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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335239 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER Clove Lakes Health Care and Rehab Center, Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE 25 Fanning Street Staten Island, NY 10314 | |
| 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 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** 50894</p> <p>Based on observations, record review, and staff interviews conducted during the Recertification survey between 10/08/2024 and 10/16/2024, the facility did not ensure that Minimum Data Set (MDS) 3.0 assessments accurately reflected the residents' status. Specifically, the most recent Minimum Data Set (MDS) 3.0 assessments did not reflect that a resident had psychiatric behaviors. This was evident for 1 of 1 residents reviewed for Assessment Accuracy out of a sample of 39 residents (Resident #228).</p> <p>The findings are:</p> <p>Resident #228 was admitted to the facility on [DATE] with diagnoses including Nondisplaced fracture of medial condyle of left tibia, Anxiety Disorder, and Depression.</p> <p>The Minimum Data Set Admission assessment dated [DATE] documented that the Resident #228 did not have any hallucinations or delusions, did not display any physical or verbal behaviors directed at themselves or others, and did not reject care.</p> <p>The Minimum Data Set Quarterly assessment dated [DATE] and the Minimum Data Set Quarterly assessment dated [DATE] documented that the resident did not have any hallucinations or delusions, did not display any physical or verbal behaviors directed at themselves or others, and did not reject care.</p> <p>The Minimum Data Set Comprehensive assessment dated [DATE] documented that Resident #228 had a new diagnosis of Psychotic Disorder. It documented that the resident did not have any hallucinations or delusions, did not display any physical or verbal behaviors directed at themselves or others, and did not reject care.</p> <p>Multiple Behavior Notes created between 12/09/2022 and 03/25/2023 documented that the resident had behaviors including refusing medication, hiding medications, calling the police, talking to themselves, portraying agitated and verbally abusive behavior towards others, and threatening to physically assault others.</p> <p>On 12/23/2022, a Nursing Progress Note documented that the Resident #228 called 911 despite being in no apparent distress. A Nurse Practitioner was notified of this and ordered for the resident to be sent to the emergency room for a psychiatric evaluation. The resident's family refused the transfer to the emergency room and the facility did not send the resident to the emergency room .</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 335239 |
| | | If continuation sheet Page 1 of 11 |

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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>On 12/27/2022, an order was placed for Haldol Solution 5 mg/mL, inject 0.4 mL intramuscularly once daily for psychosis.</p> <p>A psychiatric assessment completed on 02/25/2023 documented that the Resident #228 was diagnosed with Psychosis, Not Otherwise Specified, due to behaviors including noncompliance with treatment, irritability, physical aggression, and paranoid behaviors.</p> <p>A behavior care plan was created for Resident #228 on 10/26/2022 and revised on 10/08/2024 with a focus of Resident demonstrates problem behavior as evidenced by: accusatory behavior, verbally inappropriate towards staff and other residents, calls specific names. The care plan references that on 10/18/2023, the resident was verbally aggressive towards staff. On 01/04/2023, the resident called 911 for transport to go home despite not being discharged , and on 03/13/2024, the resident called 911 with vague complaints.</p> <p>On 10/15/2024 at 10:11 AM, Registered Nurse Supervisor #4 was interviewed and stated that Resident #228 has many behaviors including screaming, cursing, hitting staff members, talking to themselves, and refusing care.</p> <p>On 10/15/2024 at 10:52 AM, Registered Nurse #12 was interviewed and stated that the resident displayed behaviors including being physically and verbally aggressive and combative. They stated that Resident #228 was off the charts psychologically unwell and that the doctors and staff working with the resident were all aware of this. Registered Nurse #12 stated that the facility should have referred the resident to a higher level of care such as a psychiatric hospital, but the facility wanted the money so they kept the resident even though they knew that they were a danger to staff.</p> <p>On 10/16/2024 at 11:02 AM, Certified Nursing Assistant #12 was interviewed and stated that they have provided care to Resident #228 for around 1 or 2 years. Certified Nursing Assistant #12 stated that the resident has many behaviors problems including cursing, yell, accusatory behaviors against staff members, and refusing care.</p> <p>On 10/16/2024 at 11:15 AM, the Director of Nursing was interviewed and stated that Resident #228 has been discussed frequently in the facility's staff meetings regarding behavior concerns. They stated that Resident #228's behaviors include yelling, using profane language towards anyone who passes her door including staff and visitors, refusing care, refusing medications, and verbal aggression.</p> <p>On 10/15/2024 at 11:53 AM, the Minimum Data Set Coordinator was interviewed and stated that the Social Services department is responsible for inputting the Minimum Data Set information related to mood and behavior.</p> <p>On 10/15/2024 at 11:58 AM, the Director of Social Services was interviewed and stated that the Social Services department is responsible for inputting the Minimum Data Set information related to mood and behavior. They do this by reviewing the behavior progress notes in the resident's chart, speaking with staff members that care for the resident, and utilizing any contact they have had when communicating with the resident. The Director of Social Services stated that they did not know why the behaviors were not listed in the assessments but that if the resident had behaviors including refusing care, having physical and verbal behavior symptoms, and calling 911, that they should have all been coded in the Minimum Data Set.</p> <p>(continued on next page)</p> | | |

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| F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | 10 NYCRR 415.11 (b) |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894</p> <p>Based on observations, record review, and staff interviews conducted during the recertification survey from 10/08/2024 to 10/16/2024, the facility did not ensure assessments were coordinated with the Pre-Admission Screening and Resident Review (PASARR) program under Medicaid. Specifically, a resident with a new diagnosis of a serious mental disorder was not referred for a PASARR Level II Evaluation. This was evident for 1 of 1 residents reviewed for PASARR services (Resident #228).</p> <p>The findings are:</p> <p>A facility Policy and Procedure titled Screen/Pre-Admission Screen Resident Review (PASSR) Process did not include any procedure related to referring residents with new diagnoses of serious mental health disorders for a PASARR Level II evaluation.</p> <p>Resident #228 was admitted to the facility on [DATE] with diagnoses including Nondisplaced fracture of medial condyle of left tibia, Anxiety Disorder, and Depression.</p> <p>The Minimum Data Set Admission assessment dated [DATE] documented that the resident did not have any hallucinations or delusions, did not display any physical or verbal behaviors directed at themselves or others, and did not reject care.</p> <p>A SCREEN dated 09/23/2022 documented that Resident #228 did not have a diagnosis of a serious mental illness or dementia.</p> <p>Multiple Behavior Notes created between 12/09/2022 and 03/25/2023 documented that the resident had behaviors including refusing medication, hiding medications, calling the police, talking to themselves, portraying agitated and verbally abusive behavior towards others, and threatening to physically assault others.</p> <p>On 12/23/2022, a Nursing Progress Note documented that the Resident #228 called 911 despite being in no apparent distress. A Nurse Practitioner was notified of this and ordered for the resident to be sent to the emergency room for a psychiatric evaluation. The resident's family refused the transfer to the emergency room and the facility did not send the resident to the emergency room .</p> <p>On 12/27/2022, an order was placed for Haldol Solution 5 mg/mL, inject 0.4 mL intramuscularly once daily for psychosis.</p> <p>A Psychiatric Assessment completed on 02/25/2023 documented that the resident was diagnosed with Psychosis, Not Otherwise Specified, due to behaviors including noncompliance with treatment, irritability, and paranoid behaviors.</p> <p>The Minimum Data Set Comprehensive assessment dated [DATE] documented that Resident #228 had diagnoses including Psychotic Disorder.</p> <p>(continued on next page)</p> |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/15/2024 at 10:52 AM, Registered Nurse #12 was interviewed and stated that they had provided care to Resident #228 on multiple occasions. Registered Nurse #12 stated that the resident displayed behaviors including being physically and verbally aggressive and combative. They stated that Resident #228 was off the charts psychologically well and that the doctors and staff working with the resident were all aware of this. Registered Nurse #12 stated that the facility should have referred her to a higher level of care such as a psychiatric hospital, but the facility wanted the money so they kept the resident even though they knew that she was a danger to staff.</p> <p>On 10/15/2024 at 11:58 AM, The Director of Social Services was interviewed and stated that the Social Work department is responsible for PASARR screens. They stated that the facility did not rescreen Resident #228 for a possible Level II referral because the facility does not complete PASARR Level II screens in the facility, even if a resident has a psychiatric change in condition. The Director of Social Services stated that PASARR Level II screens would only be completed if a resident is transferred to a psychiatric hospital and the screen is completed by the hospital.</p> <p>10 NYCRR 415.11(e)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081</p> <p>Based on record review, and interview conducted during the Recertification Survey and Abbreviated survey (NY00356497) from 10/08/2024 to 10/16/2024, the facility did not ensure services provided met professional standards of quality. This was evident for 1 (Resident #369) out of 40 total sampled residents. Specifically, Resident #369 did not receive Brivaracetam (medication for seizure) in accordance with Physician's Orders due to the medication not being available. Additionally, there was no documented evidence indicating the physician was notified that the medication was not available.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Medication Administration revised 11/2023 states that it is the Standard of Practice that medications be administered as ordered by the physician. When medication cannot be administered, or is refused, it is documented electronically on the electronic- Medication Administration Record including the reason and physician notification.</p> <p>Resident #369 was admitted with diagnoses including Encephalitis and Encephalomyelitis, Non- Traumatic Brain Dysfunction, Respiratory Failure and Tracheostomy Status.</p> <p>The Minimum Data Set, dated dated dated [DATE] documented Resident #369 was moderately impaired cognition.</p> <p>The Medication Review Report for Resident #369 dated 09/01/2024 to 09/30/2024 documented Brivaracetam Oral Tablet 75 milligram - give 2 tablets by mouth every 12 hours for seizure.</p> <p>The Medication Administration Record dated September 2024 revealed that from 09/13/2024 to 09/30/2024, on 10 of 36 occasions, the Brivaracetam medications' documentation entered on the Medication Administration Record was 9. The Medication Administration Record Chart Codes indicated that 9 =Others/See Progress Notes.</p> <p>Nursing Progress Notes dated 09/28/2024 to 09/30/2024 documented medication on order and pending delivery from pharmacy.</p> <p>There was no documented evidence the medical provider was notified of the medication that was not administered due to not being available.</p> <p>On 10/09/2024 at 12:25 PM, a family member was interviewed and stated that Resident #369 had no anti-seizure medications for 3 days. Family member stated they informed the supervisor and the nurse on duty about the medication and stated to them that was not acceptable.</p> <p>(continued on next page)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/15/2024 at 12:06 PM, Registered Nurse Supervisor #1 was interviewed and stated it was noted that the anti-seizure medication was not available and not given on specific days. Registered Nurse Supervisor # 1 stated that they should have notified the medical doctor when not available. Registered Nurse Supervisor #1 stated they should have not waited for the last tablet to be given before requesting a refill. Registered Nurse Supervisor #1 stated that the family member came to them and notified them (Registered Nurse Supervisor #1) on 09/30/2024 when they returned to work that Resident # 369 did not receive the antiseizure medication over the weekend. Registered Nurse Supervisor #1 stated they resent the order and notified the doctor to sign the order. Registered Nurse Supervisor #1stated that the Medication Administration Record documented that the medication was not given for 3 days.</p> <p>On 10/15/2024 at 12:21 PM, Registered Nurse #3 was interviewed and stated they worked on 09/29/2024 but does not remember if the medication was available or not. Registered Nurse #3 stated they do not remember calling the pharmacy to follow up or informing the supervisor.</p> <p>On 10/15/2024 at 12:26 PM, Registered Nurse #4 was interviewed and stated that the seizure medication was ordered to be given every 12 hours. Registered Nurse #4 stated they charted code 9 that means the medication was not in their supply or not available. Registered Nurse #4 stated the medication has been reordered. Registered Nurse #4 stated that in the blister pack there was a blue label that triggers the medication nurse to reorder the medication. Registered Nurse #4 stated they did not follow up the medication order with the pharmacy or informed their supervisor.</p> <p>On 10/15/2024 at 3:27 PM, Registered Nurse #2 was interviewed and stated they knew that there were days that the medication, Brivaracetam was not delivered. Registered Nurse #2 stated before running out of supply, there was blue line in the blister pack that signal the medication nurse to reorder the medication to prevent it from running out. Registered Nurse #2 stated that they did not give the medication on the second day. Registered Nurse #2 stated that the family member was asking why the medication was not available. Registered Nurse #2 stated they called the pharmacy. Registered Nurse #2 stated that the one responsible for ordering the medication is either the morning or evening medication nurse, once they reach the blue line this indicates that it is time to request a refill. Registered Nurse #2 stated they informed the Registered Nurse Supervisor #1 on 10/01/2024.</p> <p>On 10/16/2024 at 8:49 AM, Director of Nursing stated that if they are running out of medication within 7 days they should start asking for refills. Director of Nursing stated that everyone is responsible for reordering medications whether the medication nurse is a regular or a float nurse.</p> <p>On 10/16/2024 at 12:23 PM, Medical Doctor #1 was interviewed and stated that they do not remember if they were notified by the nurse otherwise, they would have documented that they were notified.</p> <p>10 NYCRR 415.11(c)(3)(i)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44472</p> <p>Based on record review and interviews conducted during a Recertification Survey initiated on 10/8/2024 and completed on 10/16/2024, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (Resident #275) of two residents reviewed for quality of care related to drugs and medication. Specifically, Resident #275 with a diagnosis that includes Hyperlipidemia and Thyroid disorder had a physician's order to administer Levothyroxine Sodium tablet 112 mcg one tablet by mouth one time a day for low thyroxin hormone. The facility policy is to administer Levothyroxine Sodium at six in the morning. Resident #275 was given this medication on multiple days after seven in the morning.</p> <p>The finding is:</p> <p>The facility's policy dated 06/2024, titled Quality of Care Policy and Procedure documents the facility will ensure it identifies and provides needed care and services that are person centered, in accordance with the resident's professional standards of practice that will meet each resident's physical, mental and psychological needs. Policy dated 11/2023 for Medication Administration times documents for Synthroid administration is 6 AM.</p> <p>Resident #275 was admitted with diagnoses that includes Hyperlipidemia and Thyroid Disorder.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documents</p> <p>Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Preferences for customary routine was conducted documents resident states very important to have family in discussion about their care.</p> <p>The physician's order dated from 7/30/2024 to 10/11/2024 documents to administer</p> <p>Levothyroxine Sodium tablet 112 mcg one tablet by mouth one time a day for low thyroxin hormone.</p> <p>The August 2024, September 2024 and October 2024 Medication Administration Audit Report revealed Resident #275 was administered Levothyroxine tablet, fifteen times late that is beyond 7 in the morning that included dates on 8/30/2024 at 7:34 AM, 8/31/2024 at 7:20AM, 9/3/2024 at 7:19AM, 9/4/2024 at 9:44AM, 9/5/2024 at 9:06AM, 9/6/2024 at 12:16 PM, 9/7/2024 at 10:39AM, 9/8/2024 at 9:53AM, 9/9/2024 at 1PM, 9/10/2024 at 8:28AM, 9/11/2024 at 9:03 AM, 9/12/2024 at 7:44AM, 9/16/2024 at 7:54AM, 9/17/2024 at 7:39AM, and 10/12/2024 at 7:09AM.</p> <p>The Comprehensive Care Plan for Thyroid replacement therapy dated 8/4/2022 latest revised 10/9/2024 documents to give thyroid replacement therapy as ordered, stress to resident importance of taking medication every day. Monitor side effects and effectiveness.</p> <p>There was no documentation in the medical record that Resident #275 refused Levothyroxine Sodium tablet.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Accessdata.fda.gov which lists Food and Drug Administration approved product labeling documents, Administer once daily, preferably on an empty stomach, one half to one hour before breakfast.</p> <p>On 10/08/24 at 11:06 AM Resident #275 is in the room and stated my lawyer have called the Department of Health and filed a report about my thyroid medication not being given on time that is scheduled for 6 in the morning, Resident #275 also stated. must beg for that medication to the nurse and explain that it is needed before eating breakfast.</p> <p>On 10/11/24 at 02:10 PM Resident #275 stated, got the thyroid medication on time for the past days since the state surveyors were in the building however they gave the medication late again.</p> <p>On 10/16/24 02:05 PM Licensed Practical Nurse #4 was interviewed and stated the Day shift Registered Nursing Supervisor #3 will give Resident #275 the thyroid medication whenever the night nurse missed to give that medication.</p> <p>On 10/16/24 at 02:18 PM Registered Nurse Supervisor #3 was interviewed and stated, that they are aware the thyroid medication, Levothyroxine tablet for the Resident #275 was missed multiple times because the night nurse did not see that it is in an orange container, not in the normal blister pack. When they come in the morning the resident complained that it was not given at 6AM. The dayshift medication nurse or the Nursing Supervisor will give the Levothyroxine medication to the resident immediately. Registered Nurse Supervisor #3 further stated that communication with the Night Nursing Supervisor regarding location of Levothyroxine tablet will be mentioned in the report to prevent missing the medication.</p> <p>On 10/16/24 at 02:30 PM The Director of Nursing was interviewed stated they are aware that if the thyroid medication is sometimes not given to Resident #275, it is because it is not in the normal container not in the blister pack and the night nurse might have not seen it. Going forward they stated that they will in-service all nurses to look attentively for medications and inform the supervisor immediately if they did not locate certain medications.</p> <p>10NYCRR 415.12</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081</p> <p>Based on record review, and interview conducted during the Recertification and Abbreviated Survey (NY00356497) from 10/08/2024 to 10/16/2024, the facility did not ensure residents were free of significant medication errors for 1 of 1 residents (Resident #369) reviewed for medications. Specifically, Resident #369 did not receive Brivaracetam (medication for seizure) in accordance with Physician's Orders due to the medication not being available. Additionally, there was no documented evidence indicating the physician was notified that the medication was not available.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Medication Administration revised 11/2023 states that it is the Standard of Practice that medications be administered as ordered by the physician. When medication cannot be administered, or is refused, it is documented electronically on the electronic- Medication Administration Record including the reason and physician notification.</p> <p>Resident #369 was admitted with diagnoses including Encephalitis and Encephalomyelitis, Non- Traumatic Brain Dysfunction, Respiratory Failure and Tracheostomy Status.</p> <p>The Minimum Data Set, dated dated dated [DATE] documented Resident #369 was moderately impaired cognition.</p> <p>The Medication Administration Record dated September 2024 revealed that from 09/13/2024 to 09/30/2024, 10 of 36 occasions, the Brivaracetam medications' documentation entered on the Medication Administration Record was 9. The Medication Administration Record Chart Codes indicated that 9 =Others/See Progress Notes.</p> <p>The nursing progress notes dated 09/28/2024 to 09/30/2024 documented medication on order and pending delivery from pharmacy.</p> <p>There was no documented evidence the medical provider was notified of the medication that were not administered due to being unavailable.</p> <p>On 10/09/2024 at 12:25 PM, family member was interviewed and stated that Resident #369 had no anti-seizure medications for 3 days. Family member stated they informed the supervisor and the nurse on duty about the medication and stated to them that was not acceptable.</p> <p>On 10/15/2024 at 12:06 PM, Registered Nurse Supervisor #1 was interviewed and stated it was noted that the anti-seizure medication was not available and not given on specific days. Registered Nurse Supervisor # 1 stated that they should have notified the medical doctor when not available. Registered Nurse Supervisor #1 stated they should have not wait for the last tablet to request for refill. Registered Nurse Supervisor #1 stated that the family member came to them and notified them (Registered Nurse Supervisor #1) on 09/30/2024 when they returned to work that Resident # 369 did not receive the antiseizure medication over the weekend. Registered Nurse Supervisor #1 stated they resent the order and notified the doctor to sign the order. Registered Nurse Supervisor #1stated that it showed that the medication was not given for 3 days.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335239 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER Clove Lakes Health Care and Rehab Center, Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE 25 Fanning Street Staten Island, NY 10314 | |
| 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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/15/2024 at 12:21 PM, Registered Nurse #3 was interviewed and stated they worked on 09/29/2024 but does not remember if the medication was available or not. Registered Nurse #3 stated they do not remember calling the pharmacy to follow up or informing the supervisor.</p> <p>On 10/15/2024 at 12:26 PM, Registered Nurse #4 was interviewed and stated that the seizure medication was ordered to give every 12 hours. Registered Nurse #4 stated they charted code 9 that means the medication was not in their supply or not available. Registered Nurse #4 stated the medication has been reordered. Registered Nurse #4 stated that in the blister pack there was a blue label that triggers the medication nurse to reorder the medication. Registered Nurse #4 stated they did not follow up the medication from the pharmacy or informed the supervisor.</p> <p>On 10/15/2024 at 3:27 PM, Registered Nurse #2 was interviewed and stated they knew that there were days that the medication, Brivaracetam was not delivered. Registered Nurse #2 stated before running out of supply, there was blue line in the blister pack that signal the medication nurse to reorder the medication to prevent from running out. Registered Nurse #2 stated that they did not give the medication on the second day. Registered Nurse #2 stated that the family member was asking why the medication was not available. Registered Nurse #2 stated they called the pharmacy. Registered Nurse #2 stated that the one responsible for ordering the medication it is either the morning or evening medication nurse once they reached the blue line that it is time to request for refill. Registered Nurse #2 stated they informed the Registered Nurse Supervisor #1 on 10/01/2024.</p> <p>On 10/16/2024 at 8:49 AM, Director of Nursing stated that if they are running out of medication within 7 days they should start asking for refills. Director of Nursing stated that everyone is responsible to reorder medications whether the medication nurse is a regular or float nurse.</p> <p>On 10/16/2024 at 12:23 PM, Medical Doctor #1 was interviewed and stated that they do not remember if they were notified by the nurse otherwise they have documented that they were notified.</p> <p>10NYCRR 415.12(m)(2)</p> | | |