

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Fieldston Lodge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 666 Kappock Street Riverdale, NY 10463	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136</p> <p>Based on observation, interviews, and record review conducted during the Recertification Survey from 03/26/2024 through 04/02/2024, the facility did not ensure that a resident's privacy was maintained. This was evident for 1 (Resident #119) of 1 resident reviewed for Privacy out of 38 sampled residents. Specifically, a Respiratory Therapist was observed performing tracheostomy care with the resident's room door opened.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Residents Rights, with a last revised date of November 2023, documented that the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p> <p>Resident # 119 was admitted with diagnoses of Respiratory Failure and Tracheostomy Status.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documented that Resident #119 had severe impairment in cognition. The assessment documented that the resident required suctioning and tracheostomy care.</p> <p>A physician's order dated 02/02/2024 documented an order to cleanse tracheostomy area every shift and as needed; and suction tracheal and nasopharyngeal every 4 hours and as needed.</p> <p>On 04/01/2024 at 10:10 AM, Respiratory Therapist #1 was observed suctioning and performing tracheostomy care for Resident #119 with the room door opened.</p> <p>On 04/01/2024 at 10:30 AM, Respiratory Therapist #1 was interviewed and stated everybody was not supposed to see what they were doing in the room. They stated they were supposed to keep the door closed and the curtains pulled to maintain privacy. Respiratory Therapist #1 stated they made a mistake.</p> <p>On 04/01/2024 at 12:20 PM, the Director of Respiratory Therapy was interviewed and stated they are to maintain residents' privacy during tracheostomy care. The door must be closed and the curtains pulled.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>04/02/2024 at 2:43 PM, the Director of Nursing was interviewed and stated the staff must provide privacy during tracheostomy care.</p> <p>10 NYCRR 415.3(e)(1)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136</p> <p>Based on record review and interviews conducted during the Recertification Survey from 03/26/2024 through 04/02/2024, the facility failed to ensure that the resident and their representative were provided with a written summary of the baseline care plan. This was evident for 3 (Residents # 5, #39, and #119) of 3 residents reviewed for baseline care plan out of a total sample of 38 residents. Specifically, 1) Resident #5 did not get a copy of their baseline care plan summary. 2) Resident #39's representative did not receive a copy of the resident's baseline care plan summary, and 3) Resident #119's representative did not receive a copy of the resident's baseline care plan summary.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Care Plan - Baseline with a revised date of October 2023 documented that a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. The resident and their representative will be provided with a summary of the baseline care plan.</p> <p>1. Resident #5 was admitted to the facility with diagnoses of Depression and Respiratory Failure.</p> <p>The admission Minimum Data Set assessment dated [DATE] documented Resident #5's cognition was intact.</p> <p>A Care Plan History for Resident #5 documented that a Baseline Care Plan was created on 01/26/2024. There was no documentation that the resident or their representative acknowledged receipt of the baseline care plan.</p> <p>A review of Resident #5's medical record did not reveal documented evidence that a copy of baseline care plan was provided to the resident and / or their representative.</p> <p>2. Resident #39 was admitted with diagnoses of Depression and Toxoplasma Meningoencephalitis.</p> <p>The admission Minimum Data Set assessment dated [DATE] documented Resident #39's cognition as moderately impaired.</p> <p>A Care Plan History for Resident #39 documented that a Baseline Care Plan was created on 01/27/2024. There was no documentation that the resident or their representative acknowledged receipt of the baseline care plan.</p> <p>A review of Resident #39's medical record did not reveal documented evidence that a copy of baseline care plan was provided to the resident and / or their representative.</p> <p>3. Resident #119 was admitted to the facility with diagnoses of Respiratory Failure and Tracheostomy Status.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The admission Minimum Data Set assessment dated [DATE] documented Resident #119's cognition as severely impaired.</p> <p>A Care Plan History for Resident #119 documented that a Baseline Care Plan was created on 02/01/2024. There was no documentation that the resident or their representative acknowledged receipt of the baseline care plan.</p> <p>A review of Resident #119's medical record did not reveal documented evidence that a copy of baseline care plan was provided to the resident and / or their representative.</p> <p>On 04/02/2024 at 12:15 PM Registered Nurse #4, who was the unit manager, was interviewed and stated that the admission nurse initiates the baseline care plan and that they complete it within 48 hours. Registered Nurse #4 stated they do not give out a summary of the baseline care plan and that residents or their representatives do not get a copy of the baseline care plan.</p> <p>On 04/01/2024 at 4:12 PM, the Social Worker was interviewed and stated that a baseline care plan is created within 48 hours from admission. They stated that the social workers are responsible for providing the baseline care plan to the residents and their family representatives to inform them of the plan of care. The Social Worker stated resident does not have a copy of the summary of the baseline care plan because they were not provided.</p> <p>On 04/02/2024 at 2:37 PM, the Director of Nursing was interviewed and stated that the baseline care plan must be completed within 48 hours. They stated that the plan is discussed with the resident and resident representative, and a copy of the summary must be provided to them.</p> <p>10 NYCRR 415.11 (c)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136</p> <p>Based on observations, interviews, and record review conducted during the Recertification and Complaint Survey (NY00331841) from 03/26/2024 through 04/02/2024, the facility did not ensure that a comprehensive person-centered care plan was developed and implemented for each resident. This was evident for 5 (Resident #s 39, 82, 108, 109, and 253) of 38 sampled residents. Specifically, 1.) Resident #39 had no care plan in place for antibiotic therapy. 2.) A care plan was not developed to address Resident #108's preference to wear a night gown in the dayroom. 3.) Resident #82 had no care plan for hospice care. 4.) Resident #109 had no care plan developed to address wandering behavior. 5.) Resident #253 had no care in place for ecchymosis on the forehead.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Comprehensive Care Plan with a revised date of 10/2023 stated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and their family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.</p> <p>1. Resident #39 was admitted with diagnoses of Depression and Toxoplasma Meningoencephalitis.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documented Resident #39's cognition was moderately impaired.</p> <p>A physician's order dated 02/25/2024 documented Bactrim DS (sulfamethoxazole-trimethoprim) tablet; 800-160 milligram; 1 tablet oral once a day for prophylactic measures.</p> <p>A review of the Medication Administration Record dated 03/01/2024 to 03/31/2024 revealed that Bactrim DS was administered to Resident #39.</p> <p>A review of Resident #39's medical records revealed no documented evidence that a comprehensive care plan with interventions for Resident #39's antibiotic therapy was initiated and implemented.</p> <p>On 03/26/2024 at 2:17 PM, Registered Nurse #4, who was the unit manager, was interviewed and stated that Resident #39 was started on Bactrim DS (sulfamethoxazole-trimethoprim) on 02/26/2024 for the prevention of toxoplasmosis. Registered Nurse #4 stated a care plan should have been in place for the antibiotic use, but they forgot to include it.</p> <p>On 04/02/2024 at 2:31 PM, the Director of Nursing was interviewed and stated there should be a care plan for Bactrim use. They stated the unit manager, the supervisor, or the Registered Nurse who picked up the order were responsible for initiating the care plan. They also stated the Infection Control Nurse was supposed to ensure that the care plan was in place for antibiotic therapy.</p> <p>44842</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #108 was admitted with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Seizures, and Schizoaffective Disorder.</p> <p>The Minimum Data Set assessment dated [DATE] documented that Resident #108 had severely impaired cognition. The Minimum Data Set assessment further documented that Resident #108 required supervision with bed mobility, transfer, upper body dressing, toilet use, personal hygiene, and eating.</p> <p>During observation on 03/26/2024 at 10:10 AM and on 03/27/2024 at 9:40 AM, Resident #108 was noted in the day room sitting in their wheelchair wearing a night gown.</p> <p>A review of Resident #108's medical record revealed no documented evidence that a Comprehensive Care Plan to address Resident #108's preference to wear their night gown in the day room was developed.</p> <p>On 3/28/2024 at 11:15 AM, Certified Nursing Assistant #5 was interviewed and stated Resident #108 sometimes wheels self to the day room in their gown in the early morning. They try to redirect Resident back to their room to get dressed but Resident refused to get dressed until later in the morning.</p> <p>On 3/28/2024 at 2:36 PM, Licensed Practical Nurse #2 was interviewed and stated Resident #108 was resistive to care and has a habit of going to the day room in their night gown. They stated they try to redirect Resident back to their room for care, but Resident would refuse.</p> <p>On 03/28/2024 at 2:51 PM, Registered Nurse #1, who was the unit manager, was interviewed and stated the Certified Nursing Assistants try to encourage Resident #108 to get washed and dressed before going to the day room but Resident would refuse. Registered Nurse #1 stated there should be a care plan for Resident #108's preference to go to the day room wearing a night gown. Registered Nurse #1 stated it was their responsibility to create and update Resident #108's Comprehensive Care Plan.</p> <p>On 03/29/2024 at 2:23 PM, the Director of Nursing Services was interviewed and stated a care plan should have been developed to reflect Resident #108's preference to attend the day room in their gown. They stated that the Registered Nurse Manager is responsible for developing, implementing, and updating the care plans.</p> <p>45351</p> <p>3. Resident #82 was admitted with diagnoses of Diabetes Mellitus and Hypothyroidism.</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #82 was severely cognitively impaired and was receiving hospice care.</p> <p>The social service progress note dated 09/18/2023 documented Resident #82 was assigned to hospice care.</p> <p>A physician's order dated 09/18/2023 documented Resident #82 was in hospice care.</p> <p>A review of the comprehensive care plans for Resident #82 revealed there was no documented evidence that a care plan for hospice care was initiated.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2024 at 12:18 PM, the Assistant Director of Nursing was interviewed and stated Resident #82 was currently receiving hospice service. They stated they reviewed Resident #82's medical record and was not able to locate the care plan for hospice care. They stated the care plan for hospice care was supposed to be created by the social worker.</p> <p>On 3/28/2024 at 12:26 PM, the Director of Social Service was interviewed and stated the care plan for hospice care was not created for Resident #82. They stated that it was an oversight and should have been created when resident started hospice.</p> <p>10 NYCRR 415.11(c)(1)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45351</p> <p>Based on record review and interviews conducted during the Recertification and Complaint Survey (NY00327454) from 03/26/2024 through 04/02/2024, the facility did not ensure that each resident's comprehensive care plan was reviewed and revised by the interdisciplinary team following an occurrence of resident-to-resident physical abuse. This was evident for 1 (Resident #35) of 35 total sampled residents. Specifically, the comprehensive care plan was not reviewed and revised for Resident #35 following their involvement in a resident-to-resident altercation.</p> <p>The findings are:</p> <p>The facility policy titled Comprehensive Care Plan dated 10/2023 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> <p>Resident #35 was admitted to the facility with diagnoses of Diabetes Mellitus, Acute Respiratory Failure, and Bipolar Disorder.</p> <p>The Minimum Data Set assessment dated documented that Resident #35 had severely impaired cognition.</p> <p>The facility investigation summary documented that on 11/04/2023 at 6:35AM, Resident #35 was involved in an unwitnessed altercation with another resident in their room. Both residents were transferred to the hospital for evaluation. Resident #35 returned to the facility with staples to the head.</p> <p>A comprehensive care plan for psychosocial well-being that was initiated on 12/13/2022 documented resident evidences the potential for abuse due to cognitive and medical decline.</p> <p>There was no documented evidence that Resident #35's comprehensive care plan was revised with new interventions following an occurrence of resident-to-resident altercation on 11/04/2023.</p> <p>On 04/01/2024 at 9:06AM, Registered Nurse #7, who was the Registered Nurse Supervisor, stated Resident #35 was involved in an altercation with another resident on 11/04/2023. Registered Nurse #7 stated they reviewed Resident #35's medical record and was not able to find an updated care plan with new interventions for Resident #35 following the altercation. Registered Nurse #7 stated that care plans must be updated after each incident of altercation.</p> <p>10 NYCRR 415.11(c)(2)(i-iii)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136</p> <p>Based on observation, record review, and interviews conducted during the Recertification Survey from 03/26/2024 through 04/02/2024, the facility did not ensure that an ongoing activities program was provided based on the comprehensive assessment, care plan, and preferences of each resident, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. This was evident for 1 (Residents #39) of 3 residents reviewed for Activities out of 38 total sampled residents. Specifically, there was no evidence Resident #39 was engaged in a meaningful activity program on the unit.</p> <p>The findings are:</p> <p>The facility's policy and procedure titled Quality of Life - Resident Self-Determination and Participation with the last reviewed date of November 2023 documented that the facility respects and promotes the right of each resident to exercise their autonomy regarding what the resident considers to be important facets of their life. Each resident is allowed to choose activities, schedules, and health care that are consistent with their interests, values, assessment, and plan of care.</p> <p>Resident #39 was admitted with diagnoses of Depression and Toxoplasma Meningoencephalitis.</p> <p>The admission Minimum Data Set assessment dated [DATE] documented Resident #39's cognition was moderately impaired. The assessment documented that Resident #39 found it very important to have books, newspapers, and magazines to read, listen to music they like, keep up with the news, do things with groups of people, do favorite activities, and participate in religious services or practices.</p> <p>During observations, on 03/26/2024 at 12:37 PM, Resident # 39 was observed in bed with the television off. There was no ongoing recreation activity noted in the unit. On 03/27/2024 at 10:05 AM, Resident # 39 was observed resting in bed with the television off. No activity was noted on the unit. The resident had their phone on playing Christian music. On 04/01/2024 at 9:27 AM, Resident #39 was observed resting in bed and listening to preaching on their phone. There was no activity noted in the unit.</p> <p>On 03/26/2024 at 12:38 PM, Resident #39 was interviewed and stated they like to listen to music. They stated they listen to Christian music on their phone. Resident #39 stated there were no activities that they want to do but was wondering if the facility had bingo. Resident #39 stated they are of Catholic faith and used to go to church when they were back home. They stated they do not know if there was church service in the facility.</p> <p>The activities care plan that was initiated on 01/29/2024 documented that Resident #39 prefers activities that identify with their prior lifestyle. The interventions include informing them of upcoming activities by providing an activity calendar, verbal reminders, escort, and encouragement and providing materials of interest, such as magazines and newspapers, upon request. The recreation aide will provide room visits, daily orientation, and program invitations.</p> <p>A review of the facility activity calendar for March 2024 showed no listed activity for the 2nd 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 - Few</p>	<p>A review of Resident #39's medical records revealed no documented evidence of activity assessment, activity notes, and activity attendance records.</p> <p>On 04/01/2024 at 12:30 PM, Certified Nursing Assistant #2 was interviewed and stated they did not see activity staff coming to the unit. They stated Resident #39 stays in bed and would have their phone and television on.</p> <p>On 04/01/2024 at 12:37 PM, Certified Nursing Assistant #3 was interviewed and stated there was no staff from activity department who came to the unit. They stated there had been no activity on the unit. Certified Nursing Assistant #3 stated there was an activity calendar every month but there was no activity scheduled on the unit.</p> <p>On 04/01/2024 at 12:56 PM, Registered Nurse #3 was interviewed and stated that they have an activity calendar on the 2nd floor, but there was no activity on the unit.</p> <p>On 04/02/2024 at 12:50 PM, Registered Nurse #4, who was the unit manager, was interviewed and stated the residents who can ambulate go to the recreation department downstairs for activities. They stated that prior to COVID-19, they would take residents on ventilator out of bed and take them in the dayroom to watch television. They stated recreation staff used to come and play music for the residents. Registered Nurse #4 stated they have had not returned to this usual routine after COVID-19. They stated there was no activity in the unit and that recreation staff would just turn the television on in residents' room. Registered Nurse #4 stated Resident #39 stays in bed and would play music on their phone.</p> <p>On 04/01/2024 at 4:01 PM, the Director of Recreation was interviewed and stated they do room visits and give daily orientation on the 2nd floor in the morning and sometimes in the afternoon. They stated residents who get out of bed attend activities downstairs, and they invite the alert residents to attend the activities on the first floor. The Director of Recreation stated there was no room visit listed on the calendar.</p> <p>On 04/02/2024 at 2:37 PM, the Director of Nursing was interviewed and stated that the activities on the 2nd floor should be at the bedside, but they cannot confirm that there was activity on the unit.</p> <p>10 NYCRR 415.5 (f) (1)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44472</p> <p>Based on record review and interview conducted during the Recertification Survey from 03/26/2024 to 04/02/2024, the facility failed to address an irregularity identified by the pharmacist during Medication Regimen Review. This was evident in 1 (Resident #31) of 5 residents reviewed for unnecessary medications. Specifically, the pharmacist identified a potential medication irregularity during the Medication Regimen Review dated 02/28/2024 and recommended to change the administration time for Montelukast for maximum benefit. The facility did not address the irregularity.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure for Drug Regimen Review which was last revised on 02/2024 documented that the Consultant Pharmacist shall identify, document, and report possible medication irregularities for review and action by the attending Physician, where appropriate. The attending Physician or licensed designee shall respond to the Drug Regimen Review within 7-14 days or more promptly, whenever possible.</p> <p>Resident #31 was admitted to the facility with diagnosis of Schizophrenia, Chronic Obstructive Pulmonary Disease, and Obstructive Sleep Apnea.</p> <p>The annual Minimum Data Set assessment dated [DATE] documented that Resident #31 had intact cognition.</p> <p>A Medication Regimen Review dated 02/28/2024 documented that Resident #31 was currently receiving Montelukast at 9:00 AM. Recommended to be given at bedtime for maximum benefit. Consider switching to bedtime dosing, if appropriate. The Physician/Prescriber Response documented agreed, will do.</p> <p>The physician order report dated 03/01/2024 through 04/01/2024 documented an order for Montelukast tablet, 10 milligram, 1 tablet, orally, once daily at 9:00 AM for Chronic Obstructive Pulmonary Disease. The start date was on 08/08/2023.</p> <p>The Medication Administration Record dated 02/28/2023 through 03/31/2024 documented Montelukast Scheduled time was at 9:00 AM.</p> <p>During an interview on 04/02/2024 at 09:33 AM, Licensed Pharmacist Consultant #1 stated they made the recommendation for Montelukast, and it was the facility's responsibility to address it.</p> <p>During an interview on 04/02/2024 at 10:42 AM, the Medical Director stated it was an oversight. The Medical Director stated they should have checked the section that says disagree but made a mistake.</p> <p>During an interview on 04/02/2024 at 11:10 AM, the Director of Nursing stated that the physician should have acted upon the recommendation made by the licensed pharmacist. The Director of Nursing stated in this case, the recommendation was not acted upon appropriately and they take full responsibility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Fieldston Lodge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 666 Kappock Street Riverdale, NY 10463	

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

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10 NYCRR 415.18 (c)(2)</p>