STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335274	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Simeon by the Sound Center for Nursing & Rehab	61700 Route 48 Greenport, NY 11944

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 9/5/2024, the facility did not ensure that all residents were provided a safe, clean comfortable, and homelike environment. This was identified for two (B Unit and [NAME] Unit) of four units reviewed during the environmental task; and for two residents (Resident #48 and Resident #100) of three residents reviewed for the environment task. Specifically, 1) the suction machine on the [NAME] Unit dining room was observed with used suction tubing and a dirty suction canister that contained cloudy fluid with food particles, and 2) the privacy curtains for Resident #47 and Resident #100 were observed to be soiled. 3) The hallway bathroom on B Unit and the bathroom in room [ROOM NUMBER] were observed to have a dried brown feces-like substance on the toilet bowl seat. The findings are: The facility's undated policy titled, Department Protocols: Housekeeping Department documented that the purpose of the policy was to prevent infections. Resident rooms and toilets are cleaned daily and when needed. The documented department protocols for terminal cleaning were to remove and clean the drapes and cubicle curtains. The facility's policy for Bathroom Cleaning dated 11/14/2023 documented that housekeepers were to clean each resident's bathroom including all surfaces, toilets, and handrails at least once daily and as needed. The facility's policy for Suction Equipment revised on 6/1/2009, documented that all suction equipment will be cleansed after each use to reduce the possibility of contamination. Procedures include: Licensed Nursing Staff will disinfect a suction bottle or machine by wiping down the suction machine after each use and at the end of each shift; discarding the disposable suction bottle at the end of each shift; replacing the tubing on the suction bottle once each week; and replacing suction tubing between residents. 1) On 8/26/2024 at 12:45 PM during the lunch meal observation, the [NAME] Unit dining room was observed to have a dirty suction canister that contained cloudy fluid with food particles and used suction tubing attached to the suction machine. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse Supervisor #2 was interviewed immediately after the observation on 8/26/2024 and stated the suction machine was not used today and the canister/tubing should have been replaced after every use. Registered Nurse Supervisor #2 stated they were supposed to check the suction machine before each meal I had not checked the machine prior to lunch meal. The Infection Control Registered Nurse was interviewed on 9/04/2024 at 12:16 PM and stated the suction machine should be checked every night by the night shift staff. When the suction machine is used, the nurse should change the canister and the suction tubing after each use. The suction machine should be ready at meal times, in the event there is an emergency. 41051 2) Resident #47 had diagnoses of Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of six, which indicated severe cognitive impairment. Resident #47 had moderate visual impairment with corrective lenses. During an environmental tour of Resident #47's room on 8/26/2024 at 11:49 AM, Resident #47's privacy curtain was observed with staining along the bottom edge of the curtain and had gray spots and streaks of gray stains throughout the rest of the curtain. Resident #47 stated they could not see the stains on the curtain. During an observation on 8/29/2024 at 4:05 PM Resident #47's privacy curtain was observed with staining along the bottom edge of the curtain and had spots and streaks of stains throughout the rest of the curtain. Resident #100 had diagnoses of Fracture of Facial Bones, Fracture of Lumbosacral (lower back) Spine and Pelvis, and Schizoaffective Disorder. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, indicating an intact cognition. Resident #100 had adequate vision without corrective lenses. During an environmental tour of Resident #100's room on 8/26/2024 at 12:03 PM, Resident #100's privacy curtain was observed to have a large reddish-brown stain in the middle of the curtain. Resident #100 stated they would like a clean curtain. During an observation on 8/29/2024 at 4:08 PM, The privacy curtain was observed with the same reddish-brown stain. There was no resident in the room at the time of the observation. Certified Nursing Assistant #6, Resident #47's assigned Certified Nursing Assistant, was interviewed on 8/30/2024 at 1:17 PM and stated they saw the stains on Resident #47's privacy curtain but they did not know how long the stains had been there. Certified Nursing Assistant #6 stated they should have reported the stained privacy curtain to the nurse on the unit or the housekeeper so the curtain could be cleaned. Certified Nursing Assistant #6 stated Resident #100 moved to a new room on 8/28/2024 and a new resident moved into the room on 8/28/2024 and was discharged on [DATE]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeper #1 was interviewed on 8/30/2024 at 1:20 PM and stated they were the assigned housekeeper for the unit and they cleaned all the resident rooms on the unit. Housekeeper #1 stated they are supposed to check the privacy curtains as part of their room cleaning task. Housekeeper #1 stated they did not see the dirty privacy curtain in Resident #47's room, but they should have checked it. Housekeeper #1 stated the privacy curtain in Resident #100's room should have been removed and laundered after Resident #100 moved to another room. Housekeeper #1 stated when a resident moves out of a room the room is cleaned and disinfected, and the privacy curtain is removed and laundered. Licensed Practical Nurse #2, the charge nurse, was interviewed on 8/30/2024 at 1:36 PM and stated they did not notice the dirty privacy curtains in Resident #47's or Resident #100's room. Licensed Practical Nurse #2 stated the resident's privacy curtains should be clean and without stains. Licensed Practical Nurse #2 stated when a resident moves out, the room should be thoroughly cleaned and disinfected, including laundering the privacy curtains before a new resident moves in the room. The Director of Operations was interviewed on 9/3/2024 at 4:50 PM and stated they oversee housekeeping operations and that the housekeepers on the unit are responsible for the cleanliness of resident rooms, including the privacy curtains. The Director of Operations stated the housekeeper would be responsible for removing the privacy curtains and taking them to the laundry room. The Director of Operations stated when a resident moves out of a room, the room should have a terminal cleaning, meaning the room is thoroughly cleaned and disinfected, including the privacy curtains. The Administrator was interviewed on 9/5/2024 at 4:06 PM and stated the resident's privacy curtains should be clean and free of stains. The Administrator stated they expected the privacy curtains to be inspected during daily room cleaning and if they are dirty they should be removed and replaced immediately. 44925 3) During an environmental tour of the B Unit, on 8/29/2024 at 4:26 PM, the resident bathroom in the hallway was observed with a dried brown feces-like substance on the toilet bowl seat. During an environmental tour of the [NAME] Unit on 8/30/2024 at 12:53 PM, room [ROOM NUMBER]'s bathroom was observed with a dried brown feces-like substance on the toilet bowl seat. Housekeeper #2, assigned to the B Unit, was interviewed on 8/30/2024 at 1:03 PM and stated they cleaned each resident's room daily and had already cleaned the bathroom in room [ROOM NUMBER] this morning. Licensed Practical Nurse #3 was interviewed on 9/4/2024 at 10:10 AM and stated the housekeepers clean the resident bathrooms every day and as needed. Licensed Practical Nurse #3 stated when the housekeeper had already cleaned the bathroom, and the bathroom was soiled afterward, then Certified Nursing Assistants should have notified the housekeepers to clean the bathroom. The Director of Housekeeping and Maintenance was interviewed on 9/5/2024 at 9:18 AM and stated that it was not acceptable that the toilet seat in the resident's bathroom and the toilet in the hallway were soiled. The Director of Housekeeping and Maintenance stated they would start doing frequent rounds on the floors to ensure the resident environment remains clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing Services was interviewed on 9/5/2024 at 1:08 PM and stated it was not acceptable to have a soiled toilet seat in the resident's bathroom and would expect nursing staff to report soiled and dirty toilets and other resident areas to the housekeeping department to maintain a clean environment for each resident. 10 NYCRR 415.5(h)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 9/5/2024, the facility did not ensure it developed and implemented a comprehensive person-centered care plan for each resident. This was identified for one (Resident #85) of four residents reviewed for Advanced Directives and for one (Resident #99) of one resident reviewed for skin conditions. Specifically, 1) Resident #85 had physician's orders for advance directives to include Do Not Resuscitate, Do Not Intubate, and No Feeding Tube. There was no comprehensive care plan developed to reflect the resident's Advanced Directives status. 2) Resident #99 had a physician's order to treat the left shin (front of the leg below the knee) wound twice a day. There was no documented evidence that the staff consistently provided the wound care as ordered by the Physician. The findings are: 1) The facility's policy titled, Minimum Data Set/Care Planning dated 11/20/2017 documented, that the facility shall have a care planning process that is person-centered which includes: integrating assessment findings in care planning, developing an interdisciplinary care plan, regularly reviewing and revising the care plan, and providing the care and documenting the care. The care plan shall describe the services that are being provided and any services/treatment that would otherwise be required but are not provided due to the resident's/patient's exercise of the right to refuse treatment. The facility's policy titled, Advanced Directives last reviewed on 2/17/2017 documented the resident's advanced directives will be reviewed with the resident and/or their representative upon admission and periodically to ensure that such directives reflect the current wishes of the resident or representative, in light of the resident's medical status and life circumstances. As part of the admission process, the social worker will review any accompanying advanced directives for completeness, accuracy, and validity, and will review such directives with the resident and/or representative to ascertain the current wishes of the resident or representative. The resident's physician and staff involved in the resident's care will be notified of any change in advanced directives and the medical record and comprehensive care plan will be amended accordingly. Resident #85 had diagnoses of a Fracture of the Right Femur (Thighbone), Dementia, and Alzheimer's Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #85 had a Brief Interview for Mental Status score of 14 indicating an intact cognition. The Quarterly Minimum Data Set documented the resident's Advanced Directives as Do Not Resuscitate, Do Not Intubate (no breathing tube will be placed), and Feeding Restrictions. The resident had an invoked healthcare proxy (a designated person to make healthcare decisions on their behalf if they are unable to do so). A physician's order dated 5/11/2024 documented Resident #85's advanced directives as Do Not Resuscitate. Treatment guidelines- limited medical interventions. Instructions for intubation and mechanical ventilation- Do not intubate. Future hospitalization /Transfer - Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled. Artificially administered fluid and nutrition- No feeding tube, a trial period of IV fluids. Antibiotics- Determine the use or limitation of antibiotics when infection occurs. Use antibiotics. The physician's order was renewed on 7/24/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #85's electronic medical record revealed that Resident #85 did not have an active Comprehensive Care Plan for Advanced Directives. Further review revealed an inactive Comprehensive Care Plan for Advanced Directives with an effective date of 2/2/2024 and the status of the Comprehensive Care Plan was documented as the resident was discharged on [DATE]. The admission, discharge, and transfer history in the electronic medical record documented that Resident #85 was discharged to the hospital on 5/8/2024 and was readmitted to the facility on [DATE]. A social work progress note dated 5/15/2024 documented the resident was readmitted to the facility and the Medical Orders for Life Sustaining Treatment and advanced directives were in place. A social work progress note dated 5/26/2024 documented a care plan meeting was held with Resident #85 and the healthcare proxy. The interdisciplinary team updated and reviewed the plan of care. The resident had advanced directives and Medical Orders for Life-Sustaining Treatment in place with no changes. The Licensed Master Social Worker assigned to Resident #85 was unavailable for an interview. Licensed Master Social Worker #1 was interviewed on 9/3/2024 at 3:34 PM and stated Resident #85 should have an active Comprehensive Care Plan for Advanced Directives. Licensed Master Social Worker #1 reviewed Resident #85 physician's orders and stated the Comprehensive Care Plan for Advanced Directives was not active in the electronic medical record. Licensed Master Social Worker #1 stated Resident #85 was sent to the hospital on 5/8/2024 and because the resident did not return by midnight, the electronic medical record software automatically inactivated all of the resident's Comprehensive Care Plans. Licensed Master Social Worker #1 stated the assigned Licensed Master Social Worker was responsible for reviewing and reactivating the Comprehensive Care Plan for Advanced Directives when the resident was readmitted . The Comprehensive Care Plan for Advanced Directives with an effective date of 2/2/2024 appeared active in the electronic medical record on 9/3/2024 after the surveyor interviewed the Licensed Master Social Worker. The Acting Director of Nursing Services was interviewed on 9/5/2024 at 3:55 PM and stated an active Comprehensive Care Plan for Advanced Directives should have been in place for Resident #85. The Acting Director of Nursing Services stated when a resident is readmitted , after a hospital stay, all their relevant Comprehensive Care Plans should be reactivated. The Acting Director of Nursing Services stated they expected that a resident with Medical Orders for Life-Sustaining Treatment and physician's orders for advanced directives should have an active Comprehensive Care Plan for Advanced Directives. 17585 2) Resident #99 was admitted with diagnoses including Multiple Rib Fractures and an open wound to the left lower leg. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. The resident had an application of nonsurgical dressings (with or without topical medications) other than to feet. The resident did not have pressure ulcers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan dated 8/5/2024 documented the resident had skin impairment with a full thickness wound to the left shin. Interventions included but were not limited to provide treatment as per the physician's orders. The physician's orders dated 8/9/2024 to 8/16/2024 documented to apply Dakin's (an antiseptic wound cleansing solution) solution 0.25% wet to moist dressing to the left lower extremity wound and cover with an abdominal pad and Kling. Soak with normal saline to remove the old dressing twice daily. A review of the resident's Treatment Administration Record from 8/1/2024 to 8/31/2024 revealed there was no documented evidence that the wound treatments were administered on 8/10/2024 and from 8/14/2024 to 8/17/2024 during the 7:00 PM to 7:00 AM shift. Registered Nurse #5, who was assigned to Resident #99 on 8/15/2024 and 8/16/2024 was not available for an interview. Registered Nurse #7, who was assigned to Resident #99 on 8/17/2024 was interviewed on 9/4/2024 at 5:03 PM and stated they could not recall if they had administered the treatments for Resident #99 on 8/17/2024. Registered Nurse # 8, who was assigned to Resident #99 on 8/14/2024, was interviewed on 9/4/2024 at 5:06 PM and stated if the treatment record was not signed that means the treatment was not done. Registered Nurse #8 stated, I don't recall treating the resident's wound with Dakin's dressing. I have always applied Xeroform dressing. The Director of Nursing Services was interviewed on 9/4/2024 at 5:08 PM and stated that all nurses should provide treatment as per the physician's orders and document in the resident's medical record. The Director of Nursing Services stated that if the treatment administration is not signed for, it is considered that the treatment was not provided. The Administrator was interviewed on 9/4/2024 at 5:15 PM and stated that all nurses should sign in the Treatment Administration Record that the treatment was provided as per the physician's orders. The Administrator stated if the Treatment Administration Record was not signed, that means the treatment was not provided. 10 NYCRR 415.11(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 9/5/2024, the facility did not ensure that all residents received treatment and care in accordance with professional standards of practice. This was identified for one (Resident #256) of one resident reviewed for Pain Management. Specifically, Resident #256 reported left-hand pain on 8/4/2024. The medical provider was contacted and ordered an x-ray of the left hand. Registered Nurse #6 wrote the telephone order in the medical record and erroneously indicated an x-ray order for the right hand. The x-ray of the right hand was completed; however, neither the Medical Doctor nor the Nurse Practitioner reviewed the x-ray results. The facility staff were not aware of the transcription error until it was brought to the facility's attention by the surveyor. The finding is: The facility's untitled and undated policy statement regarding medication administration documented, that the Licensed Nurse may obtain orders from a Physician, a Nurse Practitioner, or a Physician Assistant. Telephone orders must be read back to the medical practitioner to ensure that the order is correct. The facility's undated policy titled, Radiology Services documented, it is the Attending Physician's responsibility to provide a written order for an x-ray. The Licensed Nursing staff are responsible for completing the x-ray requisition form ensuring all pertinent diagnoses and the physician's rationale for ordering the diagnostic services. The Licensed Nurse presents the results to the medical doctor. Resident #256 had diagnoses that included Morbid Obesity, Type 2 Diabetes, and Unspecified Pain. The Quarterly Minimum Data set assessment dated [DATE] documented Resident #256 had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Quarterly Minimum Data set documented Resident #256 did not have an upper extremity impairment. The Musculoskeletal Disease Comprehensive Care Plan effective 8/29/2024 documented Resident #256 was diagnosed with gout as evidenced by pain. Interventions included to monitor for pain or swelling of joints, to administer medications as per the medical doctor's orders, and to obtain diagnostic services as per the medical doctor's orders. The Pain Comprehensive Care Plan effective 6/26/2024 documented Resident #256 had the potential for pain. Interventions included to administer medications as per the medical doctor's orders, monitor for effectiveness and side effects, re-evaluate as necessary, and report any redness, pain, or swelling promptly. A Comprehensive Care Plan note dated 8/4/2024 documented Resident #256 complained of pain in their left hand, their index finger appeared slightly swollen, and the resident reported pain to the finger when touched. A Nursing Progress note dated 8/4/2024 documented the resident complained of pain to their left hand. The index finger looked slightly swollen and they had pain when touched. The Medical Doctor and Nurse Practitioner were notified, and an x-ray of the right hand was ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, entered by Registered Nurse #6, dated 8/4/2024 documented an order for an x-ray with three views of the right hand. The Nurse Practitioner's note dated 8/5/2024 documented they saw Resident #256 to assess the left index finger and trace edema (swelling caused by fluid trapped in the body's tissues). The assessment and plan documented inflammatory osteoarthritis (a type of osteoarthritis that is characterized by inflammation and typically affects the middle and last joints of the fingers) and mild gout (a form of arthritis that occurs when high levels of uric acid in the blood cause crystals to form and accumulate in and around a joint). The recommendation was to wait for the x-ray of the left hand. An x-ray report dated 8/5/2024 documented an x-ray of the right hand with three views. The right hand was noted with arthritic changes. There was no documented evidence that the x-ray report was reviewed by the physician or nurse practitioner. Resident #256 was interviewed on 8/26/2024 at 11:21 AM and stated they often had pain in their hands. Resident #256 stated they received acetaminophen (Tylenol-drug used to treat pain) for pain. Resident #256 stated they could not recall how long they had the hand pain and did not recall injuring their hands. Resident #256 stated they were told by a nurse (they did not know the nurse's name) that they had Gout and Arthritis which could cause the pain and they received medication for Gout and acetaminophen for pain. A Nurse Practitioner's note dated 8/28/2024 documented that Resident #256 had a complaint of pain to their left hand. Resident #256 was to continue acetaminophen and have bloodwork to check their uric acid level (an indicator of gout). A second interview was conducted with Resident #256 on 9/4/2024 at 10:30 AM. Resident #256 stated they were having pain in their left hand. Resident #256 stated the index finger on their left hand hurt the most and they could not bend the finger, could not grip anything, or close their hand. Resident #256 stated they asked for and received acetaminophen that morning for their left-hand pain. Licensed Practical Nurse #6 was interviewed on 9/4/2024 at 10:48 AM and stated Resident #256 complained of pain in their left hand and was given acetaminophen that morning 9/4/2024 at about 8:00 AM. Licensed Practical Nurse #6 stated the resident has a physician's order for acetaminophen and Resident #256 would ask for their pain medication when they are experiencing pain. A nursing progress note dated 9/4/2024 documented that Resident #256 complained of pain to the left hand. Tylenol was administered and the nursing supervisor was notified. Orders were placed for an x-ray of the left hand. A Nurse Practitioner's progress note dated 9/4/2024 documented Resident #256 reported pain to their left hand. There was trace edema (swelling caused by fluid trapped in the body's tissues) of #1-#4 digits (the thumb, index finger, middle finger, and the ring finger) of the left hand, no erythema (redness of the skin), and decreased active range of motion (movement using their own muscles) to digits (fingers) at metacarpophalangeal joint (knuckle joint). The Nurse Practioner recommend to obtain an x-ray of the left hand. The Nurse practitioner documented to adding ibuprofen (a nonsteroidal anti-inflammatory drug) 400 milligrams every twelve hours for forty-eight hours and starting Methylprednisone (a steroidal medication used to treat arthritis) in the morning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 9/4/2024 documented the x-ray results of Resident #256's left hand were received and documented left-hand Arthritis. The Nurse Practitioner was notified of the findings. Registered Nurse #6 was interviewed on 9/4/2024 at 12:39 PM and stated they could not recall Resident #256 reporting pain in their left hand on 8/4/2024, whether or not they contacted the Nurse Practitioner, and entered an order for the x-ray of the right hand instead of the left hand. Nurse Practitioner #1 was interviewed on 9/4/2024 at 1:21 PM and stated Resident #256 had chronic pain in their left hand. On 8/4/2024 they gave Registered Nurse #6 a telephone order for an x-ray of the resident's left hand. Nurse Practitioner #1 stated they should have ensured the correct order had been placed when they signed off on the order. Nurse Practitioner #1 stated they did not review the right-hand x-ray report when it was received from the Radiologist because they were not informed of the receipt of the results. Nurse Practitioner #1 stated they are supposed to be notified by unit nurses that a radiology report was received. The Nurse Practitioner stated when they give a telephone order, they expect the order to be transcribed accurately. Nurse Practitioner #1 stated they also expect to be notified of the radiology results when received by the facility staff. The Acting Director of Nursing Services was interviewed on 9/5/2024 at 3:47 PM and stated the Registered Nurse is responsible for entering telephone orders as directed by the Physician or the Nurse Practitioner. The Acting Director of Nursing Services stated the Physician or the Nurse Practitioner was also responsible for ensuring the order's accuracy. The Acting Director of Nursing Services stated the unit nurses are responsible for notifying the Physician or the Nurse Practitioner when x-ray reports are received from the vendor company. The Acting Director of Nursing stated the Physician and the Nurse Practitioner were responsible for following up on the radiology results. 10 NYCRR 415.15(b)(2)(iii)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 9/5/2024, the facility failed to ensure the residents' environment remained free of accident hazards. This was evident at the resident sinks and common shower rooms on all 4 of 4 resident units. Specifically, the facility failed to protect all 114 residents from the likelihood of burns related to excessive hot water temperatures from the facility's domestic hot water system. This resulted in no actual harm with likelihood of serious harm that is Immediate Jeopardy and Substandard Quality of Care to all residents' health and safety. The findings are: 42 CFR 483.470 (d)(3) PART 483-REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES 483.470 Condition of Participation: Physical environment. (d) Standard: Client bathrooms. The facility must ensure: (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 Fahrenheit. NYS Rules and Regulations, Article 2 Medical Facility Construction, Part 713- Standards of Construction for Nursing home facilities, Section 713-1.9- Mechanical requirements, (m) Domestic hot water systems shall provide adequate hot water at each outlet at all times. Hot water temperature at fixtures used by residents shall not exceed one hundred ten degrees Fahrenheit. The facility's policy and procedure for Heating System and Water Temperature last revised in December 2009 documented the tap water in the facility shall be kept within a temperature range to prevent scalding of residents. The water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit or the maximum allowable temperature per state regulation. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. During an on-site visit on 8/27/2024 between 1:00 PM and 4:00 PM following observations were made: At 1:00 PM Surveyor #1, tested the hot water in the bathroom located in the main lobby, by running the water over their hand. After approximately 25-30 seconds, the hot water became so hot the surveyor had to remove their hand. On 8/27/2024 between 1:10 PM to 3:00 PM, Surveyor #2 tested the hot water temperature throughout the facility. The temperature readings were as follows: At 1:10 PM, the water temperature in the bathroom, located in the facility lobby, was measured at 124.3 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	At 1:21 PM, the water temperature in the [NAME] Unit tub/shower room was measured at 127.9 degrees Fahrenheit. At 1:26 PM, the sink water temperature in the [NAME] Unit room [ROOM NUMBER] was measured at 125 degrees Fahrenheit. At 1:35 PM, the water temperature in the East Unit tub/shower room was measured at 124.3 degrees Fahrenheit. At 1:40 PM, the sink water temperature in the East Unit room [ROOM NUMBER] was measured at 124.7 degrees Fahrenheit. At 1:50 PM, the sink water temperature in Unit B room [ROOM NUMBER] was measured at 121.8 degrees Fahrenheit. During an observation and interview of the boiler room on 8/27/2024 at 3:00 PM with the Director of Plant Operations, the mixing valve digital display indicating the water temperature at the mixing valve was set at 130 degrees Fahrenheit. There were two boilers present in the boiler room. The water temperature of the boilers was checked and found to be 165 degrees Fahrenheit. In an immediate interview the Director of Plant Operations stated that the water temperatures at the mixing valve are manually adjusted if the temperature is noted to be too high. The Director of Plant Operations stated the water temperature at the mixing valve usually fluctuates between 115-118 degrees Fahrenheit and should not be set at more than 120 degrees Fahrenheit. During an observation and interview on 8/27/2024 at 3:10 PM, the Director of Plant Operations was observed checking the hot water temperature in the resident rooms on all units. There were mercury thermometers in the resident shower rooms and tub room secured with a string next to the shower faucet. The Director of Plant Operations used an infrared thermometer to measure the hot water temperature collected in a cup. The Infrared thermometer was unable to register the hot water temperature that was taken from the shower in room [ROOM NUMBER]. The Director of Plant Operations stated they would bring a calibrated digital thermometer from the kitchen. In an immediate interview the Director of Plant Operations stated they check the water temperatures daily at 8:00 AM by using the mercury thermometers that are present in the resident shower rooms and the tub rooms. The Director of Plant Operations stated that all resident shower rooms have mercury thermometers which can only read temperatures up to 120 degrees Fahrenheit. The Director of Plant Operations stated the water temperature is only checked for the resident shower rooms and tub rooms. The Director of Plant Operations stated the water temperature was checked on 8/27/2024 at 8:00 AM and was noted to be 115 degrees Fahrenheit. On 8/27/2024 at 3:15 PM, the Director of Plant Operations obtained a digital stem kitchen thermometer and used the thermometer to measure the water temperatures. Four resident rooms were checked between 3:15 PM to 4:00 PM. At 3:40 PM, the water temperature in the East unit room [ROOM NUMBER] shower was measured at 124.5 degrees Fahrenheit. At 3:45 PM, the water temperature in the [NAME] unit room [ROOM NUMBER] shower was measured at 122 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	At 3:55 PM, the sink water temperature in Unit C room [ROOM NUMBER] was measured at 127 degrees Fahrenheit. At 4:00 PM, the sink water temperature in Unit B room [ROOM NUMBER] was measured at 129 degrees Fahrenheit. A review of the Temperature Logs for August 2024 indicated that the water temperature levels were documented at 115 degrees Fahrenheit each day. During an interview on 8/27/2024 at 3:22 PM, Certified Nurse Assistant # 2 stated they provide showers to the residents during the evening shift and use the shower thermometer to test the water temperatures. The thermometer only reads up to 120 degrees Fahrenheit. Certified Nurse Assistant # 2 stated they also use their hand to test the water to make sure it is not too hot and then adjust the water temperature to the residents' preference. During an interview on 8/27/2024 at 3:27 PM, Certified Nurse Assistant #1 stated they usually provide showers to the residents in their rooms. Some bathrooms have thermometers, and some do not. If there is no thermometer available, they test the water temperature by using their hands. Certified Nurse Assistant #1 stated that water temperature above 110 degrees Fahrenheit is considered unsafe. During an interview on 8/27/2024 at 3:35 PM, Certified Nurse Assistant # 4 stated they check the water temperature by using their hand to make sure the water is comfortable for the resident. If the resident wants the water to be hot, they make the water hot. They do not use the thermometer to check the water temperature before showering a resident. During an interview on 8/27/2024 at 3:37 PM, Certified Nurse Assistant #3 stated they do not use the thermometer to check the water temperature before they shower a resident. They usually put the resident's feet in the water first to see if the resident is comfortable with the water temperature. Certified Nurse Assistant #3 stated for showers, safe water temperature should be between 70-89 degrees Fahrenheit. During an interview on 8/27/2024 at 3:28 PM, Certified Nurse Assistant # 5 stated they first check the water with their hands to make sure it is not too hot and then they use the thermometer to measure the water temperature before showering a resident. The water temperature should not be over 100 degrees Fahrenheit. If the water temperature is above 100 degrees Fahrenheit, they notify the charge nurse. During an interview on 8/27/2024 at 4:58 PM, the Administrator stated they were recently hired and were unaware of any unsafe hot water temperature issues at the facility. The Administrator stated water temperature above 120 degrees Fahrenheit is unsafe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	During an interview on 8/28/2024 at 11:40 AM, the Director of Nursing Services (DNS) stated there were no reported burn injuries. The Director of Nursing Services stated the staff should run the water prior to showering a resident to ensure water temperatures are between 100 to 120 degrees Fahrenheit. The staff should check the temperature by using the thermometers that are available in the shower rooms. The Director of Nursing Services stated they did not know the thermometers that were in the shower rooms and the tub room could only measure temperature levels up to 120 degrees Fahrenheit. The Director of Nursing Services stated water temperatures above 120 degrees Fahrenheit would put residents at risk for burns. During an interview on 8/28/2024 at 11:55 AM, the Medical Director stated excessive hot water temperatures would increase the risk of burns to the residents, especially residents with certain medical conditions such as Neuropathy or other sensory issues. The Medical Director stated the water temperatures should be maintained below 120 degrees Fahrenheit. During an interview on 8/28/2024 at 5:00 PM, the Administrator stated they were unaware that the unsafe hot water temperature regulation was changed from 120 degrees Fahrenheit to 110 degrees Fahrenheit. The Administrator stated the facility policy and procedures did not match the regulatory requirements and would be changed to reflect the new regulations. 10 NYCRR 415.12(h)(l). The facility was notified of the Immediate Jeopardy on 8/28/2024. The Immediate Jeopardy was removed on 8/30/2024 prior to the completion of the survey. The facility implemented the following to remove the immediacy: -The facility revised the Water Temperature policy, and the procedure was updated to reflect the date, time, location, and intervention applicable. All Maintenance staff were re-in serviced on the usage of the new water temperature log sheet. - A full house audit of all residents was completed by the facility for the potential to be affected by this deficient practice, no issues were identified (8/28/2024). - Water Temperature in each resident room was tested and water temperature logs dated 8/28/2024 through 8/30/2024 were presented to the survey team by the facility with no negative findings. - The survey team interviewed 18 staff members from various disciplines and various shifts (including all 4 maintenance staff). All staff demonstrated knowledge of the new/revised policy related to Water Temperature. The facility provided in-service education to 99 % staff: Rehabilitation: 99%; Recreation- 100%; Maintenance/Housekeeping; 100%, Administration; 100%; Nursing- 99%; and Dietary- 100%

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on record review and interviews the facility did not ensure that each resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable weight range, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. This was evident for one (Resident #79) of four residents reviewed for Nutrition. Specifically, Resident #79 was admitted to the facility on [DATE] and was receiving tube feeding via enteral means. The facility did not obtain and monitor the resident's weight since the resident was admitted to the facility. The finding is: A facility policy titled Weight and Weight Changes last updated in March 2024, documented to obtain weights on all residents as per the medical doctors' orders. All residents will be weighed within 72 hours of admission and/or readmission to the facility. The resident's weight is rechecked on two consecutive days for accuracy and to verify initial weight; and then weekly for the next four weeks to establish a baseline. Thereafter, monthly weights will be obtained unless otherwise indicated by the Physician, Nurses, or Dietitian. Resident #79 had diagnoses of Malnutrition, Cerebral Vascular Accident, and Quadriplegia. An Admission Minimum Data Set assessment dated [DATE] documented Resident #79 had a Brief Interview for Mental Status score of 9, which indicated the resident had moderate cognitive impairment. Resident #79 had no behaviors or refusal of care and was dependent on staff for Activities of Daily Living. The Minimum Data Set indicated the resident had an active diagnosis of Malnutrition (protein or calorie) or was at risk for Malnutrition. The resident's height was 74 inches, and the weight was 172 pounds. Resident #79 was fed via the enteral (tube feeding) route. A comprehensive care plan titled Nutritional Status, effective 8/2/2024 documented the resident had nutritional deficiency and was on gastrostomy tube feeding. The interventions included aspiration precautions, to monitor laboratory values as per physician's orders, and to monitor the resident's weight: weekly for four weeks and as needed. The Physician's orders included multiple orders for obtaining Resident #79's weight: The admission physician's order dated 8/2/2024 documented: weight upon admission, daily weight for three days, and then weekly weight every Tuesday for four weeks. The Initial Nutrition Assessment completed on 8/3/2024 documented that the resident's current weight per hospital records was 172 pounds. A request for admission weight was made. The resident received enteral feeding as their primary source of nutrition and hydration and was at risk for malnutrition related to dependence on tube feeding related to dysphagia and a wound. Resident #79 received 1350 milliliters of Jevity 1.5 (a high-fiber tube feeding formula). The physician's order dated 8/8/2024 documented: a one-time weight. The physician's order dated 8/11/2024 documented: a one-time weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 8/12/2024 documented: a one-time weight. The physician's order dated 8/15/2024 documented: a one-time weight. The physician's order dated 8/21/2024 documented: a one-time weight. The physician's order dated 8/25/2024 documented: a one-time weight. A review of the medical record from 8/2/2024 to 8/27/2024 lacked documented evidence that the resident's weights were obtained as per the physician's orders. Resident #79 was transferred to the hospital on 8/28/2024 at 6:00 PM for evaluation for bleeding around urinary catheter insertion. Licensed Practical Nurse #1 was interviewed on 9/3/2024 at 2:03 PM and stated that the Certified Nursing Assistants are responsible for obtaining the resident's weights. The Certified Nursing Assistant should then verbally tell the Nurse the weight, and the Nurse should enter the information into the medical record. Licensed Practical Nurse #1 stated that for a new admission, the weight is taken on admission and then weekly. Licensed Practical Nurse #1 was not aware that Resident #79's weight was not obtained. Registered Dietitian #1 was interviewed on 9/3/2024 at 2:08 PM and stated that nursing staff is responsible for obtaining the resident's weights on admission and then daily for three days. The Dietitian will enter one-time orders for weights when additional weights are needed. When the resident's weights are missing, it is discussed in the morning meeting, and directly with the unit nurse and the nursing supervisors. Registered Dietitian #1 further stated that several attempts were made to alert the nursing staff to provide weights for Resident #79; however, the weights were never obtained. The Registered Nurse Supervisor was interviewed on 9/4/2024 at 1:05 PM and stated during the morning meeting they instructed the staff to obtain the residents' weights and the unit charge nurse also should have indicated the need for the resident's weights on the certified nursing assistant assignment sheet. They further stated that every nurse needs to make sure that the weights are completed. The Registered Nurse Supervisor was not aware that Resident #79's weights were not obtained. The Acting Director of Nursing Services was interviewed on 9/5/2024 at 10:50 AM and stated the unit nurses should have made sure that Resident #79's weights were obtained as per the physician's orders and if the weights were not obtained a note should have been written to explain why the weights were not obtained. The Acting Director of Nursing Services stated Ultimately, it is everyone's responsibility to ensure that the weights are taken. 10 NYCRR 415.12 (i)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44925 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 9/5/2024, the facility did not ensure that all drugs and biologicals were labeled in accordance with currently accepted professional principles. This was identified for three (Unit B, Unit C, and East Unit) of four units observed during the Medication Storage Task. Specifically, loose unidentifiable medications were observed in a medication cart for Unit B, East Unit, and Unit C. Additionally, the medication carts were utilized for storing items other than the medications. The findings are: The Medication Rooms/Areas Policy dated 6/1/2009 and last reviewed in February 2023 documented to assure that the medication room/area contains only drugs, biological or other items needed for the administration of medication. The Medication cart policy dated 6/1/2024 and last updated February 2023 documented that all medication carts will be maintained with adequate supplies, in a state of cleanliness, and will be appropriately safeguarded to assure the safety of the residents. The Unit B medication cart was observed on 8/26/2024 at 11:06 AM, in the presence of Licensed Practical Nurse #3. There were seven unidentified loose medications including capsules and tablets on the base of the second drawer of the medication cart. Licensed Practical Nurse #3 was interviewed on 8/26/2024 at 11:06 AM and stated they were not aware that the cart had loose pills and capsules. Licensed Practical Nurse #3 stated there should not be any unidentified loose pills in the cart. The East Unit medication cart was observed on 8/26/2024 at 11:25 AM, in the presence of Licensed Practical Nurse #4. There were 18 unidentified loose medications including capsules and tablets on the base of the second and third drawer of the medication cart. Licensed Practical Nurse #4 stated they did not know there were loose medications tablets and capsules in the medication cart and it was not okay to have the loose medications on the medication carts. The Unit C medication cart was observed on 8/26/2024 at 11:31 AM, in the presence of Licensed Practical Nurse #5. There were two unidentified loose medication tablets at the base of the second drawer. Additionally, a large nail clipper which was not kept in a separate bag was stored in the medication cart. Licensed Practical Nurse#5 was interviewed immediately after the observation on 8/26/2024 and stated they did not know who placed the nail clipper in the medication cart, but it should not be there because it is not a medication. Licensed Practical Nurse #5 stated the medication cart should not have loose medications in it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing Services was interviewed on 9/5/2024 at 12:52 PM and stated it was not acceptable to have loose medications and nail clippers in the medication cart. 10 NYCRR 415.18(e)(1-4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45349 Based on observations, record review, and interviews conducted during the Recertification Survey, initiated on 8/26/2024 and completed on 9/5/2024, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was identified during the Kitchen Task. Specifically, 1) an opened, undated package of cod fish and pancakes was observed in a single-door refrigerator. In the dry storage area, four packages of opened and undated dry cereals were observed 2) Dietary Aide #1 was observed licking their fingers and then setting up napkins and utensils on resident trays without performing hand hygiene. 3) A chicken salad sandwich temperature was not maintained within the acceptable temperature range for food safety. The findings are: A facility policy titled Label & Date Food, last reviewed on 8/29/2024, documented that the marking of the date of preparation and or opening of the food is required. Food that is not readily identifiable is to be stored in properly labeled original product containers or in containers labeled to identify the food by common name. Food removed from the original container or package is to be protected from contamination by storing the items in a clean, covered, sanitized container and maintained at safe temperatures. Unused, unprotected food of any kind may not be served again. A facility policy titled General Hazard Analysis and Critical Control Points (HACCP) Guidelines for Food Safety, dated 2010, documented that staff must be educated and supervised on all Hazard Analysis and Critical Control Points information and procedures. The Temperature Danger Zone (TDZ): Food must be held greater than 135 degrees Fahrenheit or less than 41 degrees Fahrenheit. A facility policy titled Hand Washing, dated 11/27/2000, last reviewed 8/29/2024 documented that all employees will ensure hands are clean by using the proper hand washing technique. At a minimum, this technique should be done when arriving for work, before and after handling food, before and after cleaning any equipment, when changing any job in the Nutritional Services Department, after eating, after smoking, after sneezing, after coughing, after using the bathroom, and when leaving for the day. 1) During the initial tour of the kitchen conducted on 8/26/2024 at 10:38 AM with the Food Service Director, the single-door freezer was observed with a bag of unidentified food items and a bag of pancakes with no date or a label. The unidentified bag of food, according to the Food Service Director, was cod fish. The dry storage room was observed with an open, unlabeled, and undated bag of rice crispy, cheerios, and cornflakes that were not stored in a tightly sealed container as instructed in the policy and procedure for food storage. There were also four pouches of tuna, four pouches of salmon, six bottles of ketchup, five bottles of relish, and six bottles of grape jelly observed removed from their original packaging, without a delivery date in the dry storage area. 2. During the initial tour of the kitchen conducted on 8/26/2024 at 10:46 AM with the Food Service Director, Dietary Aide #1 was observed licking their fingers and then continuing to pull napkins and other condiments to set up resident trays for the lunch meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary Aide #1 was interviewed immediately after the observation on 8/26/2024 and stated they did not realize that they had licked their fingers as they were preparing the tray. Dietary Aide #1 stated they should have performed hand hygiene after licking their fingers and before returning to setting up the resident meal trays. The Food Service Director was also interviewed immediately after the observation on 8/26/2024 and acknowledged that Dietary Aide #1 was licking their fingers while preparing the meal tray. The Food Service Director stated that Dietary Aide #1 should have performed hand hygiene. 3. During the follow-up tour of the kitchen conducted on 8/28/2024 at 11:41 AM with the Food Service Director, the [NAME] was observed making a chicken salad sandwich; however, the chicken salad was not chilled in an ice bath. The [NAME] was interviewed immediately after the observation on 8/28/2024 and stated they usually refrigerate the sandwiches prior to the start of the lunch meal service/tray-line; however, on this day they were running late and there was not enough time to chill the sandwiches to a proper temperature. The [NAME] stated that the temperature of the sandwich should not be above 41 degrees Fahrenheit. The temperature of a sandwich was taken and measured at 75 degrees Fahrenheit. The Food Service Director was interviewed on 8/28/2024 at 11:44 AM and stated that the chicken salad sandwich temperature of 75 degrees Fahrenheit was in the danger zone. The cook should have chilled the chicken salad in an ice bath. 10 NYCRR 415.14(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335274	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Simeon by the Sound Center for Nursing & Rehab	61700 Route 48 Greenport, NY 11944

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 17585 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 9/5/2024, the facility did not maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This was identified for one (West Unit) of four Units during the infection control task. Specifically, the facility did not ensure staff appropriately discarded dirty linens in a sanitary manner and did not timely change suction canister and tubing after use. The findings are: The facility's Policy and Procedure titled, Infection Prevention and Control last reviewed January 2023, documented that an Infection Control Program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Important facets of infection prevention include educating staff and ensuring they adhere to proper techniques and procedures. The facility's policy for Suction Equipment revised on 6/1/2009, documented that all suction equipment will be cleansed after each use to reduce the possibility of contamination. Procedures include: Licensed Nursing Staff will disinfect a suction bottle or machine by wiping down the suction machine after each use and at the end of each shift; discarding the disposable suction bottle at the end of each shift; replacing the tubing on the suction bottle once each week; and replacing suction tubing between residents. According to the Centers for Disease Control and Prevention's Core Infection Prevention and Control Practices for best practices for linen (and laundry) handling found online at https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html, documented: - Always wear reusable rubber gloves before handling soiled linen (e.g., bed sheets, towels, curtains). - Never carry soiled linen against the body. Always place the soiled linen in the designated container. - Carefully roll up soiled linen to prevent contamination of the air, surfaces, and cleaning staff. Do not shake linen. - If there is any solid excrement on the linen, such as feces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container. -Place soiled linen into a clearly labeled, leak-proof container (e.g., bag, bucket) in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) During an observation on the [NAME] Unit, on 8/26/2024 at 11:17 AM, Licensed Practical Nurse #2 was observed walking out of a resident room. The resident's room was identified by signage as being under Enhanced Barrier Precautions. Licensed Practical Nurse #2 was wearing gloves and was transporting the used linen to the dirty linen cart. The linen was not secured in a sealed bag and was observed touching Licensed Practical Nurse #2's uniform. Licensed Practical Nurse #2 was interviewed immediately after the observation on 8/26/2024 and stated I know I am not supposed to carry dirty linen without a plastic bag, but there were no plastic bags in the room. 2) On 8/26/2024 at 12:45 PM during the lunch meal observation, the [NAME] Unit dining room was observed to have a dirty suction canister that contained cloudy fluid with food particles and used suction tubing attached to the suction machine. Registered Nurse Supervisor #2 was interviewed immediately after the observation on 8/26/2024 and stated the suction machine was not used today. The canister and tubing should have been replaced after every use. Registered Nurse Supervisor #2 stated they were supposed to check the suction machine before each meal but they did not check the suction machine before today's lunch meal. The Infection Control Registered Nurse was interviewed on 9/04/2024 at 12:16 PM and stated the suction machine should be checked every night by the night shift staff. When the suction machine is used, the nurse should change the canister and the suction tubing after each use. The suction machine should be ready at meal times, in the event there is an emergency. The Infection Control Registered Nurse also stated all dirty linens should be sealed in a plastic bag and placed in the dirty linen cart. If there was no plastic bag available, the nurse should have called someone to bring the plastic bag to the room. 10 NYCRR 415.19 (a) (1-3)(c)