

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2023
NAME OF PROVIDER OR SUPPLIER Silver Lake Specialized Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 275 Castleton Avenue Staten Island, NY 10301	

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 - Few</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** 40565</p> <p>Based on observation, record review, and interviews conducted during the Recertification Survey from 12/06/2023 to 12/13/2023, the facility did not ensure that resident was cared for in a manner that maintained their dignity. This was evident for 1 (Resident #238) of 2 residents reviewed for Urinary Catheter out of 39 total sampled residents. Specifically, Resident #238 had a Foley catheter (FC) bag that was exposed and in public view.</p> <p>The findings are:</p> <p>The facility policy titled Catheter Care, Urinary dated 01/2023 documented the FC collection bag is kept inside a dignity bag cover at all times, except while providing care, to maintain resident dignity.</p> <p>Resident #238 had diagnoses of myocardial infarction and heart failure.</p> <p>The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #238 was moderately cognitively impaired.</p> <p>On 12/11/23 at 08:11 AM, 11:02 AM, and 12:16 PM, Resident #238 was observed in bed with their FC drainage bag exposed and visible from the hallway. The FC tubing connecting Resident #238 to the drainage bag was on the floor. Resident #238's drainage bag was not contained in a dignity bag.</p> <p>The Comprehensive Care Plan (CCP) related to indwelling catheter dated 11/30/2023 documented Resident #238's FC required monitoring.</p> <p>Physician's Order dated 11/30/2023 documented Resident #238 received FC care every shift.</p> <p>On 12/11/2023 at 12:16 PM, an interview was conducted with the Certified Nursing Assistant (CNA) #1 who stated Resident #238 was given FC care every shift and all residents with FCs should have a dignity bag to cover their FC drainage bag. CNA #1 was unable to provide a reason that Resident #238's FC drainage bag was not in a dignity 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 - Few</p>	<p>On 12/11/2023 at 12:24 PM, an interview was conducted with Licensed Practical Nurse (LPN) #2 who stated they perform frequent rounds on the unit and FC drainage bags should be contained in dignity bags. LPN #2 attended to other residents on the unit this morning and did not observe Resident #238 and their FC drainage bag.</p> <p>On 12/12/2023 at 01:16 PM, an interview was conducted with the Assistant Director of Nursing (ADON)/Infection Control Preventionist (ICP) who stated staff were aware FC drainage bags should always be kept in a dignity bag. The supervisors on the units were responsible for monitoring the staff to ensure they were doing the right thing when giving care to residents.</p> <p>10 NYCRR 415.5</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565</p> <p>Based on observations, record review, and interviews conducted during the Recertification survey from 12/6/2023 to 12/13/2023, the facility did not ensure the resident's right to participate in the development and implementation of their person-centered plan of care. This was evident for 1 (Resident #121) of 39 total sampled residents. Specifically, Resident #121 was not invited to attend their scheduled Comprehensive Care Plan (CCP) meetings.</p> <p>The findings are:</p> <p>The facility policy titled Interdisciplinary Care Plan Conference dated 01/2023 documented residents and health care agents/family members were invited to participate in admission, annual, significant change, and discharge meetings. All quarterly meetings were held with the interdisciplinary team members.</p> <p>Resident #121 had diagnoses of anemia and paraplegia.</p> <p>The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #121 was cognitively intact.</p> <p>On 12/06/2023 at 11:32 AM, Resident #121 was interviewed and stated they were not invited to their CCP meetings since their admission to the facility.</p> <p>There was no documented evidence Resident #121 was invited to or attended their scheduled CCP meetings.</p> <p>On 12/12/2023 at 12:13 PM, an interview was conducted with the Director of Social Worker (DSW) who stated residents were invited to annual, significant change, admission, and discharge CCP meetings. Residents were not invited to quarterly CCP meetings.</p> <p>On 12/12/2023 at 01:11 PM, an interview was conducted with the Assistant Director of Nursing (ADON) and stated the social workers were responsible for inviting residents to the CCP meetings. The ADON did not know that residents were not invited to all the scheduled meetings.</p> <p>On 12/13/2023 at 12:25 PM, the Director of Nursing (DON) was interviewed and stated residents were not invited to the quarterly CCP meetings and these were only held with the interdisciplinary team members. The DON stated they did not know residents should be invited to all the CCP meetings.</p> <p>10 NYCRR 415.11(c)(2)(i-iii)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101</p> <p>Based on observation, record review, and interviews conducted during the recertification survey from 12/06/2023 to 12/13/2023, the facility did not ensure a clean, comfortable, and homelike environment was maintained. This was evident for 4 of 4 resident floors (Floors 1, 2, 3, 4) reviewed for Environment. Specifically, 1) the 1st Floor had stained walls and curtains, missing and mismatched paint, missing baseboards, torn wallpaper, , and a dirty air conditioning (AC) unit, 2) the 2nd Floor had tables with mismatched and missing paint and rust, 3) the 3rd Floor had missing baseboards, mismatched and missing paint, and chipped and missing veneer on shelves , and 4) the 4th Floor had tables with mismatched and missing paint.</p> <p>The findings are:</p> <p>The facility policy titled Preventative Maintenance for Residents Rooms dated 1/2023 documented the Maintenance workers conducted one audit per floor each workday and completed the maintenance inspection checklist for that room.</p> <p>From 12/06/23 10:47 AM to 12/12/2023 at 10:39 AM, the following were observed on the 1st Floor:</p> <ul style="list-style-type: none"> - room [ROOM NUMBER] had a sink with a missing right handle and 2 cracked tiles along the bottom edge. - room [ROOM NUMBER] had an AC unit covered in black debris along the top and inside the grates. - room [ROOM NUMBER] had a missing portion of baseboard on the right side of the room, brown water stain on the window drapes, peeling and brown stained paint on the walls, an outlet cover not detached from the wall, stained window blinds, and a wall outlet exposed with a taped sign Do Not Use above it that was not easily visible. - room [ROOM NUMBER] had multiple unpainted drywall patches, chips, and dents in a column by the room door, and ripped wallpaper in the bathroom that exposed mesh in the ceiling. - room [ROOM NUMBER] had torn wallpaper and discolored ceiling tiles. - room [ROOM NUMBER] had unpainted sections of dry wall. - The pantry had several unpainted patches along the wall and missing veneer under the sink. <p>2) On 12/13/2023 at 12:17 PM, the 2nd floor dining room was observed with a rusty overbed table and 7 tables with mismatched and missing black and brown paint.</p> <p>3) From 12/08/2023 at 02:39 PM to 12/13/2023 at 12:05 PM, the following was observed on the 3rd Floor:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- the hallway by room [ROOM NUMBER], 321, 317, 318, and 301 had missing baseboards and mismatched unpainted areas throughout the hallway.</p> <p>- the pantry sink and microwave area had cracked and missing veneer on the shelves. The ceiling light had no cover with wires and light bulb exposed.</p> <p>- the floor dining room had 5 tables with missing and mismatched paint.</p> <p>4) On 12/12/2023 at 11:07 AM and 12/13/2023 at 2:00 PM, the following was observed on the 4th Floor:</p> <p>- room [ROOM NUMBER] had an overbed table with mismatched paint.</p> <p>- room [ROOM NUMBER] had a bedside table with mismatched and missing paint.</p> <p>- room [ROOM NUMBER] had a bedside table with mismatched and missing paint.</p> <p>During an interview on 12/13/23 at 12:23 PM, CNA #9 stated that they have not noticed paint on table before.</p> <p>During an interview on 12/13/23 at 12:25 PM, CNA #6 stated that from time to time see and missing paint and tables old and a pleasant environment is important if was at home clean and safe environment and resident enjoy self if messy don't want to eat and e 2 years, 1 year painted day room walls done and pictures and nothing done with tables.</p> <p>During an interview on 12/13/23 at 12:34 PM, RN #6 did not notice missing paint would have reported it. They would notify their supervisor and make an entry in the maintenance book.</p> <p>During an interview on 12/13/2023 at 01:51 PM, the Maintenance Assistant (MA) stated repair requests were written in a logbook. The MA did not notice the condition of room [ROOM NUMBER]. MA stated room [ROOM NUMBER]'s door was closed, and they did not know what the vents looked like. The MA was unsure when the tables in the dining rooms were painted. The MA stated the tables did not look good. The MA was not able to address the overbed and bedside tables because they were busy doing other things.</p> <p>10 NYCRR 415.12(h)(1)(2)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101</p> <p>Based on observation, record review, and interview conducted during the recertification survey from 12/6/2023 to 12/13/2023, the facility did not ensure that the Minimum Data Set 3.0 (MDS) assessment accurately reflected a resident's status. This was evident for 1 (Resident #68) of 39 total sampled residents. Specifically, the MDS assessment for Resident #68 did not accurately reflect the resident's use of a physical restraint.</p> <p>The findings are:</p> <p>Resident #68 had diagnoses of diabetes mellitus and non-Alzheimer's dementia.</p> <p>The MDS assessment dated [DATE] documented Resident #68 was severely cognitively impaired and did not document the resident used restraints.</p> <p>On 12/06/2023 at 11:54 AM and 12/13/2023 at 12:41 PM, Resident #68 was observed wearing bilateral hand mittens.</p> <p>The Physicians Order dated 7/21/2023 documented Resident #68 used bilateral hand mittens to prevent them from pulling at tubes.</p> <p>The Certified Nursing Assistant (CNA) Accountability Record from 7/2023 to 12/2023 documented Resident #68 used bilateral hand mittens.</p> <p>The Comprehensive Care Plan (CCP) related to restraints initiated 7/25/2023 documented bilateral hand mittens were used with Resident #68.</p> <p>There was no documented evidence Resident #68's use of hand mittens accurately assessed on the 11/30/2023 MDS assessment.</p> <p>During an interview on 12/13/2023 at 01:02 PM, CNA #10 stated Resident #68 uses the bilateral hand mittens to prevent them from pulling at their Gastrostomy and trach tubes.</p> <p>During an interview on 12/13/2023 at 01:37 PM, the MDS Assessor stated Resident #68 was ordered to use hand mittens as needed and did not use physical restraints. Hand mittens were documented as a restraint in the MDS. Resident #68 did not use hand mittens at the time the MDS Assessor filled out their MDS assessment for 11/30/2023. The MDS Assessor stated it was an oversight that they did not capture Resident #68's use of hand mittens on the MDS.</p> <p>10 NYCRR 415.11(b)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101</p> <p>Based on observations, record review, and interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was evident during review of the kitchen. Specifically, 1) a 5-pound container of expired cottage cheese was in the kitchen refrigerator, 2) the 3rd floor pantry contained expired honey-thickened juices, and 3) the 4th floor pantry had an expired quart of milk.</p> <p>The findings are:</p> <p>The facility policy titled Food, Supply Storage and Receiving dated ,d+[DATE] documented all foods were labeled to ensure proper stock rotation and fresh food for the residents.</p> <p>During the initial observation of the kitchen refrigerator on [DATE] at 09:30 AM, one container of 5-pound low fat cottage cheese with a use-by date of [DATE].</p> <p>The 3rd floor pantry was observed on [DATE] at 02:47 PM and contained 15 containers of 4-ounce honey-thickened apple juice with use-by dates of ,d+[DATE], ,d+[DATE], and ,d+[DATE], 2 containers of honey-thickened cranberry juice with use-by dates of [DATE] and [DATE].</p> <p>On [DATE] at 04:03PM, the 4th floor pantry refrigerator contained a quart container of whole milk with a use-by date of [DATE].</p> <p>On [DATE] at 10:15 AM, Dietary Aide (DA) #1 was interviewed and stated they stocked the kitchen refrigerator twice weekly upon delivery. DA #1 looks at expiration dates and writes the delivery date in the items. Older food items were placed in front of newer items to be used first. DA #1 informed their supervisor within a few months of items' use-by dates. DA #1 stated they did not notice the expired cottage cheese in the kitchen refrigerator.</p> <p>On [DATE] at 03:14 PM, Certified Nursing Assistant (CNA) #9 was interviewed and stated that there were 5 residents on the 3rd floor that drank honey-thickened liquids. CNA #9 checked the dates on the thickened beverages in the pantry every 3 days to ensure they were discarded by their expiration date. The morning shift checked this pantry refrigerator and CNA #9 did not check this refrigerator as part of the evening shift routine. CNA #9 did not have an explanation for the expired honey thickened liquids in the pantry refrigerator.</p> <p>On [DATE] at 03:34 PM, Licensed Practical Nurse (LPN) #4 was interviewed and stated 11PM to 7AM shift was responsible for clearing out the pantry refrigerators of expired items. LPN #4 did not have time to check the pantry refrigerators.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 03:47 PM, the Registered Dietitian (RD) was interviewed and stated nursing and dietary staff should work together. The Dietary Department brought food items to the unit and Nursing staff should discard the expired items. Nursing staff were responsible for pantry refrigerators. The RD did not check these refrigerators. The Food Service Director (FSD) was also responsible for checking for expired food and beverages.</p> <p>On [DATE] at 09:55 AM and [DATE] at 04:21 PM, the FSD was interviewed and stated they conduct daily rounds to check for and dispose of expired foods. The FSD did not notice the cottage cheese was expired. The FSD stated they periodically check the pantry refrigerators. Other staff were also responsible for checking the pantry refrigerators.</p> <p>10 NYCRR 415.14(h)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565</p> <p>Based on observations, record review, and interviews conducted during the recertification survey from 12/6/2023 to 12/13/2023, the facility did not ensure infection control practices were maintained. This was evident for 1 (Resident #238) of 2 residents reviewed for urinary catheter out of 39 total sampled residents and the Main Dining Room (MDR). Specifically, 1) the Foley catheter (FC) tubing for Resident #238 was touching the floor, and 2) hand hygiene was not performed for multiple residents eating lunch in the MDR.</p> <p>The findings are:</p> <p>The facility policy titled Catheter Care, Urinary dated 01/2023 documented FC tubing and drainage bag are kept off the floor.</p> <p>The facility policy titled Hand Hygiene- Hand Sanitizer dated 1/2022 documented use hand hygiene to prevent the spread of infection.</p> <p>1) Resident #238 had diagnoses of myocardial infarction and heart failure.</p> <p>The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #238 was moderately cognitively impaired.</p> <p>On 12/11/23 at 08:11 AM, 11:02 AM, and 12:16 PM, Resident #238 was observed in bed with their FC drainage bag exposed and visible from the hallway. The FC tubing connecting Resident #238 to the drainage bag was on the floor.</p> <p>The Comprehensive Care Plan (CCP) related to indwelling catheter dated 11/30/2023 documented Resident #238's FC required monitoring.</p> <p>Physician's Order dated 11/30/2023 documented Resident #238 received FC care every shift.</p> <p>On 12/11/2023 at 12:16 PM, an interview was conducted with the Certified Nursing Assistant (CNA) #1 who stated Resident #238 was provided with FC care every shift. FC tubing should not be on the floor. CNA #1 had no explanation for Resident #238's FC tubing being on the floor.</p> <p>On 12/11/2023 at 12:24 PM, an interview was conducted with Licensed Practical Nurse (LPN) #2 who stated they perform frequent rounds on the unit and FC tubing should not be on the floor. LPN #2 attended to other residents on the unit this morning and did not observe Resident #238 and their FC drainage bag.</p> <p>On 12/13/2023 at 12:20 PM, an interview was conducted with the Director of Nursing (DON) who stated Resident #238's FC tubing should not have been on the floor.</p> <p>41709</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>2) On 12/06/2023 at 11:16 AM, observation of the MDR was conducted while residents and staff prepared for lunch service. Residents did not perform hand hygiene prior to Dietary Aide (DA) #3 serving juice, tea, coffee, and water. Resident #102 entered the MDR and was seated at a table without being offered hand hygiene. Resident #27 was in a wheelchair with bibs in their lap and was going to each table to hand out bibs to the residents. Resident #27 was observed licking their left hand before picking up each bib in their lap and then handing it to residents. A staff member placed Resident #238 at a table and did not offer hand hygiene. Resident #11 entered the MDR, sat down at a table, and was offered juice without being offered hand hygiene. There were 7 tables of residents who were served beverages prior to hand hygiene being offered. Resident #102 was seated at one of the tables and was interviewed during the observation. Resident #102 stated they ate in the MDR every day and has never been offered hand wipes or other forms of hand hygiene before meal service.</p> <p>On 12/06/2023 at 11:41 AM, an interview was conducted with Certified Nursing Assistant (CNA) #5 who stated they were assigned to assist with meal service in the MDR and was on break prior to coming to the MDR. When CNA #5 came back from break and entered the MDR, they saw that lunch service had already begun. CNA #5 saw that residents had already been served beverages, did not see that hand wipes were given to residents, and began offering hand wipes to residents. Serving should not begin until residents' hands were clean. Resident #27 was not assigned to give out the bibs but wants to be helpful and decided to give out the bibs teach residents.</p> <p>On 12/06/2023 at 12:07 PM, an interview conducted with Dietary Aide (DA) #3 who stated they were responsible for serving the beverages during lunch service. CNAs were responsible for cleaning residents' hands. DA #3 was not responsible for hand hygiene and did not know if staff provided resident with hand hygiene before DA #3 began serving the beverages. DA #3 was just told by the nurse that residents must have clean hands before the beverages are served.</p> <p>On 12/06/2023 at 11:43 AM, an interview was conducted with Registered Nurse (RN) #6 who stated residents' hands should be cleaned before beverages are served in the MDR. The nursing staff communicated with the dietary staff to ensure residents' hands were cleaned prior to serving. RN #6 explained to the dietary staff that residents' hands needed to be wiped before the start of lunch service.</p> <p>On 12/12/2023 at 01:18 PM, an interview was conducted with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) who stated residents entering the MDR for meals can use the hand wipes or hand sanitizer located on the wall. Nursing staff were responsible for ensuring residents had clean hands prior to meal service. The CNA assigned to the MDR was supposed to give residents a hand wipe as they enter the MDR. Resident #27 wanted to feel useful by handing out bibs to residents. The ADON/ICP will teach Resident #27 how to properly handout bibs without licking their hand in between. The ADON/ICP stated they did not make rounds to observe meal service on 12/6/2023.</p> <p>10 NYCRR 415.19(a)(1-3)</p>		