STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gold Crest Care Center	2316 Bruner Avenue Bronx, NY 10469

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on observation, interview, and record review conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure that a resident was free from physical restraints for purposes of discipline or convenience and that are not required to treat the resident's medical symptom. This was evident in 1 (Resident #60) of 1 resident reviewed for physical restraints out of 36 total sampled residents. Specifically, Resident #60 was observed, on multiple occasions, in bed with upper quarter bed side rails raised on both sides. The findings are: The facility policy titled Physical Restraints with a revision date of 04/2024 documented physical restraint is defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restricts the freedom of movement or normal access to one's body. The policy documented that bed rails are considered physical restraints and that the use of restraint must be documented in the medical records, including reason for each continued use or discontinuance. Resident #60 had diagnoses of Non-Alzheimer's Dementia, Hemiplegia and Hemiparesis following Non-Traumatic Intra-cerebral Hemorrhage affecting the right dominant side. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #60 was severely cognitively impaired, dependent with transfers, and required maximal assistance to roll left and right. The Minimum Data Set documented that physical restraints were not used. On 09/26/2024 at 12:09 PM, 09/30/2024 at 12:24 PM, and on 10/02/2024 at 10:12 AM, Resident #60 was observed resting in bed with upper quarter bed side rails raised on both sides. A Siderail Assessment Tool completed by the Occupational Therapist dated 07/23/2024 documented that Resident #60 was unable to get out of bed independently, was unable to use the side rail safely, there was no history of falling out of bed, was restless and disoriented at times, and was at risk of becoming entrapped if side rails were used. The assessment documented that side rails were not recommended. (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan related to activities of daily living dated 10/26/2023 and was revised on 08/01/2024 documented that Resident #60 required total assistance with all areas of activities of daily living and was dependent with bed mobility. Further review of Resident #60's comprehensive care plan did not include use of bed side rails. A review of Resident #60's medical record revealed no documented evidence that a physician's order was obtained with instruction and clinical rationale for use of bed side rails. There was no documented evidence of family consent and / or that direct monitoring was provided during the use of bed side rails. On 10/02/2024 at 2:47 PM, Certified Nursing Assistant #1 was interviewed and stated that Resident #60 was in their assignment. They stated that Resident #60 is dependent with bed mobility and that they raise the side rails in Resident #60's bed during care although it was not listed on the Certified Nursing Assistant instructions. The Certified Nursing Assistant stated that they put the bed side rails down when they finish providing personal care to the Resident. Certified Nursing Assistant #1 was not able to explain why the bed side rails for Resident #60 was left raised. On 10/03/2024 at 9:43 AM, Certified Nursing Assistant #3 was interviewed and stated that Resident #60 was on their assignment on 09/30/2024. The Certified Nursing Assistant stated they left the bed side rails raised as a safety precaution because Resident #60 moves around in bed. They stated that Resident #60 is confused, does not talk, and is unable to release the side rails. Certified Nursing Assistant #3 stated they raise the side rails during care and forgot to put them down when they were finished. On 10/03/2024 at 10:18 AM, Registered Nurse #4, who was the Unit Manager, was interviewed and stated that the bed side rails should only be used for Resident #60 when personal care is being provided and should be lowered when not in use. Registered Nurse #4 stated side rails are considered a restraint if the resident cannot bring the side rail down on their own. Registered Nurse #4 further stated that there is no physician's order for use of side rails and that side rails were not recommended by the rehabilitation department either. On 10/30/2024 at 12:59 PM, the Occupational Therapist was interviewed and stated they completed a side rail assessment for Resident #60 and that side rails were not recommended. The Occupational Therapist stated that Resident #60 is fidgety in bed and could be trapped if side rails are used. They also stated that Resident #60 does not use their hands purposely and cannot follow instructions. On 10/03/2024 at 2:29 PM, the Director of Nursing was interviewed and stated that some beds in the facility came with side rails attached and cannot be removed from the bed. They stated that Certified Nursing Assistants raise the side rails when performing resident care. They stated that the Certified Nursing Assistants were instructed to place the side rails down after care is completed. The Director if Nursing stated that bed side rails are considered a restraint when a resident cannot put the side rails up or down independently, which Resident #60 is unable to do. 10 NYCRR 415.4(a)(2-7)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on record review and interview conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure that a comprehensive care plan was developed and implemented to meet each resident's needs. This was evident in 2 (Resident #228 and #17) out of 36 sampled residents. Specifically, 1.) Resident #228, who had a diagnosis of osteomyelitis, had no comprehensive care plan developed to address the presence of infection. 2.) Resident #17, who had a diagnosis of osteomyelitis, had no comprehensive care plan developed to address the presence of infection. The findings are: The facility policy titled Care Plans - Comprehensive with a last revision date of July 2024 documented that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Each resident's comprehensive care plan is designed to incorporate identified problem areas , reflect treatment goals, and reflect currently recognized standards of practice for problem areas and condition. 1.) Resident #228 was admitted to the facility with diagnoses that include Acute Osteomyelitis of Left Ankle and Foot and Diabetes Mellitus with Diabetic Chronic Kidney Disease. The Admission Minimum Data Set assessment dated [DATE] documented that Resident #228's cognition was intact. The admission nurse's progress notes dated 09/10/2024 at 9:03 PM documented that Resident #228 was admitted from the hospital. The Resident had a peripherally inserted central catheter and continues with intravenous antibiotic until 10/13/2024 due to Osteomyelitis to lower extremity. A review of Resident #228's physician's order dated 09/11/2024 documented to administer Ceftriaxone intravenous piggyback 2 grams / 50 milliliters daily at 10:00 AM and Doxycycline 100 milligram capsule, 1 capsule by mouth every twelve hours for Osteomyelitis. A nurse's progress note dated 09/25/2024 at 8:27 PM documented that Resident #228 continues on intravenous antibiotic Ceftriaxone and oral antibiotic Doxycycline for osteomyelitis. A review of Resident #228's comprehensive care plan revealed that a care plan was not developed to address the Resident's diagnosis of osteomyelitis. On 10/02/2024 at 11:49 AM, Registered Nurse #1, who was the Nurse Manager, was interviewed and stated that the admission nurse was responsible for initiating the comprehensive care plan and might have missed the care plan for osteomyelitis. Registered Nurse #1 stated they should have checked the comprehensive care plans to make sure that it was initiated and implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/2024 at 3:35 PM, Registered Nurse #2, who was the Nursing Supervisor, was interviewed and stated that they admitted Resident #228 and developed the initial care plans. They stated that Resident #228 was admitted with osteomyelitis and was receiving antibiotic through the peripherally inserted catheter. They stated they assumed that the Nurse Manager would go over the care plans to ensure that none was missed. Registered Nurse #2 stated it was an oversight. On 10/03/2024 at 10:44 AM, the Director of Nursing was interviewed and stated that they do not know why the care plans for use of antibiotics and diagnosis of osteomyelitis were missed. The Director of Nursing stated it is the nurse manager's responsibility for ensuring that comprehensive care plans are in place. 48876 2.) Resident #17 was admitted to the facility with diagnoses that include Osteomyelitis of the Vertebra and Polyarthritis. The Admission Minimum Data Set assessment dated [DATE] documented that Resident #17's cognition was intact. A nurse's progress notes dated 09/25/2024 at 1:14 PM documented that Resident #17 continues on Meropenem until 09/29/2024 due to osteomyelitis to lumbar spine. A review of Resident #17's comprehensive care plan revealed that a care plan was not developed to address the Resident's diagnosis of osteomyelitis. On 09/30/2024 at 4:11 PM, the Assistant Director of Nursing was interviewed and stated that Resident #17's care plan on infection was overlooked. On 10/03/2024 at 2:15 PM, the Director of Nursing was interviewed and stated that it is the Registered Nurse Supervisor's responsibility to develop the care plans. They stated that it was an oversight that the care plan for infection was not developed for Resident #17. 10 NYCRR 415.11(c)(1)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on observation, interview, and record review conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure that a resident was assessed for risk of entrapment from bed rails prior to use. Additionally, the facility did not ensure that the risk and benefits of bed rails were discussed with the resident, or their representative, and that informed consent was obtained prior to bed rail use. This was evident in 1 (Resident #60) of 1 resident reviewed for physical restraints out of 36 total sampled residents. Specifically, Resident #60 was observed, on multiple occasions, in bed with upper quarter bed side rails raised on both sides. The facility had no documented evidence of assessment for risk of entrapment and informed consent prior to bed rail use. There was also no documented evidence that preventive maintenance of bed rails was conducted. The findings are: The facility policy titled Physical Restraints with a revision date of 04/2024 documented physical restraint is defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restricts the freedom of movement or normal access to one's body. The policy documented that bed rails are considered physical restraints and that the use of restraint must be documented in the medical records, including reason for each continued use or discontinuance. The facility was not able to provide a policy related to siderail safety and entrapment risk. Resident #60 had diagnoses of Non-Alzheimer's Dementia, Hemiplegia and Hemiparesis following Non-Traumatic Intra-cerebral Hemorrhage affecting the right dominant side. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #60 was severely cognitively impaired, dependent with transfers, required maximal assistance to roll left and right. The Minimum Data Set documented that physical restraints were not used. On 09/26/2024 at 12:09 PM, 09/30/2024 at 12:24 PM, and on 10/02/2024 at 10:12 AM, Resident #60 was observed resting in bed with upper quarter bed side rails raised on both sides. A review of Resident #60's medical record revealed no documented evidence that a physician's order was obtained with instruction and clinical rationale for use of bed side rails. There was no documented evidence of family consent and / or that direct monitoring was provided during the use of bed side rails. The facility was not able to provide documented evidence that Resident #60 was assessed for risk of entrapment prior to bed side rail use. There was also no documented evidence that preventive maintenance of bed rails was conducted. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/2024 at 2:47 PM, Certified Nursing Assistant #1 was interviewed and stated that Resident #60 was in their assignment. They stated that they raise the bed side rails in Resident #60's bed during care and that they put the bed side rails down when they finish providing personal care to the Resident. Certified Nursing Assistant #1 was not able to explain why the bed side rails for Resident #60 was left raised. On 10/03/2024 at 9:43 AM, Certified Nursing Assistant #3 was interviewed and stated that Resident #60 was on their assignment on 09/30/2024. The Certified Nursing Assistant stated they left the bed side rails raised as a safety precaution because Resident #60 moves around in bed. Certified Nursing Assistant #3 stated they raise the side rails during care and forgot to put them down when they were finished. On 10/03/2024 at 10:18 AM, Registered Nurse #4, who was the Unit Manager, was interviewed and stated that the bed side rails should only be used for Resident #60 when personal care is being provided and should be lowered when not in use. On 10/03/2024 at 11:45 AM, The Director of Maintenance was interviewed and stated they had not checked residents for risk of entrapment related to the use of bed side rails because they were informed over 2 years ago that the facility discontinued bed side rail use. They stated that since the bed rails were attached to the beds and cannot be removed, they tied down the side rails and conducts continuous checks to make sure that all side rails were tied down. The Director of Maintenance stated that sometimes the Certified Nursing Assistants cut the ties and use the side rails. On 10/30/2024 at 12:59 PM, the Occupational Therapist was interviewed and stated that side rails were not recommended for Resident #60. The Occupational Therapist stated that Resident #60 is fidgety in bed and could be trapped if side rails are used. They also stated that Resident #60 does not use their hands purposely and cannot follow instructions. On 10/03/2024 at 2:29 PM, the Director of Nursing was interviewed and stated that some beds in the facility came with side rails attached and cannot be removed from the bed. They stated that Certified Nursing Assistants raise the side rails when performing resident care. They stated that the Certified Nursing Assistants were instructed to place the side rails down when care has been completed. 10 NYCRR 415.12(h)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on observation, record review, and interview conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident in 2 (Residents #14 and #60) of 4 residents observed for medication administration. Specifically, Enhanced Barrier Precautions were not maintained during medication administration for residents with gastrostomy tube. The findings are: The Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memorandum titled Enhanced Barrier Precautions in Nursing Homes, Ref: QSO-24-08-NH dated 03/20/2024 documented that effective 04/01/2024, Centers for Medicare and Medicaid Services is issuing a new guidance for long term care facilities on the use of enhanced barrier precautions to align with nationally accepted standards. Enhanced Barrier Precautions recommendations now include use of enhanced barrier precautions for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. The new guidance related to enhanced barrier precautions is being incorporated into F880 Infection prevention and Control. The facility policy and procedure titled Enhanced Barrier Precautions with a revised date of 03/21/2024 documented that the facility will implement enhanced barrier precautions during high contact resident care activities for any resident with an indwelling medical device, including feeding tubes, regardless of Multi Drug Resistant Organism colonization or infection status. Staff will perform hand hygiene before entering a resident's room, don gown and gloves when providing high contact care activities. Staff will remove personal protective equipment and perform hand hygiene before exiting resident's room. 1.) Resident #14 was admitted to the facility with diagnoses that include Non-Alzheimer's Dementia and Dysphagia. The Minimum Data Set assessment dated [DATE] documented that Resident #14 had severely impaired cognitive skills for daily decision making and had a gastrostomy tube. A physician's order dated 04/15/2024, documented enhanced barrier precautions due to presence of feeding tube. 2.) Resident #60 was admitted to the facility with diagnoses that include Non-Alzheimer's Dementia and Dysphagia. The Minimum Data Set assessment dated [DATE] documented that Resident #60 had severely impaired cognitive skills for daily decision making and had a gastrostomy tube. A physician's order dated 04/15/2024 documented enhanced barrier precautions due to presence of feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During medication administration observation on 10/01/2024 at 09:07 AM, Licensed Practical Nurse #3 was observed performing medication administration via gastrostomy tube for Resident #14 without wearing a gown. At 9:20 AM, same Licensed Practical Nurse was observed performing medication administration via gastrostomy tube for Resident #60. Licensed Practical Nurse #3 entered Resident #60's room and donned a gown prior to administering the Resident's medication. Licensed Practical Nurse #3 then exited Resident's room without removing the gown and immediately went to the medication cart in the hallway. On 10/01/2024 at 09:40 AM, Licensed Practical Nurse #3 was interviewed and stated that Resident #14 has a gastrostomy tube and that they should have worn a gown before administering the Resident's medications. They stated that they wore a gown when they administered Resident #60's medication but did not remove the gown before exiting the room. On 10/01/2024 at 10:00AM, Registered Nurse #3, who was the Unit Manager, was interviewed and stated enhanced barrier precautions starts when the nurse enters the room of the resident with a gastrostomy tube. Gown and gloves should be worn for any close contact care or treatment and must be removed while inside the resident's room when treatment has been completed and placed in a red bin. On 10/03/2024 at 08:29 AM, the Director of Nursing, who was also the Infection Preventionist, was interviewed and stated that enhanced barrier precautions are required when administering medications to residents with gastrostomy tube. 10 NYCRR 415.19 (a)(1-3)