STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335320	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sprain Brook Manor Rehab	77 Jackson Ave Scarsdale, NY 10583

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45478 Based on observation, record review and interview conducted during a recertification survey, the facility did not ensure for 1 of 1 resident (Resident #95) reviewed for dignity that care was provided in a manner to maintain dignity. Specifically, Resident #95's urinary (Foley) catheter tubing and drainage collection bag were not concealed to prevent direct observation by other residents and their families to maintain dignity and privacy. The findings are: Resident #95 had diagnoses and conditions including subdural hemorrhage, hemiplegia, and urinary retention. The Significant Change Minimum Data Set (MDS; a resident assessment and screening tool) dated 4/1/24 documented Resident #95 had moderately impaired cognition; and had an indwelling urinary catheter in place. On 5/07/24 at 9:55 AM Resident #95 was observed lying in bed with catheter bag laying in the bed next to him with no privacy bag over it and was visible hallway. On 5/07/24 at 11:58 AM Resident #95 was observed in wheelchair in room waiting for lunch, catheter bag attached to their wheelchair, no privacy bag over it and was visible from hallway. The Urinary Catheter Care Plan last revised 3/23/24 had no documented evidence of any intervention to provide a privacy bag over the catheter bag. When interviewed on 5/10/24 at 1:47 PM, Staff #4 (certified nurse aide) stated they were the resident's assigned certified nurse aide on 5/7/24. Staff #4 acknowledged they did not put the a privacy bag over the catheter bag and stated they were now aware they need to put the privacy bag over the catheter bag. 10 NYCRR 415.5 (a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Sprain Brook Manor Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 77 Jackson Ave Scarsdale, NY 10583	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45478 Based on observations, record review and interviews, during the recertification survey conducted from 5/7/24 to 5/14/24, the facility did not ensure that the Comprehensive Care Plans (CCP) were reviewed and revised in a timely manner for 2 of 4 residents reviewed for accidents. Specifically, (1) Resident #7 had an unwitnessed fall on 3/9/24 and the Fall Care Plan was not updated to reflect new interventions to prevent a fall; (2) Resident #215 had an unwitnessed fall on 4/18/24 and the Fall Care Plan was not updated to reflect new interventions to prevent a fall. The findings are: 1. Resident #7 was admitted to the facility 11/26/23 with a diagnoses including cancer, congestive heart failure, diabetes and lack of coordination. The Quarterly Minimum Data Set (MDS; a resident assessment tool) dated 3/3/24, documented the resident's cognition was moderately impaired. It further documented the resident was dependent on staff for transfers and the resident had a fall without injury since admission or reentry. The Fall/Injury Care Plan created 11/26/23, documented the resident fell in the last 31-180 days, date: 1/1/24 and 3/9/24. The interventions included the following: Anticipate needs of resident; encourage resident to seek assistance as needed; maintain safe environment free of any hazards; monitor activities of resident; and physical therapy evaluation for transfer/ambulation status as needed. There was no further documented evidence the Fall/Injury Care plan was revised with new interventions after the falls on 1/1/24 and 3/9/24. According to facility Accident/Incident Reports, Resident #7 had an unwitnessed fall with injury on 3/9/24. The corrective action was to monitor resident's activity and visual monitoring every hour. Hospital Discharge Papers dated 3/11/24 documented the resident was admitted for fall and an x-ray showed a left tibia (lower leg) fracture, a splint was placed. When interviewed on 5/13/24 at 2:30 PM, Staff #6 (Registered Nurse) stated they were supervising the night of the incident. Staff #6 stated after a fall they update care plan and do an Accident and Incident Report. Staff #6 stated the interventions on the care plan needed to correlate with the date of the fall when updating. Staff #6 reviewed the care plan with the surveyor and acknowledged there were no new interventions put in place following each fall and had no explanation as to why. When interviewed on 5/13/24 at 2:49 PM, the Director of Nursing stated it was the practice of the facility to just update the monitoring notes and progress notes and have tried to reeducate the nurses on proper way to update the care plans with new interventions following a fall or incident. The Director of Nursing stated they recently provided education to the nurses about updating the interventions on the care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #215 admitted to facility 2/25/22 with diagnoses of cerebrovascular accident, diabetes, and other lack of coordination. The Admission Minimum Data Set (MDS; a resident assessment tool) dated 2/12/24 noted the resident had a BIMS (Brief Interview for Mental Status; a test used to measure memory, recall and orientation) score of 13 indicating that the resident had modified independence in cognition and it further documented Resident #215 was dependent in transfer and had 1 fall in the last month and had a fall within the last 2-6 months. The Fall/Injury Care Plan created 9/20/23 documented the resident fell in past 30 days (4/18/24); and had a history of falls on 8/8/23 and 10/4/23. The interventions included the following: Anticipate needs of resident; encourage resident to seek assistance as needed; keep personal items within reach; maintain safe environment free of any hazards; make sure assistive devices are in good working condition; monitor activities of resident; and physical therapy evaluation for transfer/ambulation status as needed. There was no further documented evidence the Fall/Injury Care Plan was revised with new interventions following the fall on 4/18/24. When interviewed on 5/13/24 at 3:43 PM, Staff #2 (Registered Nurse) stated they had to update the care plans following a fall. Staff #2 stated the supervisor updated the care plans, and they completed the incident report and assessed the resident. While reviewing the electronic medical record with the surveyor, Staff #2 stated they were the person who updated the monitoring note in the resident's care plan and stated they did not put in any new interventions. When interviewed on 5/13/24 at 4:06 PM, Staff #7 (Registered Nurse) stated after a fall they did an assessment and updated care plans. Staff #7 reviewed the care plan and stated they did not update the care plan with new interventions, and they just wrote a monitoring note. 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 49255

Based on observation record review and interviews during the recertification survey conducted from 5/7/24 to 5/14/24, the facility did not ensure treatment and care were provided in accordance with professional standards to meet the needs of one of three residents (Resident #55) reviewed for skin conditions. Specifically, for Resident #55 skin impairments were not identified or reported.

The findings include:

The facility policy for Certified Nurse Aide Competency Checklist: Bed Bath policy, effective November 2023, documented Certified Nurse Aides check, clean and clip nails as necessary, and document on Certified Nurse Aide accountability record; and note any reddened or broken skin areas to a nurse.

Resident #55 had diagnoses including history of cerebral infarction (stroke), local infection of the skin and subcutaneous tissue, and adult failure to thrive.

The Minimum Data Set quarterly assessment dated [DATE] documented the resident had severely impaired cognition and was dependent on staff for all activities of daily living.

The Resident Nursing Instructions (instructions for direct care staff), dated 12/8/22, documented weekly skin check every Monday and as needed; and to apply Vitamin A&D ointment to bilateral upper extremities and lower extremities every shift and as needed during care as skin protectant.

The comprehensive care plan, updated on 4/8/23, documented Skin Integrity-Impaired related to skin fragility. Interventions included to monitor skin during daily care and provide protective/preventive skin care.

The record review of Nursing Progress notes from 01/01/2024 to 05/12/2024 did not document any issues regarding the resident's skin condition.

Review of the February 2024 through May 13, 2024 Treatment Administration Record revealed that no skin treatment was administered.

The Certified Nurse Aide documentation, dated 3/20/24 to 5/14/24, documented Skin Check/ Care was signed for as performed every shift.

During an observation on 05/08/24 at 10:51 AM, Resident #55 was in bed with their legs uncovered. The resident had a dry skin, the left knee had excoriated (scraped) areas and scratch marks, the left anterior foot had dry scabs, the right shin had scratch marks, and the right ankle had dry scabs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/13/24 at 04:39 PM, the resident was in bed with their legs uncovered. Staff #8 (Register Nurse) looked at the resident's legs and stated they were not aware of the scratch marks and excoriated area. Staff #8 stated the skin looked very dry and it looked as if the resident had long nails and scratched themselves. Staff #8 said that currently they did not have orders to apply anything to the resident's skin. They said the Certified Nurse Aide was responsible for keeping the resident's nails short by filing them and they expected to be informed of skin impairments. Following the interview with the nurse in the resident's room the conversation continued at the nursing station in front of the computer where the nurse was asked to show a record on skin assessment. The only report Staff #8 was able to find was the nursing admission skin assessment dated [DATE]. During an interview on 05/14/24 at 11:36 AM Staff #9 (Certified Nurse Aide) stated that the nurses clipped and filed nails for the residents. Staff #9 stated filing the resident's naifs was not on their task assignment. During an interview on 05/14/24 at 12:47 PM, the Director of Nursing stated that Certified Nurse Aides clipped and filed residents' nails, as well as check the residents skin condition and report to a nurse any abnormal findings. They stated the task was in the policy for Skin Care and on the Resident Nursing Instructions which showed their assignments, and the Certified Nurse Aides documented in the Certified Nurse Aide Documentation. 10 NYCRR 415.12

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673 Based on observation, record review and interviews during the recertification and abbreviated surveys (NY00328628) conducted from 5/7/24 to 5/14/24, the facility did not ensure residents were provided timely dental services for one of one resident (Resident #13) reviewed for dental services. Specifically, Resident #13's dentures were discovered lost on 6/28/2023, and the resident did not get their dentures replaced until 12/6/2023, six months later. The findings include: Resident #13 had diagnoses including diabetes, dysphagia (difficulty swallowing), and hepatocellular carcinoma (liver cancer). The Minimum Data Set (MDS) dated [DATE] documented the resident had moderately impaired cognition, and required minimal assistance with eating and oral hygiene. The Comprehensive Care Plan for Potential Oral Dental Problems, last dated 10/29/2022, documented interventions for a dental consult annually as needed, and ensuring dentures were worn daily. A Complaint Investigation form, dated 6/28/2023, documented Resident #13's family member reported the resident's dentures were missing. A search was conducted and the dentures were not found. The corrective actions was the facility would pay for the resident's dentures and the form was signed off on 7/3/24 A Speech-language pathologist progress note dated 7/6/2023 documented the resident's upper dentures was missing and caused difficulty masticating (chewing). New recommendations were made to change from a regular-consistency solids to a chopped diet. A Registered Dietician progress note dated 9/19/2023 documented the resident had a significant undesirable weight loss possibly secondary to loss of dentures. Replacement dentures were in the works, with food texture modifications in place and tolerating well. Review of dental progress notes documented the resident was seen: - on 10/6/23 for bite registration (taking an impression of the teeth). - on 10/30/23 for try-on and retook bite. - on 12/6/23 the denture was delivered. There were no dental progress between the date of the complaint, 6/28/23, until the resident was seen on 10/6/23. During observations on 5/7/2024 at noon, 5/9/2024 at 8:00 AM, and 5/9/2024 at 12:15 PM, Resident # 13 had their dentures in place and ate a chopped diet unassisted. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 9:13 AM, the resident family member stated that the resident's dentures had been lost twice while at the faciity and the last time it took a long time to replace them. During an interview on 5/14/2024 at 9:00 AM, Staff #2 (Registered Nurse Unit Manager) stated they did not remember why it took so long for the resident's dentures to be made. They stated they made a consult sometime in July 2023 and notified the dental office. During an interview on 5/14/2024 at 9:22 AM, the Registered dietician stated that it took about six months for the resident to finally receive the dentures because there were several fittings, and the resident had many complaints. The resident did not lose weight because his diet was downgraded, and supplements were added. During an interview on 5/14/2024 at 9:34 AM, the Director of Nursing stated it took six months because there were many fittings. During an interview on 5/13/2024 at 1:00 PM, the dentist stated this was the second set of dentures, and sometimes they waited for one month to see if the dentures showed up. The dentist stated it usually takes 2-3 months for residents to get dentures and it should not take six months. 10 NYCRR 415.17

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observations and interviews during the recertification survey conducted from [DATE] to [DATE], the facility did not ensure food was stored in accordance with professional standards for food safety practice. Specifically, 1) opened perishable food was not covered properly; and 2) expired food was not discarded. The findings are: The facility policy and procedure titled Food Storage Policy, last revised ,d+[DATE], documented that all food will be stored in the refrigeration units either wrapped or in closed storage containers and be clearly dated and labeled. All expired food items will be discarded. The initial tour of the kitchen on [DATE] at 09:21 AM was conducted with the Dietary Supervisor. The following were observed: 1. In the freezer for meat products, there were two cardboard boxes of frozen vegetables on the shelf with inner plastic wrap that was opened and frozen vegetables were exposed to the air, the boxes were dated [DATE]. 2. In the dry storage room, there was a box of [NAME] Honey Dijon sauce with an expiration date [DATE]. During an interview on [DATE] at 10:02 AM the Dietary Supervisor stated that all boxes need to be kept closed with inner plastic wrap between uses of the product. The Dietary Supervisor also stated the box of Honey Dijon sauce had small print for the expiration date, and was overlooked. 10 NYCRR 415.14 (h)