p>Licensed Practical Nurse #2, who was the Unit Manager, was interviewed on 2/9/2024 at 12:20 PM and stated that the last pacemaker check for Resident #48 was completed on 10/4/2023 and the next check was due in January 2024. Licensed Practical Nurse #2 stated they were responsible for following up with the Radiology company to ensure pacemaker checks were completed as ordered by the Physician. Licensed Practical Nurse #2 stated that the pacemaker check should have been done as ordered by the Physician and that it was an oversight.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Assistant Director of Nursing Services was interviewed on 2/9/2024 at 3:35 PM and stated that Licensed Practical Nurse #2 was the Unit Manager and was responsible for ensuring all required follow-up appointments for the pacemaker check were completed. The Assistant Director of Nursing Services stated that the pacemaker checks should have been completed as ordered by the Physician.</p> <p>The Director of Nursing Services was interviewed on 2/14/2024 at 12:24 PM and stated that pacemakers should be checked every 3 to 6 months and that the charge nurses were responsible for calling the company to make appointments for residents who required pacemaker monitoring. The Director of Nursing Services stated they expected that the pacemaker should be checked every 3 months as per the Physician's orders.</p> <p>10 NYCCRR 415.21</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>34798</p> <p>Based on observation, record review, and interviews during the Recertification Survey, initiated on 2/6/2024 and completed on 2/14/2024, the facility did not ensure each resident received routine dental services to meet the needs of each resident. This was identified for one (Resident #147) of two residents reviewed for Dental Services. Specifically, Resident #147 was admitted to the facility with full upper and lower dentures. The resident lost the upper dentures while a resident at the facility. A dental consult dated 1/11/2023 documented that a preliminary impression for the lost dentures would take place at the next session. There was no documented evidence that the preliminary impression for the upper dentures was completed. In addition, the resident was not offered to use their lower dentures, as the lower dentures were being stored in the medication cart and the facility staff did not know the whereabouts of the resident's lower dentures.</p> <p>The finding is:</p> <p>The facility's Dental Policy dated October 2023, documented to assist residents in obtaining routine and emergency dental care. The routine includes taking impressions for dentures and fitting dentures. Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. Staff shall be mindful of resident dentures when providing care and alert to situations where dentures may be displaced. All actions and information regarding dental services, including any delays relating to obtaining dental services, will be documented in the resident's medical record. The resident and or representative shall be kept informed of all arrangements.</p> <p>Resident #147 was admitted with diagnoses including Non-Alzheimer's Dementia, Adult Failure to Thrive, and Dysphagia (difficulty swallowing). The 12/19/2023 Significant Change Minimum Data Set assessment documented the resident had a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. The Minimum Data Set assessment documented that the resident was edentulous (had no natural teeth).</p> <p>The nursing admission summary note dated 12/22/2022 documented resident used full upper and lower dentures.</p> <p>A Comprehensive Care Plan for Dental, effective 12/27/2022 and last revised 2/9/2024, documented the resident is at risk of oral/dental health problems related to poor oral hygiene, and use of dentures; edentulous, Resident has full upper dentures. Interventions included: Denture cleaning as per policy, ongoing observation for proper fit of dentures, and providing dentures as per resident's preference.</p> <p>A Dental consult dated 1/11/2023 documented the resident was seen for a new admission examination. The resident was fully edentulous. The resident had a full lower denture. The resident lost the upper denture and denied dental complaints. Will begin the preliminary impression next session.</p> <p>(continued on next page)</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A speech therapy note, written by Speech Therapist #1, dated 3/14/2023 documented the resident's family requested the resident to remain on a puree diet due to missing upper dentures. Ground diet was introduced; however, the resident's family declined and requested the resident to remain on puree until the Dentist followed up regarding the upper dentures. Speech Therapist #1 documented that they consulted with nursing regarding the status of the dental consult.</p> <p>A nursing progress note dated 4/24/2023, written by Registered Nurse #7, documented the resident's family requested a follow-up of the resident's denture.</p> <p>A review of the medical record revealed there was no documented follow-up and no further sessions from the Dentist to fabricate the missing upper denture.</p> <p>The dental consult dated 1/3/2024 documented that the resident was seen for an annual examination. Intraoral exam: the resident was fully edentulous. The resident was not wearing dentures and declined fabrication. As per the facility staff, the resident ate well. The resident denies dental complaints and dental services were explained.</p> <p>The Kardex (resident care instructions provided to the Certified Nursing Assistants), as of 2/9/2024, documented denture cleaning as per policy; provide dentures as per resident's preferences; and provide oral hygiene daily.</p> <p>Resident #147's assigned Certified Nursing Assistant #5 was interviewed on 2/9/2024 at 11:31 AM. Certified Nursing Assistant #5 stated Resident #147 does not wear dentures and they (Certified Nursing Assistant #5) were not aware that the resident had dentures.</p> <p>Registered Nurse #2, the Unit C Charge Nurse, was interviewed on 2/9/2024 at 11:34 AM. Registered Nurse #2 stated they were not aware of the resident's dental consults and the need for the new upper dentures. Registered Nurse #2 stated they would review the dental consult dated 1/11/2023.</p> <p>Registered Nurse #2 was re-interviewed on 2/9/2024 at 1:52 PM and stated they had just spoken to the Dentist and the Dentist informed them that the previous Director of Nursing Services had communicated to the Dentist that the resident was a short-term resident and therefore, the upper dentures were not needed.</p> <p>A review of the medical record revealed no documentation from the nursing staff of discussions with the Dentist that the upper denture was not needed.</p> <p>Dentist #1 was interviewed on 2/9/2024 at 2:09 PM and stated a follow-up session was planned after the initial visit; however, the Director of Nursing Services at that time told them that the resident was a short-term resident; therefore, the upper dentures were not necessary. Dentist #1 stated that the resident was not supposed to be staying as a long-term resident at the facility, and that is why the upper denture request was not completed. Dentist #1 stated that if they had known the resident's family had requested the denture, they (Dentist #1) would have evaluated the resident for the dentures.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #147 was observed having breakfast in their room on 2/12/2024 at 8:37 AM. Certified Nursing Assistant #5 was present and was setting up the resident's tray. The resident was not wearing any dentures. The Certified Nursing Assistant stated they (the Certified Nursing Assistant) were not aware of the resident having to use any dentures, upper or lower.</p> <p>Further review of the medical record revealed no documentation that the lower dentures were missing.</p> <p>Registered Nurse #2, Unit C Charge Nurse, was re-interviewed on 2/12/2024 at 8:40 AM. Registered Nurse #2 stated they have been working at the facility for about 6 months and they have not known the resident to use any dentures. Registered Nurse #2 stated they were not aware of the request made by the resident's family for dentures.</p> <p>Registered Nurse #7, who wrote the 4/24/2023 progress note, was interviewed on 2/12/2024 at 8:47 AM. Registered Nurse #7 stated they filled out a form requesting a follow-up dental consult in April 2023 and had sent the request form to the senior supervisor who is no longer employed at the facility. The senior supervisor was supposed to send the consult request to the Dentist. Registered Nurse #7 reviewed the medical record and stated they could not find any evidence of a follow-up by the Dentist regarding evaluating the resident for denture.</p> <p>On 2/12/2024 at 9:33 AM Registered Nurse #2 approached the surveyor and stated they found Resident #147's lower denture in the medication cart and showed the surveyor a denture storage container with lower dentures and Resident #147's name on the container. Registered Nurse #2 stated they could not explain why the lower dentures were not being applied to the resident.</p> <p>Registered Nurse #8, the regularly assigned medication nurse for Resident #147, was interviewed on 2/12/2024 at 9:41 AM. Registered Nurse #8 did not know that Resident #147's dentures were stored in the medication cart, and they were not sure why the dentures were not used by Resident #147.</p> <p>The Director of Nursing Services was interviewed on 2/12/2024 at 10:05 AM. The Director of Nursing Services stated it was not acceptable that the staff did not provide the lower dentures to the resident and that a follow-up for the lost upper dentures was not done.</p> <p>10 NYCRR 415.17(c)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798</p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 2/6/2024 and completed on 2/14/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #383) of two residents reviewed for Transmission-Based Precautions, one (Resident #48) of two residents reviewed for Choices, and one (Resident #60) of two residents reviewed for pressure ulcers. Specifically, 1) the facility did not ensure that an employee (Certified Nursing Assistant #3) wore the appropriate Personal Protective Equipment (PPE) in Resident #383's room who was on Contact and Droplet Precautions for COVID-19 infection. 2) Certified Nursing Assistant #8 was observed using the room sink as a water basin to provide hygiene care to Resident #48. The resident shares a room with another resident who also utilizes the sink for hygiene and hand washing. 3) During a wound care observation on 2/14/2024 Registered Nurse #10 did not wash their hands with soap after cleaning the wound. During the treatment change, the resident had a bowel movement. Registered Nurse #10 cleaned the resident's bowel movement and then washed their (Registered Nurse #10) hands with water without using soap and then continued with the dressing change.</p> <p>The findings are:</p> <p>1) The facility's policy titled, Infection Prevention and Control Program for SARS-CoV-2 (COVID-19 Infection), dated 6/2023, documented health care personnel caring for residents with confirmed SARS-CoV-2 infection will use full personal protective equipment, including gowns, gloves, eye protection, and an N95 respirator with the door closed.</p> <p>The facility's policy titled, Personal Protective Equipment Policy dated 10/2023, documented all staff who have contact with residents and /or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely.</p> <p>Resident #383 was admitted with diagnoses including COVID-19 infection, a history of Cerebral Infarction, and Prostate Cancer.</p> <p>The hospital discharge instructions dated 2/8/2024 documented that the resident tested positive for COVID-19 infection upon hospital admission on 2/5/2024.</p> <p>The facility nursing admission note dated 2/8/2024 documented that the resident was admitted to the facility and was positive for COVID-19 infection. The resident was on respiratory isolation. The note documented that the resident was alert and oriented to person, place, and time.</p> <p>A physician's order dated 2/9/2024 documented single-room isolation for COVID-19 infection until 2/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Certified Nursing Assistant #3 was observed in Resident #383's room on 2/9/2024 at 8:30 AM. Signage was observed at the resident's door that included: Stop-Personal Protective Equipment Required Beyond this Point; Pick Up and Dispose Gown and Gloves at Personal Protective Equipment Station; Please Don (put on) and Doff (take off) Personal Protective Equipment at Resident Room Door Only. There was a personal protective equipment cart outside the doorway. The resident was in bed, and Certified Nursing Assistant #3 was observed leaning over the resident's bed, coming in contact with the resident's bed, and preparing the resident's breakfast tray, which was on the overbed table directly in position over the resident. Certified Nursing Assistant #3 was wearing a surgical mask. Certified Nursing Assistant #3 was not wearing a gown, gloves, or eye protection. Certified Nursing Assistant #3 washed their hands prior to leaving the room and did not remove the surgical mask.</p> <p>Certified Nursing Assistant #3 was interviewed, after they left Resident #383's room, on 2/9/2024 at 8:35 AM. Certified Nursing Assistant #3 stated they had to rush into the resident's room to give the resident a urinal because the resident said they (Resident #383) had to urinate and they (Certified Nursing Assistant #3) thought the resident would fall; therefore, they (Certified Nursing Assistant #3) did not have time to put on a gown and gloves.</p> <p>The Director of Nursing Services and the Registered Nurse Infection Preventionist were interviewed concurrently on 2/9/2024 at 10:30 AM. They both stated Certified Nursing Assistant #3 was given education regarding Personal Protective Equipment usage on 2/9/2024 after being identified as not wearing the appropriate Personal Protective Equipment and will now be sent home and will have to isolate at home due to COVID-19 exposure.</p> <p>Certified Nursing Assistant #3 was again observed in Resident #383's room finishing providing care to the resident on 2/9/2024 at 10:54 AM. Certified Nursing Assistant #3 was wearing full personal protective equipment, including an N95 mask.</p> <p>Certified Nursing Assistant #3 was re-interviewed on 2/9/2024 at 10:55 AM and stated that they thought Resident #380, who had occupied Resident #383's room previously, was still in the room and had completed their isolation on 2/8/2023. Certified Nursing Assistant #3 did not realize there was a new resident (Resident #383) placed in the room on the evening of 2/8/2024.</p> <p>The Registered Nurse Infection Preventionist was interviewed on 2/12/2024 at 8:18 AM and stated Certified Nursing Assistant #3 should have put on appropriate Personal Protective Equipment including a gown, gloves, and eye protection. The signage was present on the resident's door. The Registered Nurse Infection Preventionist stated there should not have been any confusion because the new resident's name was on the door.</p> <p>The Director of Nursing Services was interviewed on 2/12/2024 at 10:02 AM. The Director of Nursing Services stated Certified Nursing Assistant #3 should have had the appropriate Personal Protective Equipment on. The fact that there was a new resident in the room should not have caused any confusion. The Director of Nursing Services further stated that Certified Nursing Assistant #3 was sent home immediately following an investigation.</p> <p>28670</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) Resident #48 was admitted with diagnoses that included Vascular Dementia, Adult Failure to Thrive, and Liver Cell Carcinoma. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident had short and long term memory problems. The resident had no behavior problems and required total staff assistance for bathing and personal hygiene.</p> <p>The Activities of Living Care Plan dated 3/24/2022 and last updated on 11/10/2023 documented that the resident was totally dependent on staff for bathing and personal hygiene.</p> <p>During an observation on 2/9/2024 at 12:00 PM, Certified Nursing Assistant #8 was observed in Resident #48's room. Certified Nursing Assistant #8 was standing by the sink. The water faucet was on, and a towel was placed in the water that was being collected in the sink. Certified Nursing Assistant #8 stated that they were assigned to Resident #48 and were in the process of administering a bed bath to the resident. Certified Nursing Assistant #8 stated that they were using the towel and the water in the sink to administer care to Resident #48. Certified Nursing Assistant #8 stated that they always provide hygiene care for the resident using the sink as the basin. Licensed Practical Nurse #2, the nurse in charge, then came into the resident's room and instructed Certified Nursing Assistant #8 to use the wash basin to administer care.</p> <p>Licensed Practical Nurse #2 was interviewed on 2/9/2024 at 3:24 PM and stated that Certified Nursing Assistant #8 should never wash residents from the sink as it is a break in infection control. Licensed Practical Nurse #2 stated that each resident has a designated wash basin and Certified Nursing Assistant #8 should have used Resident #48's basin to administer care.</p> <p>The Staff Educator, who is also the Infection Preventionist, was interviewed on 2/9/2024 at 3:59 PM and stated that under no circumstances should the sink be used to collect water to wash the resident. The Staff Educator stated that Certified Nursing Assistant #8 should have used a wash basin that was designated for Resident #48 to administer care. The Staff Educator further stated that the sink was a mode of transmission of infection.</p> <p>The Director of Nursing Services was interviewed on 2/14/2024 at 12:29 PM and stated that the Certified Nursing Assistants are educated on proper procedures for providing morning care. The Director of Nursing Services stated that Certified Nursing Assistant #8 was expected to clean the resident's wash basin with soap and water and then administer morning care by using the wash basin filled with water instead of using the sink as a mode for collecting water to administer care.</p> <p>3) The Facility Wound Treatment Administration Policy last reviewed in October 2023, documented to practice appropriate hand hygiene and washing hands with soap and water before putting on new gloves and after removing used gloves.</p> <p>Resident #60 was admitted with diagnoses that included Diabetes Mellitus, Peripheral Vascular Disease, and Coronary Artery Disease. A Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 12 which indicated the resident had moderately impaired cognition. The resident was at risk of developing pressure ulcer injuries and had pressure ulcer-reducing devices in place on the bed and chair.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Comprehensive Care Plan titled, Skin: the resident has an ACTUAL impairment of the skin integrity related to full thickness Stage 4 re-open sacral area was initiated on 2/1/2024 and documented interventions including to monitor bony prominences for redness and to monitor the ulcer for signs of progression or declination. The Comprehensive Care Plan indicated the resident was seen during wound rounds on 2/01/2024 for re-opening of a Stage IV Sacral ulcer.</p> <p>A Physician's order dated 2/10/2024 documented to cleanse the sacrum wound with normal saline; apply Collagen (wound dressing) and abdomen pad; and then cover with dry protective dressing every day and evening shift for Wound Care and as needed for soiling or dislocation.</p> <p>During a wound care dressing change observation conducted on 2/14/2024 at 10:15 AM, Registered Nurse #10 removed the soiled dressing from the resident's sacral wound and then washed their hands with water. Registered Nurse #10 did not use soap during the hand-washing procedure. Registered Nurse #10 then donned (put on) clean gloves, removed the soiled dressing, cleansed the sacral wound, and removed their gloves. Registered Nurse #10 then washed their hands with water without using the soap. After the wound was cleansed the resident was observed to have a bowel movement. Before proceeding further with the dressing change, Registered Nurse #10 was observed to clean the resident's bowel movement. After cleaning the resident, Registered Nurse #10 removed their gloves, washed their hands with water without using the soap, and proceeded to don clean gloves. Before Registered Nurse #10 donned clean gloves, the Surveyor brought to their attention that they (Registered Nurse #10) did not use soap when performing hand hygiene. Registered Nurse #10 then washed their hands with soap and water and completed the wound care.</p> <p>Registered Nurse #10 was interviewed on 2/14/2024 at 10:40 AM. Registered Nurse #10 acknowledged they were not using soap when performing hand hygiene and that when washing their hands they should use soap and water. Registered Nurse #10 stated they knew that they should have used soap and water to wash their hands, but they went blank. Registered Nurse #10 further stated they were inserviced on proper hand washing.</p> <p>The Staff Educator, who is also the Infection Preventionist, was interviewed on 2/14/2024 at 11:11 AM and stated after cleansing the wound Registered Nurse #10 should have changed the soiled gloves and washed their hands with soap and water before donning clean gloves. The Staff Educator further stated after cleaning the resident's bowel movement Registered Nurse #10 should have changed their gloves and should have washed their hands with soap and water before putting on new gloves.</p> <p>The Director of Nursing Services was interviewed on 2/14/2024 at 12:03 PM and stated that each time nurses change their gloves, they must wash their hands with soap and water. The Director of Nursing Services further stated that Registered Nurse #10 should have used a hand sanitizer or washed their hands with soap and water after cleansing the wound and after cleaning the resident.</p> <p>10 NYCRR 415.19(a)(1-3);415.19(b)(4)</p>		