

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Sapphire Center for Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 35 15 Parsons Blvd Flushing, NY 11354	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44472</p> <p>Based on observation, record review, and interviews conducted during the Recertification Survey from 04/29/2024 to 05/09/2024, the facility did not ensure each resident was treated with respect and dignity. This was evident for 4 (Resident #s 24, 125, 5, and 87) of 39 total sampled residents. Specifically, 1) Resident #24's Foley drainage bag was not placed in a dignity bag and was visible from the hallway, and 2) care was provided to Resident #125 without a privacy curtain and was visible to their 3 roommates, and 3) Resident #5's and #87's point of care testing was carried out in the unit day room without providing privacy for the residents.</p> <p>The findings are:</p> <p>The facility policy titled Providing Resident Dignity dated 04/08/2023 documented all residents will be provided with respect and dignity, ensuring the residents 's privacy is maintained at all encounters. Catheter bags are covered for privacy.</p> <p>1) Resident #24 had diagnoses of benign prostatic hyperplasia and obstructive and reflux uropathy.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #34 was moderately cognitively impaired.</p> <p>On 04/29/2024 at 10:03 AM and 05/01/2024 at 02:25 PM, Resident #24 was observed in bed in their room with their Foley catheter drainage bag uncovered and hanging at their bedside. Resident #24 was visible to passersby in the hallway.</p> <p>The Physician Order dated 4/11/2024 documented Resident #24 be provided with a Foley catheter drainage bag cover every shift for privacy.</p> <p>On 05/08/2024 at 10:05 AM, Certified Nursing Assistant #25 was interviewed and stated they asked the supply person for a Foley drainage bag cover for Resident #24 last week and was told a cover was not available. Certified Nursing Assistant #25 did not make any further attempts to obtain a cover for the drainage bag.</p> <p>On 05/09/2024 at 11:10 AM, Licensed Practical Nurse #1 was interviewed and stated they were not aware Resident #24 did not have a cover for their Foley catheter drainage bag.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/09/2024 at 01:55 PM, Registered Nurse #11 was interviewed and stated they were just made aware that Resident #24 did not have a cover for their Foley catheter drainage bag. Registered Nurse #11 stated they went to the supply closet and was able to obtain a cover. Foley catheter drainage bags were kept covered to preserve a resident's dignity and privacy.</p> <p>On 05/10/2024 at 01:58 PM, the Director of Nursing was interviewed and stated Registered Nurse Supervisors were responsible for checking all Foley catheter drainage bags to ensure they were covered.</p> <p>18881</p> <p>2.) Resident #125 had diagnoses of diabetes mellitus and hypertension.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #125 was moderately cognitively impaired and required assistance with activities of daily living.</p> <p>On 04/29/2024 at 10:33 AM, Resident #125 was observed in bed receiving a bed bath from Certified Nursing Assistant #24. The room door was closed and the privacy curtain for Resident #125 was not drawn. Resident #125's 3 roommates were observed in the room and Resident #125 was visible to all 3 roommates while they received care. Certified Nursing Assistant #24 was immediately interviewed and stated they should have drawn the privacy curtain while providing care to Resident #125.</p> <p>40565</p> <p>3) On 05/01/24 at 08:40 AM, during the medication administration observation, Registered Nurse #5 was observed administering Insulin to Resident #87 in the first-floor dining room. Another resident was sitting next to Resident #87 at the time. Registered Nurse #5 did not provide privacy for Resident #87 prior to administering the insulin.</p> <p>On 05/01/2024 at 11:39 AM, Registered Nurse #5 was observed checking Resident #5's blood glucose using a finger stick in the unit dining room with other residents and staff waiting for lunch.</p> <p>On 05/01/2024 at 11:46 AM, Registered Nurse #5 was interviewed and stated they always check residents' blood glucose and administer their insulin in the dining room before meals.</p> <p>On 05/08/2024 at 12:45 PM, the Director of Nursing was interviewed and stated that checking a resident's blood glucose should not be done in the dining room, except when there is an emergency.</p> <p>10 NYCRR 415.3(d)(1)(i)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351</p> <p>Based on observation, interview, and record review during the recertification survey from 4/29/2024 to 5/9/2024, the facility did not ensure each resident had the right to be fully informed in a language that they can understand. This was evident for 3 (Resident #159, #191, and #195) out of 39 total sampled residents. Specifically, 1) Resident #159 was Korean-speaking and was not provided with language interpretation services, 2) Resident #191 was Cantonese-speaking and was not provided with language interpretation services, and 3) Resident #195 was Mandarin-speaking and was not provided with language interpretation services.</p> <p>The findings are:</p> <p>The facility policy titled Communication with Persons with Limited English Proficiency dated 8/22/2017 documented the facility would take reasonable steps to ensure that persons with Limited English Proficiency have meaningful access and equal opportunity to participate in services, activities, programs, and other benefits.</p> <p>1. Resident #159 had diagnoses of Alzheimer's disease and hypertension.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #159 was severely cognitively impaired, preferred to communicate in the Korean language, and required an interpreter to communicate with the Medical Doctor and staff.</p> <p>On 5/09/2024 at 11:05 AM, Resident #159 was interviewed in Korean using interpretation services. Resident #159 stated they enjoyed attending group activities but were unaware when activities were offered because the staff did not speak to them in a language they understood. Resident #159 stated staff attempted to use body language to communicate with them but did not use a communication board and there were no Korean-speaking staff on their unit. There was no communication board or interpretation devices observed Resident #159's room at the time of the interview.</p> <p>The Comprehensive Care Plan related to health literacy dated 11/9/2023 documented Resident #159 had a language barrier and required an interpreter.</p> <p>The Comprehensive Care Plan related to communication dated 11/9/2023 documented Resident #159 had a diagnosis of dementia and required a translator to reduce their language barrier.</p> <p>There was no documented evidence a communication board or interpretation services were used to communicate with Resident #159 in their preferred Korean language.</p> <p>On 5/06/2024 at 10:33 AM, Certified Nursing Assistant #7 was interviewed and stated Resident #159 spoke Korean and had limited understanding of English communication. Certified Nursing Assistant #7 stated they were not aware of any communication board or interpretation services available to help better communicate with Resident #159 or any other non-English speaking residents.</p> <p>2. Resident #191 had diagnoses of hypertension and hyperlipidemia.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #191 was severely cognitively impaired, preferred to communicate in Cantonese, and required an interpreter.</p> <p>On 5/09/2024 at 9:24 AM, Resident #191 was interviewed in Cantonese using interpreter services. Resident #191 stated they were not aware of what activities were offered because staff did not communicate with them using an interpreter or communication board. During the interview, there was no communication board or other interpretation services observed in Resident #191's room.</p> <p>The Comprehensive Care Plan related to communication dated 1/29/2024 documented Resident #191 had a language barrier and required a translator to communicate effectively.</p> <p>The Therapeutic Recreation assessment dated [DATE] documented Resident #191 required a Cantonese interpreter for translation and enjoyed watching Cantonese television programming.</p> <p>There was no documented evidence Cantonese translation services were provided to effectively communicate with Resident #191.</p> <p>On 5/06/2024 at 10:24 AM Certified Nursing Assistant #8 was interviewed and stated they were hired approximately 8 months ago and started working with Resident #191 a few weeks ago. Resident #191 spoke Chinese and Certified Nursing Assistant #8 attempted to communicate with Resident #191 using simple words. Certified Nursing Assistant #8 stated they were unaware of any available interpreter or communication board to provide translation services to Resident #191.</p> <p>On 5/07/2024 at 11:02 AM, Recreation Leader #1 was interviewed and stated they invited all residents to activity programs occurring on the main floor of the facility. Recreation Leader #1 stated Resident #191 spoke Cantonese and they attempted to communicate with the resident using body language and gestures.</p> <p>18881</p> <p>3) Resident #195 had diagnoses of hypertension and thyroid disorder.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #195 had mild cognitive impairment.</p> <p>On 05/02/2024 at 11:44 AM, Resident #195 was interviewed using Mandarin interpretation services. Resident #195 stated they were unable to communicate with staff without an interpreter and there was no communication board to make their simple needs known. During the interview, there were no observations of a communication board or language interpreter services available in Resident #195's room.</p> <p>The Comprehensive Care Plan related to communication dated 02/08/2024 documented Resident #195 had a language barrier, and a translator should be used to reduce the language barrier and communicate with the residents.</p> <p>There was no documented evidence effective translation services were utilized to communicate with Resident #195 in their Mandarin language on a regular basis.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/02/2024 at 11:00AM, Certified Nursing Assistant #5 was interviewed and stated they do not know how to communicate with Resident #195 in Mandarin and did not have an interpreter.</p> <p>On 05/07/2024 at 12:33 PM, Certified Nursing Assistant #6 was interviewed and stated Resident #195 spoke Mandarin and did not understand any English. Certified Nursing Assistant #6 stated they try to point and gesture to communicate with Resident #195. There was no language line interpretation services or communication boards available to communicate with Resident #195.</p> <p>On 05/07/2024 at 2:45 PM, Certified Nursing Assistant #4 was interviewed and stated they were regularly assigned to Resident #195 and used gestures to communicate with the resident because the resident only spoke Mandarin. The facility did not have any Mandarin-speaking staff to communicate with Resident #195. The facility did not have a communication board that Certified Nursing Assistant #4 knew of and there were no language interpretation line services available.</p> <p>On 05/03/2024 at 10:45 AM, Registered Nurse #14 was interviewed and stated they were currently the supervisor for the building and would find out about a language line to provide interpretation services for residents. After looking for information for a language line, Registered Nurse #14 provided a phone number and personal identification number for a language interpretation service. Registered Nurse #14 attempted to call the language line service and was unable to complete the call as the personal identification number was no longer active. Registered Nurse #14 was unable to provide information on the last time the service was used to communicate with residents that did not speak English.</p> <p>On 05/03/2024 at 3:00PM, the Administrator was interviewed and stated they just paid the bill for language line service and was provided with a new personal identification number. The Administrator stated they would ensure the new information was posted on all the units.</p> <p>10 NYCRR 415.3(f)(1)(i)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44472</p> <p>Based on observation, record review, and interviews conducted during the Recertification Survey from 04/29/2024 to 05/09/2024, the facility did not ensure ea resident's right to privacy. This was evident for 4 (Resident #s 24, 125, 5, 87)) of 39 total sampled residents. Specifically, 1) Resident #24's foley drainage bag was not placed in a dignity bag and was visible from the hallway, 2) care was provided to Resident #125 without a privacy curtain and the resident was visible to their 3 roommates, and 3) Resident #5's and #87's point of care testing was carried out in the unit day room without providing privacy for the residents.</p> <p>The findings are:</p> <p>The facility policy titled Providing Resident Dignity dated 04/08/2023 documented all residents will be provided with respect and dignity, ensuring the residents 's privacy is maintained at all encounters. Catheter bags are covered for privacy.</p> <p>1) Resident #24 had diagnoses of benign prostatic hyperplasia and obstructive and reflux uropathy.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #34 was moderately cognitively impaired.</p> <p>On 04/29/2024 at 10:03 AM and 05/01/2024 at 02:25 PM, Resident #24 was observed in bed in their room with their foley catheter drainage bag uncovered and hanging at their bedside. Resident #24 was visible to passersby in the hallway.</p> <p>The Physician Order dated 4/11/2024 documented Resident #24 be provided with a foley catheter drainage bag cover every shift for privacy.</p> <p>On 05/08/2024 at 10:05 AM, Certified Nursing Assistant #25 was interviewed and stated they asked the supply person for a foley drainage bag cover for Resident #24 last week and was told a cover was not available. Certified Nursing Assistant #25 did not make any further attempts to obtain a cover for the drainage bag.</p> <p>On 05/09/2024 at 11:10 AM, Licensed Practical Nurse #1 was interviewed and stated they were not aware Resident #24 did not have a cover for their foley catheter drainage bag.</p> <p>On 05/09/2024 at 01:55 PM, Registered Nurse #11 was interviewed and stated they were just made aware that Resident #24 did not have a cover for their foley catheter drainage bag. Registered Nurse #11 stated they went to the supply closet and was able to obtain a cover. Foley catheter drainage bags were kept covered to preserve a resident's dignity and privacy.</p> <p>On 05/10/2024 at 01:58 PM, the Director of Nursing was interviewed and stated Registered Nurse Supervisors were responsible for checking all foley catheter drainage bags to ensure they were covered.</p> <p>18881</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2.) Resident #125 had diagnoses of diabetes mellitus and hypertension.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #125 was moderately cognitively impaired and required assistance with activities of daily living.</p> <p>On 04/29/2024 at 10:33 AM, Resident #125 was observed in bed receiving a bed bath from Certified Nursing Assistant #24. The room door was closed and the privacy curtain for Resident #125 was not drawn. Resident #125's 3 roommates were observed in the room and Resident #125 was visible to all 3 roommates while they received care. Certified Nursing Assistant #24 was immediately interviewed and stated they should have drawn the privacy curtain while providing care to Resident #125.</p> <p>40565</p> <p>3) On 05/01/24 at 08:40 AM, during the medication administration observation, Registered Nurse #5 was observed administering Insulin to Resident #87 in the first-floor dining room. Another resident was sitting next to Resident #87 at the time. Registered Nurse #5 did not provide privacy for Resident #87 prior to administering the insulin.</p> <p>On 05/01/2024 at 11:39 AM, Registered Nurse #5 was observed checking Resident #5's blood glucose using a finger stick in the unit dining room with other residents and staff waiting for lunch.</p> <p>On 05/01/2024 at 11:46 AM, Registered Nurse #5 was interviewed and stated they always check residents' blood glucose and administer their insulin in the dining room before meals.</p> <p>On 05/08/2024 at 12:45 PM, the Director of Nursing was interviewed and stated that checking a resident's blood glucose should not be done in the dining room, except when there is an emergency.</p> <p>10 NYCRR 415.3(e)(1)(ii)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864</p> <p>Based on observation, record review, and interviews conducted during the Recertification and Abbreviated (NY00340290) survey from 4/29/2024 to 5/9/2024, the facility did not ensure a resident was free from physical abuse. This was evident for 1 (Resident #77) of 3 residents reviewed for abuse out of 39 total sampled residents. Specifically, surveillance camera footage revealed on 4/23/2024 at 12:06 PM, Certified Nursing Assistant #1 struck Resident #77 causing the resident to fall backwards onto the floor. Certified Nursing Assistant #1 then grabbed Resident #77 by their wrists, lifted the resident off the floor, and pulled them to their room. Registered Nurse #1 and Certified Nursing Assistant #2 witnessed the incident and did not intervene. Subsequently, Resident #77 was diagnosed with a left wrist fracture because of the incident. This resulted in Substandard Quality of Care that was Immediate Jeopardy that resulted in serious injury for Resident #77 with the likelihood of a serious adverse outcome occurring to other residents on the unit.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Prevention/Prohibition dated 11/2022 stated that all residents will be screened for potential abuse, an investigation will be conducted, the Administrator is responsible for completing the investigation report, any person having reasonable cause to believe that an older adult is in need of protective services may report such information to the local provider, and all interventions will be documented in the resident's medical record.</p> <p>Resident #77 had diagnoses of dementia and osteoarthritis (degeneration of joint cartilage and underlying bone.)</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 1/14/2024 documented Resident #77 was severely cognitively impaired, did not display inappropriate behavior, ambulated with supervision or touch assistance, and required assistance when using a wheelchair.</p> <p>A Comprehensive Care Plan related to potential for abuse and neglect initiated 1/7/2024 and last reviewed 4/24/2024, documented Resident #77 was at risk for abuse due to their dementia diagnosis and one-to-one interaction would be provided until the resident was calm.</p> <p>The facility's video surveillance dated 4/23/2024 at 12:05 PM revealed Resident #77 was in the hallway on their unit and attempted to walk into their room. Certified Nursing Assistant #1 exited the room and stood in between Resident #77 and the entrance to their room. Resident #77 slapped Certified Nursing Assistant #1. Certified Nursing Assistant #1 then struck Resident #77 causing the resident to fall backwards and land on the floor in a supine position (flat on their back). Certified Nursing Assistant #1 grabbed Resident #77's wrists, lifted the resident to their feet, and pulled the resident into their room. Registered Nurse #1 and Certified Nursing Assistant #2 were seated at the nursing station directly in front of Resident #77 and Certified Nursing Assistant #1 when the incident occurred. Registered Nurse #1 and Certified Nursing Assistant #2 did not intervene during the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Accident/Incident Report on 4/23/2024 documented Resident #77 was pacing in the hallway on their unit, hit Certified Nursing Assistant #1, and then fell to the floor causing a left wrist fracture.</p> <p>The Nursing Note written by Registered Nurse #1 was dated 4/23/2024 at 12:08 PM and documented Resident #77 became physically aggressive toward staff, slapped a Certified Nursing Assistant, fell to the floor, and reported left wrist pain. Resident #77's left wrist was swollen, the Medical Doctor was informed, and an x-ray was done. At 10:29 PM, a Registered Nurse on the evening shift documented Resident #77's next of kin requested the resident be sent to the hospital for evaluation and Resident #77 was transferred to the hospital.</p> <p>A Nursing Note dated 4/24/2024 documented Resident #77 returned from the hospital with a cast to their left wrist due to left wrist fracture.</p> <p>The Summary of Investigation completed by the Director of Nursing, dated 4/25/2024, documented video surveillance footage and staff statements were reviewed. Registered Nurse #1 failed to report Resident #77's incident accurately, falsified documentation, and misled the investigation. Abuse of Resident #77 did occur on 4/23/2024.</p> <p>A review of facility inservice and training records from 1/2023 to 4/2024, revealed no documented evidence that Certified Nursing Assistant #1 received training on the abuse policy and procedures in 2023 or 2024. A review of staffing sheets dated 4/23/2024 and 4/24/2024, revealed that Certified Nursing Assistant #1 was still scheduled and continued to work on the unit with residents after the incident involving Resident #77.</p> <p>On 4/29/2024 at 10:30 AM and 5/06/2024 at 10:28 AM, Certified Nursing Assistant #2 was interviewed and stated they were assigned to Resident #77 on 4/23/2024. They heard a loud noise while sitting at the nursing station and saw Certified Nursing Assistant #1 grab Resident #77 off the floor and bring the resident back to their room. Certified Nursing Assistant #2 stated they were confused about what they saw and did not know how to react. Registered Nurse #1 went to Resident #77's room to follow up after Certified Nursing Assistant #1 brought the resident there.</p> <p>On 4/29/2024 at 10:52 AM, Registered Nurse #2 was interviewed and stated they were the supervisor for the building on 4/23/2024 at the time of the incident involving Resident #77 and Certified Nursing Assistant #1. Registered Nurse #1 reported to them that Resident #77 fell, and they both viewed the video at 1:40 PM on 4/23/2024. Registered Nurse #2 stated they could not determine what transpired from watching the surveillance footage and reported the incident to the Inservice Coordinator because Registered Nurse #2 was busy.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/29/2024 at 12:01 PM, Registered Nurse #1 was interviewed and stated they were the charge nurse on Resident #77's unit on 4/23/2024. They were seated at the nurse's station, heard a loud slapping sound, and looked up to see Resident #77 lying on the floor. Registered Nurse #1 stated they were unable to determine what transpired in front of them, so they reviewed the surveillance footage. They stated Certified Nursing Assistant #1 provided their statement of occurrence to them and reported that Resident #77 fell after slapping Certified Nursing Assistant #1. Registered Nurse #1 stated after reviewing the surveillance footage, they believed Certified Nursing Assistant #1 provided assistance to assisted Resident #77 when lifting them off the floor and taking them to their room. Registered Nurse #1 informed the supervisor, Registered Nurse #2, of the fall incident so that another Registered Nurse could provide input into the events that transpired on surveillance footage.</p> <p>On 4/29/2024 at 1:17 PM, an interview was conducted with the Medical Director who stated they were informed on 4/25/2024 of Resident #77's incident on 4/23/2024, saw the surveillance footage with the Administrator, and advised the Director of Nursing and the Administrator to report the incident to the New York State Department of Health.</p> <p>On 4/29/2024 at 3:10 PM, the Administrator was interviewed and stated they were made aware of Resident #77's incident on 4/25/2024, reviewed the surveillance footage, and contacted the New York City Police Department to report Certified Nursing Assistant #1 was involved in an abuse incident. The Administrator was unable to provide an explanation for staff members' inability to identify and adequately address incidents of abuse. The Administrator stated the staff did receive inservices and education regarding abuse prior to the incident on 4/23/2024; however, the staff needed more in-service and training regarding abuse prevention and reporting.</p> <p>On 5/09/2024 at 2:59 PM, the Director of Nursing was interviewed and stated they became aware of an incident involving Resident #77 on 4/24/2024. Registered Nurse #1 reported the resident hit Certified Nursing Assistant #1. The Director of Nursing saw the surveillance footage at 5:00 PM on 4/24/2024 and determined Certified Nursing Assistant #1 struck Resident #77 and picked the resident up off the floor by themselves. The Administrator was not in the facility at the time and the Director of Nursing informed the Administrator the next day on 4/25/2024. Certified Nursing Assistant #1 and Registered Nurse #1 were terminated as a result of the Director of Nursing's investigation. Registered Nurse #2 should have informed the Director of Nursing if they were unsure of the events that took place on the surveillance footage and was suspended for 1 day due to their failure to inform the Director of Nursing after reviewing surveillance footage related to Resident #77.</p> <p>Multiple attempts were made to contact Certified Nursing Assistant #1, who was no longer employed at the facility. Certified Nursing Assistant #1 did not return calls for an interview.</p> <p>On 4/29/2024 at 8:22 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified.</p> <p>On 5/03/2024 at 2:00 PM, a removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility:</p> <p>-Termination Letter documents Certified Nursing Assistant #1 was terminated dated 4/26/2024 and letter was sent to Certified Nursing Assistant #1 dated 5/1/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Sapphire Center for Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 35 15 Parsons Blvd Flushing, NY 11354	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Termination letter documents dated 4/29/2024 for Registered Nurse #1 for failing to accurately report and document instance of abuse, not intervening on behalf of the resident and improperly completing the Accident and Incident Report related to abuse, mistreatment, and neglect.</p> <p>-Resident #77's care plan was updated on 4/24/2024, and resident was seen by a psychiatrist on 5/02/2024, who documented resident does not appear to be suffering from emotional stress from the incident and will be followed up as necessary.</p> <p>- The facility's investigation regarding abuse allegation was completed on 4/25/2024 by the Director of Nursing.</p> <p>-The policy on Behavior and Dementia Care and Abuse prevention were reviewed 1/2022, 1/2023, 4/2024.</p> <p>-The following documents were received and reviewed. Social worker care plan for abuse prevention was updated, Medical Doctor assessment and evaluation dated 4/24/2024; Registered Nurse assessment dated [DATE].</p> <p>- Lesson plans on Abuse, neglect and mistreatment, Behavioral Health, Alzheimer's Disease and Dementia and Incident reporting, with attendance and sign-in sheets were reviewed and documented that 76% (182 of 239) of all staff in serviced, including Certified Nursing Assistants= 80%, Licensed Practical Nurses= 75%, Registered Nurses= 65%, Recreation = 81%, and Social Services= 100%.</p> <p>-Multiple observations were conducted on Resident #77 from 4/24/2024 - 5/09/2024 and no concerns noted.</p> <p>-Team observation on staff while performing resident care did not reveal any sign of abuse, neglect, or mistreatment.</p> <p>Based on observation, interview and record review conducted on 5/03/2024, the facility fully implemented the Immediate Jeopardy Removal Plan, and the Immediate Jeopardy was removed as of 5/03/2024 at 2:00 PM.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 44864</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated (NY00340290) Survey from 4/29/2024 to 5/9/2024, the facility did not ensure that all alleged violations involving abuse were immediately reported to the New York State Department of Health, but not later than 2 hours after the allegation was made. This was evident for 5 (Resident #77, Resident #32, Resident #111, Resident #79, and Resident #91) of 39 total sampled residents. Specifically, 1) an allegation of staff-to-resident abuse involving Certified Nursing Assistant #1 and Resident #77 occurred on 4/23/2024 and was not reported to the New York State Department of Health until 4/25/2024, 2) the facility did not report to the New York State Department of Health when Resident #32 was found on the floor and determined to have a left wrist fracture, 3) Resident #111 sustained swollen wrist which was an injury of unknown origin, was not reported New York State Department of Health within 2 hours of occurrence. 4) the facility did not report to the New York State Department of Health when Resident #79 was found on the floor with a laceration to the forehead that required an evaluation at the hospital, and 5) Resident #91 was hit in the arm by another resident and the facility did not report the allegation of resident-to-resident abuse to the New York State Department of Health.</p> <p>This resulted in Substandard Quality of Care that was Immediate Jeopardy which resulted in serious injury for Resident #77 with the likelihood of a serious adverse outcome of occurring to other residents on the unit.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Reporting Suspected Crimes under the Federal Elder Justice Act dated 10/2022 states that covered individuals must report suspicion of a crime to the New York State Department of Health and local law enforcement immediately, but not later than 2 hours after forming suspicion if the events involved serious bodily injury. If the reportable event does not result in serious bodily injury, the covered individual must report the suspicion not later than 24 hours after forming suspicion.</p> <p>1) Resident #77 had diagnoses of dementia and osteoarthritis (degeneration of joint cartilage and underlying bone.)</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #77 was severely cognitively impaired, did not display inappropriate behavior, ambulated with supervision or touch assistance, and required assistance when using a wheelchair.</p> <p>A Comprehensive Care Plan related to potential for abuse and neglect initiated 1/7/2024 and last reviewed 4/24/2024 documented Resident #77 was at risk for abuse due to their dementia diagnosis and one-to-one interaction would be provided until the resident was calm.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's video surveillance dated 4/23/2024 at 12:05 PM revealed Resident #77 was in the hallway on their unit and attempted to walk into their room. Certified Nursing Assistant #1 exited the room and stood in between Resident #77 and the entrance to their room. Resident #77 slapped Certified Nursing Assistant #1. Certified Nursing Assistant #1 then struck Resident #77 causing the resident to fall backwards and land on the floor in a supine position (flat on their back). Certified Nursing Assistant #1 grabbed Resident #77's wrists, lifted the resident to their feet, and pulled the resident into their room. Registered Nurse #1 and Certified Nursing Assistant #2 were seated at the nursing station directly in front of Resident #77 and Certified Nursing Assistant #1 when the incident occurred. Registered Nurse #1 and Certified Nursing Assistant #2 did not intervene during the incident.</p> <p>The facility's Accident/Incident Report initiated on 4/23/2024 documented Resident #77 was pacing in the hallway on their unit, hit Certified Nursing Assistant #1, and then fell to the floor causing a left wrist fracture.</p> <p>The Nursing Note written by Registered Nurse #1 was dated 4/23/2024 at 12:08 PM and documented Resident #77 became physically aggressive toward staff, slapped a Certified Nursing Assistant, fell to the floor, and reported left wrist pain. Resident #77's left wrist was swollen, the Medical Doctor was informed, and an x-ray was done. At 10:29 PM, a Registered Nurse on the evening shift documented Resident #77's next of kin requested the resident be sent to the hospital for evaluation and Resident #77 was transferred to the hospital.</p> <p>A Nursing Note dated 4/24/2024 documented Resident #77 returned from the hospital with a cast to their left wrist due to left wrist fracture.</p> <p>The Summary of Investigation completed by the Director of Nursing, dated 4/25/2024, documented video surveillance footage and staff statements were reviewed. Registered Nurse #1 failed to report Resident #77's incident accurately, falsified documentation, and misled the investigation. Abuse of Resident #77 did occur on 4/23/2024.</p> <p>There was no documented evidence the facility reported Resident #77's abuse incident to the New York State Department of Health within 2 hours of occurrence.</p> <p>On 4/29/2024 at 10:52 AM, Registered Nurse #2 was interviewed and stated they were the supervisor of the building on 4/23/2024 when Resident #77 was involved in an abuse incident and sustained a fractured left wrist. Registered Nurse #2 stated they could not determine what transpired from watching the surveillance footage and reported the incident to the Inservice Coordinator because Registered Nurse #2 was busy. Registered Nurse #2 stated they thought the Inservice Coordinator would inform the Director of Nursing.</p> <p>On 4/29/2024 at 12:01 PM, Registered Nurse #1 was interviewed and stated they were the charge nurse on the unit and was present and initiated the Accident/Incident investigation when Resident #77's incident occurred. Registered Nurse #1 stated they were unable to determine whether abuse occurred when they viewed the surveillance footage and informed the building supervisor, Registered Nurse #2, so they could view the surveillance footage.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/29/2024 at 3:10 PM, the Administrator was interviewed and stated they were made aware of Resident #77's incident on 4/25/2024, reviewed the surveillance footage, and contacted the New York City Police Department to report Certified Nursing Assistant #1 was involved in an abuse incident. The Administrator was unable to provide an explanation for staff members' inability to identify and adequately address incidents of abuse. The Administrator stated the staff needed more in-service and training regarding abuse prevention and reporting.</p> <p>On 5/09/2024 at 2:59 PM, the Director of Nursing was interviewed and said they initially were made aware of the incident on 4/24/2024 and they didn't rush to review the surveillance footage or report the incident because they didn't realize the incident was serious. The Director of Nursing reviewed the surveillance footage at 5:00 PM on 4/24/2024, observed the incident of abuse involving Resident #77, and informed the Administrator the next day, on 4/25/2024. The Director of Nursing stated they should have called the New York State Department of Health within the 2 hours of becoming aware of the alleged violation.</p> <p>2) Resident #32 had diagnoses of dementia and generalized osteoarthritis.</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 11/10/2023 documented Resident #32 had severely impaired cognition.</p> <p>The facility Accident/Incident Report dated 12/4/2023 documented staff responded to Resident #32 calling for help and observed the resident sitting on the floor complaining of left wrist pain. The Medical Doctor was made aware, Resident #32 was hospitalized, and x-ray revealed Resident #32 had a closed fracture of their left wrist.</p> <p>There was no documented evidence Resident #32's unwitnessed incident and left wrist fracture were reported to the New York State Department of Health.</p> <p>On 5/08/2024 at 10:18 AM, Registered Nurse #8 was interviewed and stated the Registered Nurses were responsible for initiating investigations of incidents and submitting their completed reports to the Administrator and the Director of Nursing.</p> <p>On 5/08/2024 at 11:02 AM, the Director of Nursing was interviewed and stated they were aware of Resident #32's left wrist fracture. The facility's Accident/Incident Report was completed in a timely manner, but the alleged violation was not reported to the New York State Department of Health.</p> <p>On 5/09/2024 at 10:14 AM, the Administrator was interviewed and stated they were not aware that Resident #32's left wrist fracture was not reported to the New York State Department of Health. The Administrator stated the Director of Nursing had access to the reporting system and should have reported the incident within 2 hours of occurrence.</p> <p>3) Resident #111 had diagnoses of seizure disorder and schizophrenia (a mental condition involving the breakdown in the relation between thought, emotion, and behavior).</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 02/03/2024 documented Resident #111 had moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Nursing Note dated 4/05/2024 documented Resident #111 was evaluated by the Nurse Practitioner following a fall without injury.</p> <p>The Nursing Note dated 4/14/2024 documented Resident #111 was observed with discoloration to their left knuckles of unknown origin. Resident #111 was unable to state how the discoloration occurred and an ice pack was applied to Resident #111's knuckles.</p> <p>There was no documented evidence Resident #111's injury of unknown origin to their left knuckles was reported to the New York State Department of Health.</p> <p>On 5/02/2024 at 10:02 AM, Registered Nurse #5 was interviewed and stated they have been covering as the supervisor for the building at times and was responsible for completing the Accident/Incident Reports for the Director of Nursing. Registered Nurse #5 stated there was no Accident/Incident Report or Investigations completed for Resident #111's fall on 4/05/2024 or for the injury to their left knuckles on 4/14/2024.</p> <p>On 5/08/2024 at 12:16 PM, Registered Nurse #15 was interviewed and stated they were made aware of Resident #111's left knuckles discoloration and did not initiate an investigation or report the incident to the Director of Nursing or the New York State Department of Health. Registered Nurse #15 stated they only worked at the facility per diem on the day shift as a supervisor and there was no one available for them to consult with when they did not know how to address an incident or situation.</p> <p>On 4/29/2024 at 8:22 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified.</p> <p>On 5/03/2024 at 2:00 PM, a removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility:</p> <ul style="list-style-type: none"> -Termination Letter documents Certified Nursing Assistant #1 was terminated dated 4/26/2024 and letter was sent to Certified Nursing Assistant #1 dated 5/01/2024. -Termination letter documents dated 4/29/2024 for Registered Nurse #1 for failing to accurately report and document instance of abuse, not intervening on behalf of the resident and improperly completing the Accident and Incident Report related to abuse, mistreatment, and neglect. -Resident #77's care plan was updated on 4/24/2024, and resident was seen by a psychiatrist on 5/02/2024, who documented resident does not appear to be suffering from emotional stress from the incident and will be followed up as necessary. - The facility's investigation regarding abuse allegation was completed on 4/25/2024 by the Director of Nursing. -The policy on Behavior and Dementia Care and Abuse prevention were reviewed 1/2022, 1/2023, 4/2024. -The following documents were received and reviewed. Social worker care plan for abuse prevention was updated, Medical Doctor assessment and evaluation dated 4/24/2024; Registered Nurse assessment dated [DATE]. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Lesson plans on Abuse, neglect and mistreatment, Behavioral Health, Alzheimer's Disease and Dementia and Incident reporting, with attendance and sign-in sheets were reviewed and documented that 76% (182 of 239) of all staff in serviced, including Certified Nursing Assistants= 80%, Licensed Practical Nurses= 75%, Registered Nurses= 65%, Recreation = 81%, and Social Services= 100%. -Multiple observations were conducted on Resident #77 from 4/24/2024 - 5/09/2024 and no concerns noted.</p> <p>-Team observation on staff while performing resident care did not reveal any sign of abuse, neglect, or mistreatment.</p> <p>Based on observation, interview and record review conducted on 5/03/2024, the facility fully implemented the Immediate Jeopardy Removal Plan, and the Immediate Jeopardy was removed as of 5/03/2024 at 2:00 PM.</p> <p>10 NYCRR 415.4(b)(2)</p> <p>44472</p> <p>18881</p> <p>45351</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 44864</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated (NY00340290) Survey from 4/29/2024 to 5/9/2024, the facility failed to ensure that all alleged violations involving abuse, neglect, and mistreatment were thoroughly investigated, prevent further potential abuse while an investigation was in progress, and report the results of the investigation to the New York State Department of Health within 5 working days. This was evident for 2 (Resident #77 and Resident #111) of 39 total sampled residents. Specifically, 1) an allegation of staff-to-resident abuse involving Certified Nursing Assistant #1 and Resident #77 occurred on 4/23/2024 and the investigation results were not reported to the New York State Department of Health until 5/3/2024. Additionally, Certified Nurse Assistant #1 was not removed from direct care of residents on the unit until 4/25/2024. 2) Investigations were not conducted when Resident #111 fell on [DATE] and sustained discoloration of unknown origin to their left knuckles on 4/14/2024.</p> <p>This resulted in Substandard Quality of Care that was Immediate Jeopardy which resulted in serious injury for Resident #77 with the likelihood of a serious adverse outcome of occurring to other residents on the unit.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Identification and assessment dated ,d+[DATE] states the facility was required to report the final investigation report to the New York State Department of Health within 5 days of the incident.</p> <p>1) Resident #77 had diagnoses of dementia and osteoarthritis (degeneration of joint cartilage and underlying bone.)</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 1/14/2024 documented Resident #77 was severely cognitively impaired, did not display inappropriate behavior, ambulated with supervision or touch assistance, and required assistance when using a wheelchair.</p> <p>A Comprehensive Care Plan related to potential for abuse and neglect initiated 1/07/2024 and last reviewed 4/24/2024 documented Resident #77 was at risk for abuse due to their dementia diagnosis and one-to-one interaction would be provided until the resident was calm.</p> <p>The facility's video surveillance dated 4/23/2024 at 12:05 PM revealed Resident #77 was in the hallway on their unit and attempted to walk into a room. Certified Nursing Assistant #1 exited the room and stood in between Resident #77 and the entrance to their room. Resident #77 slapped Certified Nursing Assistant #1. Certified Nursing Assistant #1 then struck Resident #77 causing the resident to fall backwards and land on the floor in a supine position (flat on their back). Certified Nursing Assistant #1 grabbed Resident #77's wrists, lifted the resident to their feet, and pulled the resident into their room. Registered Nurse #1 and Certified Nursing Assistant #2 were seated at the nurse's station directly in front of Resident #77 and Certified Nursing Assistant #1 when the incident occurred. Registered Nurse #1 and Certified Nursing Assistant #2 did not intervene during the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Accident/Incident Report initiated on 4/23/2024 documented Resident #77 was pacing in the hallway on their unit, hit Certified Nursing Assistant #1, and then fell to the floor causing a left wrist fracture.</p> <p>The Nursing Note written by Registered Nurse #1 was dated 4/23/2024 at 12:08 PM and documented Resident #77 became physically aggressive toward staff, slapped a Certified Nursing Assistant, fell to the floor, and reported left wrist pain. Resident #77's left wrist was swollen, the Medical Doctor was informed, and an x-ray was done. At 10:29 PM, a Registered Nurse on the evening shift documented Resident #77's next of kin requested the resident be sent to the hospital for evaluation and Resident #77 was transferred to the hospital.</p> <p>A Nursing Note dated 4/24/2024 documented Resident #77 returned from the hospital with a cast to their left wrist due to left wrist fracture.</p> <p>The Summary of Investigation completed by the Director of Nursing, dated 4/25/2024, documented video surveillance footage and staff statements were reviewed. Registered Nurse #1 failed to report Resident #77's incident accurately, falsified documentation, and misled the investigation. Abuse of Resident #77 did occur on 4/23/2024.</p> <p>Staffing Attendance Sheets dated 4/23/2024 to 4/25/2024 documented Certified Nursing Assistant #1 worked after the incident on 4/23/2024 at 12:00 PM - their entire shift of 4/23/2024 until 3:00 PM, the entire shift from 7:00 AM to 3:00 PM on 4/24/2024, and from 7:00 AM to 1:00 PM on 4/25/2024 - before being removed from patient care.</p> <p>There was no documented evidence Certified Nursing Assistant #1 was removed from duty to prevent further potential abuse following the incident with Resident #77 on 4/23/2024.</p> <p>There was no documented evidence the facility reported the results of the investigation to the New York State Department of Health into Resident #77's abuse incident until 5/03/2024, more than 5 working days after the investigation initiation.</p> <p>On 5/09/2024 at 2:59 PM, the Director of Nursing was interviewed and stated they were made aware of Resident #77's abuse incident on 4/24/2024. The Director of Nursing did not realize the seriousness of the incident. They stated they should have reported the incident to the New York State Department of Health within 2 hours of occurrence and should have reported the completion of the investigation to the New York State Department of Health within a timely manner. The Director of Nursing further stated they were initially told the incident was a fall occurrence and upon further interview with Registered Nurse #1 on 4/24/2024, they were told that Certified Nursing Assistant #1 hit Resident #77. They completed their investigation on 4/24/2024 and reported the abuse incident to the Administrator on 4/25/2024. They suspended Certified Nursing Assistant #1 on 4/25/2024.</p> <p>18881</p> <p>2) Resident #111 had diagnoses of seizure disorder and schizophrenia (a mental condition involving the breakdown in the relation between thought, emotion, and behavior).</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 2/03/2024 documented Resident #111 had moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Nursing Note dated 4/05/2024 documented Resident #111 was evaluated by the Nurse Practitioner following a fall without injury.</p> <p>The Nursing Note dated 4/14/2024 documented Resident #111 was observed with discoloration to their left knuckles of unknown origin. Resident #111 was unable to state how the discoloration occurred and an ice pack was applied to Resident #111's knuckles.</p> <p>There was no documented evidence Resident #111's fall on 4/05/2024 or the injury of unknown origin to their left knuckles on 4/14/2024, were thoroughly investigated or communicated to the Medical Doctor.</p> <p>On 5/02/2024 at 10:02 AM, Registered Nurse #5 was interviewed and stated they have been covering as the supervisor for the building at times and were responsible for completing the Accident/Incident Reports for the Director of Nursing. Registered Nurse #5 stated there was no Accident/Incident Report or Investigation completed for Resident #111's fall on 4/5/2024 or for the injury to their left knuckles on 4/14/2024.</p> <p>On 5/08/2024 at 12:16 PM, Registered Nurse #15 was interviewed and stated they were made aware of Resident #111's left knuckles discoloration and did not initiate an investigation or report the incident to the Director of Nursing or the New York State Department of Health. Registered Nurse #15 stated they only worked at the facility per diem on the day shift as a supervisor and there was no one available for them to consult with when they did not know how to address an incident or situation.</p> <p>On 4/29/2024 at 8:22 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified.</p> <p>On 5/03/2024 at 2:00 PM, a removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility:</p> <ul style="list-style-type: none"> -Termination Letter documents Certified Nursing Assistant #1 was terminated dated 4/26/2024 and letter was sent to Certified Nursing Assistant #1 dated 5/01/2024. -Termination letter documents dated 4/29/2024 for Registered Nurse #1 for failing to accurately report and document instance of abuse, not intervening on behalf of the resident and improperly completing the Accident and Incident Report related to abuse, mistreatment, and Neglect. -Resident #77's care plan was updated on 4/24/2024, and resident was seen by a psychiatrist on 5/02/2024, who documented resident does not appear to be suffering from emotional stress from the incident and will be followed up as necessary. - The facility's investigation regarding abuse allegation was completed on 4/25/2024 by the Director of Nursing. -The policy on Behavior and Dementia Care and Abuse prevention were reviewed 1/2022, 1/2023, 4/2024. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sapphire Center for Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 35 15 Parsons Blvd Flushing, NY 11354	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The following documents were received and reviewed. Social worker care plan for abuse prevention was updated, Medical Doctor assessment and evaluation dated 4/24/2024; Registered Nurse assessment dated [DATE].</p> <p>- Lesson plans on Abuse, neglect and mistreatment, Behavioral Health, Alzheimer's Disease and Dementia and Incident reporting, with attendance and sign-in sheets were reviewed and documented that 76% (182 of 239) of all staff in serviced, including Certified Nursing Assistants= 80%, Licensed Practical Nurses= 75%, Registered Nurses= 65%, Recreation = 81%, and Social Services= 100%. -Multiple observations were conducted on Resident #77 from 4/24/2024 - 5/09/2024 and no concerns noted.</p> <p>-Team observation on staff while performing resident care did not reveal any sign of abuse, neglect, or mistreatment.</p> <p>Based on observation, interview and record review conducted on 5/03/2024, the facility fully implemented the Immediate Jeopardy Removal Plan, and the Immediate Jeopardy was removed as of 5/03/2024 at 2:00 PM.</p> <p>10 NYCRR 415.4(b)(3)</p>		

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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>44472</p> <p>Based on record review and interviews conducted during the Recertification survey from 04/29/2024 to 05/09/2024, the facility did not ensure Minimum Data Set 3.0 assessments were electronically transmitted within 14 days of completion. This was evident for 3 (Resident #1, #156, and #211) of 3 residents reviewed for resident assessment out of 39 total sampled residents. Specifically, the Minimum Data Set 3.0 assessments for Residents #1, #156, and #211 were not transmitted within 14 days of completion.</p> <p>The findings are:</p> <p>The facility policy titled Minimum Data Set 3.0 dated 10/2023 documented all assessments must be transmitted in a timely manner.</p> <p>The Minimum Data Set 3.0 assessment for Resident #1 documented a completion date of 03/20/2024 and transmission date of 05/01/2024, more than 14 days after the completion date.</p> <p>The Minimum Data Set 3.0 assessment for Resident #156 documented a completion date of 03/20/2024 and transmission date of 04/27/2024, more than 14 days after the completion date.</p> <p>The Minimum Data Set 3.0 assessment for Resident #211 documented a completion date of 01/09/2024 and transmission date of 04/01/2024, more than 14 days after the completion date.</p> <p>On 05/09/2024 at 01:47 PM, Registered Nurse #12, the Minimum Data Set 3.0 Coordinator, was interviewed stated their department was short of staff and this was the reason that some assessments, including those for Resident #1, #156, and #211, were transmitted more than 14 days after completion. Registered Nurse #12 stated they informed the Administrator of their staffing concerns.</p> <p>On 05/09/2024 at 01:49 PM, the Administrator was interviewed and stated the Minimum Data Set 3.0 Coordinators communicated and the Administrator was aware that staffing concerns have caused issues with completion and transmission dates of assessments. The Administrator stated the facility utilized staffing agencies to overcome their staffing shortages and will would audit assessments to ensure more compliance.</p> <p>10 NYCRR 415.11</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 44472</p> <p>Based on record review and interviews conducted during the Recertification survey from 04/29/2024 to 05/09/2024, the facility did not ensure resident comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment. This was evident for 6 (Resident #s 116, 197, 91, 125, 462, and 195) of 39 total sampled residents. Specifically, 1) the care plan related to fall risk was not revised to reflect new interventions following Resident #116's fall, 2) Resident #197's CCP related to tracheostomy care was not revised to reflect the resident's tracheostomy removal, 3) the care plans related to behavior and abuse potential for Resident #91 were not revised following a resident-to-resident altercation, 4) the care plan related to Resident #125's activities of daily living was not reviewed or revised, 5) the care plan related to recreational activities for Resident #462 was not reviewed or revised, and 6) the care plan related to communication for Resident #195 was not reviewed and revised.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Comprehensive Care Planning dated 1/2024 documented the interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition, the desired outcome is not met, the resident has been readmitted to the facility from a hospital stay, and at least quarterly.</p> <p>1. Resident #116 had diagnoses of schizophrenia and bipolar disorder.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #116 had moderate cognitive impairment and required assistance from staff to perform activities of daily living.</p> <p>The Comprehensive Care Plan related to falls created 4/27/2023 and last updated 2/11/2024 documented interventions to prevent Resident #116 from falling included keeping their bed at the lowest position, ensuring call lights were accessible, and keeping pathways unobstructed.</p> <p>The Nursing Note dated 4/30/2024 documented Resident #116 was found sitting on the floor with an abrasion to their forehead.</p> <p>The Accident/Incident Investigation dated 5/1/2024 documented the Resident #116 would be toileted every 2-4 hours to prevent falls caused by the resident attempting to go to the bathroom without assistance.</p> <p>There was no documented evidence Resident #115's care plan related to falls was reviewed and revised following their fall on 4/30/2024.</p> <p>On 05/09/2024 at 12:53 PM, Registered Nurse #8, a supervisor, was interviewed stated the supervisors were responsible for reviewing and revising resident care plans when the resident had a change in condition or a fall. Registered Nurse #8 did not have an explanation for the lack of revision to Resident #116's care plan related to falls following the resident's fall on 4/30/2024.</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 - Some</p>	<p>40565</p> <p>2. Resident #197 had diagnoses of respiratory failure and rib fractures.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #197 was cognitively intact and received oxygen therapy, suctioning, and tracheostomy care.</p> <p>The Comprehensive Care Plan related to tracheostomy care dated 2/13/2024 documented Resident #197 had a tracheostomy tube for breathing and required suctioning every shift and as needed.</p> <p>The Nursing Note dated 2/26/2024 documented Resident #197 had their tracheostomy tube removed and was decannulated as planned.</p> <p>There was no documented evidence the care plan related to tracheostomy care was reviewed and revised to reflect removal of the Resident #197's tracheostomy tube.</p> <p>On 05/06/2024 at 10:47 AM, Registered Nurse #6 was interviewed and stated Resident #197 had their tracheostomy tube removed on 2/26/2024 and the resident's care plan should have been revised to reflect the change in condition. Registered Nurse #6 was not aware that Resident #197's care plan was not revised and stated the supervisor should have updated it.</p> <p>44864</p> <p>3. Resident #91 had diagnoses of bipolar disorder and non-Alzheimer's dementia.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #91 was severely cognitively impaired and did not display behavior symptoms.</p> <p>The Comprehensive Care Plan related to behavior initiated 07/27/20 and last reviewed 1/12/2024 documented Resident #91 displayed verbally and physically abusive behavior and was disruptive.</p> <p>The Comprehensive Care Plan related to titled abuse potential initiated 5/13/2022 and last reviewed 1/12/2024 documented Resident #91 was at risk for abuse and for abusing others due to their inappropriate behavior.</p> <p>The Nursing Note dated 4/14/2024 documented Resident #91 suddenly punched another resident's arm in the unit hallway. Both residents were immediately separated.</p> <p>On 05/08/2024 at 12:35 PM, an interview was conducted with the Director of Nursing who stated each unit was supposed to have a Registered Nurse supervisor responsible for reviewing and revising resident care plans. Three units did not have regular supervisors, and this contributed to the lack of review and revision of resident care plans.</p> <p>On 05/09/2024 at 12:31 PM, the Administrator was interviewed and stated they were not aware that nursing staff were not updating or reviewing care plans. The Administrator stated the nursing staff required more supervision and received inadequate training resulting in care plans not being updated.</p> <p>10 NYCRR 415.11(c)(2)(i-iii)</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 - Some</p>	<p>18881</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351</p> <p>Based on observation, record review, and interviews conducted during the recertification survey from 4/29/2024 to 5/9/2024, the facility did not ensure an ongoing activities program was provided to meet the interests of and support the physical, mental, and psychosocial well-being of the residents. This was evident for 4 (Resident #191, #260, #107 and #462) of 39 total sampled residents. Specifically, 1) Resident #191 was not engaged in an ongoing activity program in accordance with their preferences, 2) Resident #260 was observed for extended periods of time without meaningful activities, 3) there were multiple observations of Resident #107 not being engaged in meaningful activities, and 4) Resident #462 was not observed engaged in a meaningful activities program.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Recreation dated 1/2/2024 documented the interdisciplinary team will evaluate personal history and preferences and consider medical condition and prognosis in identifying relevant recreational and cultural activities.</p> <p>1. Resident #191 had diagnoses of hypertension and hyperlipidemia.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #191 was severely cognitively impaired, preferred to communicate in Cantonese, and required an interpreter. Activity preferences included listening to music, doing favorite activities, participating in religious services, keeping up with news, doing things with groups, and interacting with animals/pets.</p> <p>On 4/30/2024 from 10:04 AM to 11:05 AM, Resident #191 was observed sitting in their wheelchair across from the nursing station with 7 other residents in the unit hallway. There was no interaction or activity happening on the unit. The April 2024 Central Activity Calendar posted on the unit bulletin documented 4/30/2024 Morning Program: Flower Painting at 10:00 AM.</p> <p>On 5/01/2024 from 9:00 AM to 10:20 AM, Resident #191 was observed sitting in their wheelchair across from the nursing station with 8 other residents in the unit hallway. There were no ongoing activities or interaction with residents on the unit. The May 2024 Central Activity Calendar posted on the unit bulletin documented 5/1/2024 Morning Program: Sitcom Hour at 10:00 AM.</p> <p>On 5/06/2024 from 9:12 AM to 11:36 AM, Resident #191 was observed sitting in their wheelchair across from the nursing station. There were no ongoing unit activities and no Recreation Leader observed on the unit. The May 2024 Central Activity Calendar posted on the unit bulletin documented 5/6/2024 Korean Service and Coloring Hour at 10:00 AM.</p> <p>On 5/09/2024 at 9:24 AM, Resident #191 was interviewed and stated via interpreter that they primarily speak Cantonese Resident #191 did not know what recreational activities the facility provided because they were not invited to activities, and they could not understand the activity calendar in their room because it was in English.</p> <p>The Comprehensive Care Plan related to adjustment dated 1/30/2024 documented Resident #191's goals included participating in programs of choice on and off the unit.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Therapeutic Recreation assessment dated [DATE] documented Resident #191 enjoyed watching television, reading the newspaper, and music therapy.</p> <p>The Activity Attendance Log from 2/1/2024 to 4/30/2024 documented Resident #191 participated in 5 activity programs in 90 days: one-to-one visit on 3/2/2024 and 3/30/2024; variety group on 4/12/2024; and bingo on 4/13/2024 and 4/20/2024.</p> <p>There was no documented evidence Resident #191 was offered or engaged in an ongoing activity program to meet their interests and needs.</p> <p>On 5/06/2024 at 10:24 AM, Certified Nursing Assistant #8 was interviewed and stated Recreation staff did not engage Resident #191 in any activities on the unit. Resident #191 mostly sat at the nursing station without staff interaction.</p> <p>2. Resident #260 had diagnoses of intellectual disabilities and Bell's Palsy.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #260 had severely impaired cognition and their activity preferences included listening to music, having animals/pets, doing things people, doing their favorite activities, and participating in religious activities.</p> <p>On 4/29/2024 from 10:15 AM to 11:05 AM, Resident #260 was observed self-propelling their wheelchair aimlessly in the hallway and then sitting at the nursing station. There was no interaction or ongoing activity program occurring on the unit.</p> <p>On 4/30/2024 from 10:00 AM to 11:11 AM, Resident #260 was observed sitting in their wheelchair by the nursing station with several other residents. Resident #260 had a verbal outburst and threw a doll they were holding onto the floor. Staff did not interact with Resident #260 and there were no ongoing activity programs on the unit. The April 2024 Central Activity Calendar posted on the unit bulletin documented 4/30/2024 Morning Program: Flower Painting at 10:00 AM.</p> <p>On 5/01/2024 from 9:22 AM to 11:12 AM, Resident #260 was observed sitting in the hallway by the nursing station without any interaction from staff and no activity program happening on the unit. The May 2024 Central Activity Calendar posted on the unit bulletin documented 5/1/2024 Morning Program: Sitcom Hour at 10:00 AM.</p> <p>The Comprehensive Care Plan related to adjustment dated 12/1/2023 documented Resident #260 would participate in on and off unit programs of their choosing 1 to 2 times a week.</p> <p>The Therapeutic Recreation assessment dated [DATE] documented Resident #260 enjoyed music therapy, animal therapy, mind and sensory stimulating program, and watching television/movies. The recreation plan included staff visiting with Resident #260 to offer independent materials, socialize, invite, and escort to activities of interest.</p> <p>The Activity Attendance Log from 4/1/2024 to 4/30/2024 documented Resident #260 participated in 4 activities out of 30 days: variety group activity on 4/12/2024; bingo on 4/13/2024 and 4/20/2024; movie night/snack on 4/14/2024.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documented evidence Resident #260 was engaged in an ongoing meaningful activity program in accordance with their needs and preferences.</p> <p>On 5/07/2024 at 11:02 AM, Recreation Leader #1 was interviewed and stated they invite all residents to activities daily and assist in escorting them to the main floor from 9:30 AM to 10 AM. A monthly activity calendar was provided to residents and posted on the unit bulletin board. Resident #191 participated in group activities and received the Chinese newspaper when available. Resident #191 did not refuse to go to activity programs when invited. Recreation Leader #1 stated Resident #260 enjoyed music therapy, dancing, and group activities. Resident #260 received visits from Recreation Leader #1 for 5 minutes to engage the resident in conversation if staff reported the resident was agitated.</p> <p>On 5/07/2024 at 10:18 AM, the Assistant Director of Recreation was interviewed and stated activity programs occurred on the main floor daily. Recreation Leaders provided activity programs on the units to residents who refused to go to the main floor activities. The Assistant Director of Recreation stated they were not aware that the on-unit activities displayed on the monthly calendar did not occur as scheduled on the 4th floor.</p> <p>18881</p> <p>3.) Resident #107 had diagnoses of anemia and dementia.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #107 was severely cognitively impaired.</p> <p>On 05/02/2024 at 11:43 AM, 05/06/2024 at 8:58 AM and from 2:00 PM to 4:30 PM, and 05/03/2024 at 9:45AM and from 2:00 PM to 4:30 PM, Resident #107 was observed in their room or at the nursing station on the unit alert and responsive. Resident #107's television was off and there was no music playing. Recreation Leader #2 was observed on the unit interacting with and transporting residents to the main floor for recreational activities. There was no staff interaction with Resident #107, Recreation Leader #2 did not engage with Resident #107, and Resident #107 did not participate in any activities.</p> <p>The Comprehensive Care Plan related to activities initiated 11/6/2020 documented Resident #107 received 1-to-1 visits and enjoyed listening to music.</p> <p>The Activity Attendance Log from 4/1/2024 to 4/30/2024 documented Resident #107 received 1-to-1 interaction. The Log did not document the time, duration, and content of the interaction. There was no documented evidence Resident #107 was provided with music or invited to attend music programs.</p> <p>There was no documented evidence Resident #107 was engaged in an ongoing meaningful activities program based on their needs and preferences.</p> <p>On 05/08/2024 at 12:00PM, the Activity Director was interviewed and stated Recreation Leaders were tasked with engaging with residents during activity programs held on the main floor instead of interacting with residents on the unit. The calendar of on-unit activities did not include any afternoon programs because the Recreation Leaders were needed on the main floor.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10 NYCRR 415.5(f)(1)</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>45351</p> <p>Based on record review and staff interviews conducted during the Recertification and Extended Survey on 4/29/2024 to 5/9/2024, the facility did not ensure that performance reviews of every nurse aide were conducted at least once every 12 months This was evident for 12 of 12 Certified Nursing Assistants reviewed for nurse aides' training requirements. Specifically, the facility was unable to provide evidence that Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18 were provided 12 hours of in-service training, including dementia and resident abuse prevention training.</p> <p>The findings are:</p> <p>The facility policy titled In-Service Training; Nurse Aide dated 2/2024 documented performance reviews were completed for nurse aides at least every 12 months.</p> <p>On 5/1/2024 at 3:02 pm, the Surveyor reviewed the personnel files of Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18. There was no documented evidence the Certified Nursing Assistants received performance reviews in accordance with their hire date within the last 12 months.</p> <p>On 5/3/2024 at 12:24 PM, the In-service Coordinator was interviewed and stated they were hired in January 2024, and they do not know how the facility conducted performance reviews for Certified Nursing Assistants in 2023.</p> <p>On 5/7/2024 at 1:06 PM, the Director of Nursing was interviewed and stated they reviewed the files and in-service records for Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18 and were unable to find performance reviews within the past 12 months.</p> <p>On 5/09/2024 at 1:24 PM, the Administrator was interviewed and stated the nursing department was responsible for ensuring performance evaluations were conducted annually for Certified Nursing Assistants. The facility went through many personnel changes and the responsibility of performance reviews fell through the cracks.</p> <p>10 NYCRR 415.26(c)(2)(iii)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Sapphire Center for Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 35 15 Parsons Blvd Flushing, NY 11354	
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>18881</p> <p>40565</p> <p>Based on observations, interviews, and record review conducted during the recertification and extended survey from 4/29/2024 to 5/9/2024, the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evident during review of Resident Rights, Abuse, Activities, and Staffing. Specifically, 1) an Immediate Jeopardy related to abuse, abuse reporting, and abuse investigation identified areas of concern with training and inservice that should have been identified by Administration, 2) Recreation staff were not administered adequately to ensure the activity needs and preferences of all residents throughout the facility were addressed, and 3) the Administration allowed the language line telephone interpretation service payments to lapse and was aware non-English speaking residents resided in the facility and were in need of language interpretation services.</p> <p>The findings are:</p> <p>1) Please refer to F600, F609, F610, F730, and F947.</p> <p>There was no documented evidence Administration effectively implemented a training and performance review program for their Certified Nursing Assistants and other staff to ensure policies and procedures related to abuse, abuse reporting, and abuse investigation were adequately implemented to prevent abuse and immediate jeopardy.</p> <p>2) Please refer to F679.</p> <p>There was no documented evidence that, despite adequate staff in the Recreation Department, the Administration ensured staff and resources were used to provide ongoing meaningful activities to all residents that met their needs and preferences.</p> <p>3) Please refer to F552.</p> <p>There was no documented evidence Administration ensured adequate interpretation services for non-English speaking residents, including paying the language-line service to ensure staff had access to interpretation services.</p> <p>On 05/09/2024 at 3:13 PM, the Administrator was interviewed and stated staff were inexperienced and did not know the regulatory requirements for reporting abuse. This was the reason staff did not know how to report abuse to the New York State Department of Health or to Administration in a timely manner. The Administrator stated staff training was ineffective and was unable to provide documented evidence that training and inservice on abuse occurred. The facility's Inservice Coordinator employed from 1/2024 to 4/2024 resigned and the facility did not have a replacement or plan in place to address the need for inservice and training at this time. The Administrator stated they spoke with staff daily at morning report and was available most days to discuss concerns.</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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40565</p> <p>Based on observation and staff interviews conducted during the Recertification and Extended Survey on 04/29/2024 to 05/09/2024, the facility did not ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment, and to help prevent the development and transmission of communicable diseases and infections. This was evident for 3 of 6 units observed during the Medication Administration task. Specifically, licensed nurses were observed not practicing hand hygiene, not sanitizing medical equipment in between residents' use, and failed to practice Enhanced Barrier Precaution.</p> <p>The findings are:</p> <p>The facility policy titled Cleaning and Disinfection of Resident Care Items and Equipment with a last reviewed date of 01/2023 documented resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to Center for Disease Control and Prevention recommendations for disinfection and the Occupational Safety and Health Administration standard. Reusable items are cleaned and disinfected or sterilized between residents.</p> <p>The facility policy titled Hand Hygiene dated 05/2022 documented all personnel working in the facility are required to perform hand hygiene with soap and water or use an alcohol based hand rub before and after resident contact and before and after performing any procedure. The policy documented that wearing gloves is not a substitute for hand hygiene and to always clean the hands after removing gloves.</p> <p>The facility policy titled Enhanced Barrier Precautions with an effective date of 04/2024 documented that Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant organisms to residents. Enhanced Barrier Precautions employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for Enhanced Barrier Precautions include device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.).</p> <p>On 04/30/2024 at 09:47 AM, during medication administration observation on the 4th floor, Registered Nurse #2 was observed administering medication and treatment to Resident #105. Registered Nurse #2 did not perform hand hygiene prior to and after administering the medication. Registered Nurse #2 was observed putting on gloves without sanitizing their hands, then applied treatment cream to Resident #105. During interview, Registered Nurse #2 stated today was their first time on the unit, they were nervous, and forgot to sanitize their hands.</p> <p>On 05/01/2024 at 08:49 AM, Registered Nurse #4 was observed administering medications on the 2nd floor. Registered Nurse #4 administered medications via tube feeding to Resident #130 without wearing a gown. Registered Nurse #4 was further observed checking Resident #130's blood pressure without sanitizing the blood pressure cuff. At 09:29 AM, Registered Nurse #4 went to Resident #150 and used the same blood pressure machine without sanitizing the cuff.</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 - Some</p>	<p>On 05/01/2024 at 09:30 AM, Registered Nurse #4 was interviewed and stated that the blood pressure cuff should be sanitized before using and in-between every resident. They stated they have disinfecting wipe at the nursing station and that it slipped out of their memory to sanitize the blood pressure machine during use. Registered Nurse #4 further stated they were given training on enhanced barrier precautions, but they did not know they have to practice it on residents with tube feeding.</p> <p>On 05/01/2024 at 11:36 AM, during the medication administration observation on the 1st floor, Registered Nurse #5 was observed performing blood glucose (simple sugar that your body uses for energy) check for Resident #87. The glucometer (a medical device for determining the approximate concentration of glucose in the blood) dropped on the floor after checking Resident #87's blood glucose. Registered Nurse #5 picked up the glucometer from the floor, placed it on a tray without sanitizing it, and went to the dining room to check Resident #5's finger stick at 11:39 AM. Registered Nurse #5 changed their gloves without performing hand hygiene prior, and did not sanitize the glucometer prior to using it on Resident #5. Resident #5 then proceeded to administering insulin to Resident #5 without changing their gloves and / or performing hand hygiene.</p> <p>On 05/01/2024 at 11:46 AM, Registered Nurse #5 was interviewed and stated that the glucometer was sanitized every shift. They stated they have been working in the facility since June 2023 and they were regularly educated on infection control protocol.</p> <p>On 05/02/2024 at 09:32 AM, an interview was conducted with the Infection Preventionist. They stated residents' care equipment was supposed to be sanitized after every resident's use. Infection Preventionist stated they have not fully implemented the Enhanced Barrier Precautions because they have not fully compiled the list of residents on Enhanced Barrier Precautions, and they were still in the process of gathering signages.</p> <p>On 05/08/2024 at 12:45 PM, the Director of Nursing was interviewed and stated residents' care equipment must be sanitized after use in between residents. They stated they have 2 glucometers in the cart to ensure proper infection control was being followed. The Director of Nursing stated that recently had COVID-19 outbreak which might indicate that staff were not practicing adequate infection control.</p> <p>10 NYCRR 415.19 (b)(4)</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351</p> <p>Based on record review and staff interviews conducted during the Recertification and Extended Survey on 4/29/2024 to 5/9/2024, the facility did not ensure that certified nurse aides were provided the required 12 hours of in-service training per year, including dementia management and resident abuse prevention training, to ensure continuing competence. This was evident for 12 of 12 Certified Nursing Assistants reviewed for nurse aides' training requirements. Specifically, the facility was unable to provide evidence that Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18 were provided 12 hours of in-service training, including dementia and resident abuse prevention training.</p> <p>The findings are:</p> <p>The Facility assessment dated [DATE] documented that required in-service training for nurse aides must be sufficient to ensure their continuing competence but must be no less than 12 hours per year.</p> <p>The facility's policy titled In-Service Training, Nurse Aide with a reviewed date of 2/2024 documented all nurse aide personnel must participate in regular in-service education. Annual in-services are no less than 12 hours per employment year and include training in dementia management and resident abuse prevention.</p> <p>On 5/1/2024 at 3:02 pm, the Surveyor reviewed the personnel files of Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18. They were all currently employed by the facility and were due for their required annual in-service training by the end of 2023 based on their employment anniversary date and/or calendar year.</p> <p>The facility was unable to provide documented evidence that Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18 were provided 12 hours of annual in-service training. There was no documented evidence that they were provided dementia and resident abuse prevention training.</p> <p>On 5/3/2024 at 12:24 PM, the In-service Coordinator was interviewed and stated they were hired in January 2024, and they do not know how the facility conducted the in-service trainings for Certified Nursing Assistants in 2023. The In-service Coordinator stated they have not found any completed staff in-service trainings for 2023.</p> <p>On 5/7/2024 at 1:06 PM, the Director of Nursing was interviewed and stated they were the Assistant Director of Nursing in 2023 and was responsible in overseeing the trainings and orientation of newly hired staff. The Director of Nursing stated they reviewed the files and in-service records for Certified Nursing Assistants #1, #2, #9, 10, #11, #12, #13, #14, #15, #16, #17, and #18 and have not found any in-service records for them. They stated they were not able to locate the completed in-service trainings from 2023.</p> <p>10 NYCRR 415.26(c)(1)(iv)</p>		