STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335342	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Westchester Restorative Therapy & Nrsg Crt	3550 Lexington Avenue Mohegan Lake, NY 10547

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49255 Based on observation, record review and interview during the recertification survey from 7/31/24 to 8/7/24, the facility did not ensure that oxygen equipment was maintained in accordance with professional standards of practice and manufacturer specifications for 1 of 4 residents (Resident #308) reviewed for respiratory care. Specifically, the oxygen concentrator filter was not removed and cleaned on a weekly basis, according to the physician's order and the maintenance policy. Findings include: The 1/30/23 facility policy and procedure titled Oxygen Concentrator documented oxygen concentrator cabin filter will be removed and washed weekly. Resident #308 had diagnoses which included Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, and Generalized Anxiety. The 5/31/24 physician order documented wash oxygen concentrator filter with soap and water every week on Sunday 11 PM-7 AM. The 7/11/24 Quarterly Minimum Data Set (resident assessment tool) documented Resident #308 received oxygen therapy. During the observation on 8/5/24 at 9:52 AM of Resident #308's room accompanied by Licensed Practical Nurse #13, the nurse opened the oxygen concentrator filter to observe the cleanliness of the filter. The filter and the area around the filter were heavily dusted. The surveyor asked the nurse how often the filters were cleaned and who was responsible for cleaning the oxygen concentrator filters. Licensed Practical Nurse # 13 stated that the filters needed to be washed with soap and water every Sunday by the night nurse. Licensed Practical Nurse #13 stated that the filter was extremely dusty and did not look like it had been cleaned the night before. When interviewed on 08/05/24 at 2:14 PM, Licensed Practical Nurse #14 stated that during their night shift they passed medication to the resident and changed the oxygen tubing for the oxygen concentrator, but forgot to wash the filter. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 08/07/24 at 3:56 PM the Director of Nursing stated that the filter for the oxygen concentrator had to be washed with soap and water every Sunday 11PM-7 AM. The Director of Nursing stated that if this task was missed or not performed timely, the filter would collect debris and could affect the resident's health. The Director of Nursing stated nurses were educated and knew they had to take timely care of the oxygen concentrator filters. 10 NYCRR 415.12 (k) (6)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 7/31/24 to 8/07/24, the facility did not ensure for 1 (Residents #48) of 1 residents reviewed for Pharmacy Services and 1 of 4 residents (Resident #261) reviewed for Drugs/Medications, that they provided medications and/or biologicals, as ordered by the prescriber, to meet the needs of the resident. Specifically, 1. Resident #48 had requested Hydromorphone(Dilaudid) on 7/30/24 and it was not given due to being unavailable from the pharmacy and 2. Resident #261 was not given Jardiance (medication used to lower blood sugar levels in people with Type 2 Diabetes Mellitus) on 7/27/24 due to being unavailable from the pharmacy. The findings are: The facility policy titled Medication Administration-General dated 12/2018 documented that medications were to be administered to resident/s in a timely and accurate manner. 1. Resident #48 was admitted with the following diagnoses including chronic pain, polyneuropathy, stage 3 and 4 pressure ulcers of the sacral region, and a stage 3 pressure of the right lower back. The 7/8/24 Quarterly Minimum Data Set Assessment documented that Resident #48 was cognitively intact, had frequent pain, received scheduled and as needed pain medications, and received opioids. The 7/18/24 Physicians order documented Hydromorphone (Dilaudid) 4 mg tablet by oral route, every 4 hours as needed. The 7/2/24 Care Plan titled Pain documented history of chronic pain, multiple wounds, decreased mobility as evidenced by change in gait or behavior, eating poorly, vocal complaints of pain and nonverbal sounds. Interventions included assess nature, intensity, location, duration, and frequency of pain, and offer as needed medications as ordered. The 7/24/24 care plan note documented Resident #48 was seen by psychiatry and Dilaudid 4 mg every 4 hours as needed for severe pain only should be continued. The Controlled drug record for Resident #48 documented Hydromorphone (Dilaudid) 4 mg tablet (quantity 90) was delivered to the facility on [DATE], and the last dose was given on 7/29/24, and not reordered until 7/30/24. During an interview on 08/05/24 at 09:40 AM, the Director of Nursing stated that medications should never run out and that Hydromorphone (Dilaudid) was not in the Pyxis. The Director of Nursing stated that if a medication ran out, specifically controlled medications, the nurses must call the physician for a new prescription, timely to ensure the resident received the next dose. During an interview on 08/05/24 at 02:51 PM, the Pharmacy Director stated that the medication was never on backorder and should have been ordered a few days prior to running out to ensure prompt delivery. The Pharmacy Director stated that the medication Hydromorphone (Dilaudid) for Resident #48 was ordered and had not been delivered until the night of 7/30/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/24 at 04:33 PM, the Medical Doctor stated residents should never run out of medications and should be ordered timely from the pharmacy, and that they must be called in advance(3-4 days) of the resident running out of medications so that resident does not miss a dose or doses because of unavailability. The Medical Doctor stated that Licensed Practical Nurse #11 texted them on 7/29/24 at 10:32 PM to request a refill on Resident #48's Hydromorphone (Dilaudid) and that they did not reorder the medication because they were already in the bed. The Medical Director stated that the Nurse Practitioner reordered the medication the next day. 2. Resident #261 was admitted with diagnosis including but not limited to diabetes mellitus type 2, encephalopathy, and stage 4 chronic kidney disease. The 7/10/24 Physician Order documented Jardiance 10 mg by oral route, once daily, for Type 2 diabetes mellitus with hyperglycemia. The 7/15/24 Care Plan titled Diabetes documented that Resident #261 was at risk for hypoglycemia and hyperglycemia. The 7/17/24 Admission Minimum Data Set Assessment documented that Resident #261 had intact cognition. The July 2024 Medication Administration Record documented Resident #261 did not receive Jardiance 10 mg tab on 7/27/24, the medication was not available. During an interview on 07/31/24 at 12:22 PM, Resident #261 stated they had an issue with a nurse on Saturday (7/27/24) because their medicine (Jardiance) was not available and when they asked the nurse about it, the nurse told them that they did not have it and did not come back to the room. During an interview on 08/05/24 at 04:33 PM, the Medical Doctor stated they were not made aware that Resident #261 ran out of Jardiance, The Medical Doctor stated the nurses could have electronically reordered the medication a few days in advance to prevent the resident from missing a dose. During an interview on 08/06/24 at 08:46 AM, Registered Nurse Supervisor #6 stated they were scheduled to supervise on 7/27/24, and the medication cart was missing a lot of medications. Registered Nurse Supervisor #6 stated they could not remember if Resident #261 received Jardiance on that date or if they notified the physician that the medication was unavailable. During an interview on 08/06/24 at 08:55 AM, the Director of Nursing stated Resident #261 was unable to receive the Jardiance dose because it had been reordered on 7/27/24, and was not delivered until late in the evening on 7/27/24. During a follow up interview on 08/06/24 at 10:00 AM, the Director of Nursing stated they spoke with the pharmacy and that due to insurance, the pharmacy only sent 14 days of Jardiance. The Director of Nursing stated that was all the more reason the nurses should reorder the medication timely. The Director of Nursing stated the physician should have been notified that the Jardiance was not available for administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/24 at 10:31 AM, the Pharmacy Director stated that only 14 days of Jardiance was delivered to the facility for Resident #261 because the insurance would only cover 14 days at a time because of the brand name. The Pharmacy Director stated the facility must reorder medications timely. The Pharmacy Director stated the medication was first ordered on 7/10/24, and again on 7/27/24 at 3:41 PM. The Pharmacy Director stated the Jardiance was delivered to the facility on [DATE] at 10 PM . The Pharmacy Director stated the Jardiance should have been reordered by 7/24/24 to ensure timely delivery During an interview 08/06/24 at 01:35 PM. Licensed Practical Nurse #15 stated they worked on 7/26/24 and when they gave the last dose of Jardiance to Resident #261, they reordered the medication the same day. Licensed Practical Nurse #15 stated that it should have been reordered a few days ahead of time, but they were not working with Resident #261 prior to 7/26/24. Licensed Practical Nurse #15 stated the pharmacy was far away and sometimes it took a while for medications to be delivered. 10 NYCRR 415.18(a) Based on observation, record review, and interview conducted during the Recertification Survey from 7/31/24 to 8/07/24, the facility did not ensure residents were free of significant medication errors for 1 of 4 residents (Resident #261) reviewed for medications. Specifically, Resident #261 did not receive Jardiance(medication used to lower blood sugar levels in people with Type 2 Diabetes Mellitus) as per physician order due to the medication not being available. Additionally, there was no documented evidence indicating the physician was notified that the medication was not available. The findings are: The 12/2018 facility policy titled Medication Administration-General documented that medications were to be administered to resident/patients in a timely and accurate manner. Resident #261 was admitted with diagnosis including but not limited to diabetes mellitus type 2, encephalopathy, and stage 4 chronic kidney disease. The 7/10/24 Physician Order documented Jardiance 10 mg by oral route, once daily, for Type 2 diabetes mellitus with hyperglycemia. The 7/15/24 Care Plan titled Diabetes documented that Resident #261 was at risk for hypoglycemia and hyperglycemia. The 7/17/24 Admission Minimum Data Set Assessment documented that Resident #261 had intact cognition. The July 2024 Medication Administration Record documented Resident #261 did not receive Jardiance 10 mg tab on 7/27/24, the medication was not available. During an interview on 07/31/24 at 12:22 PM, Resident #261 stated that they had an issue with a nurse on Saturday (7/27/24) because their medicine(Jardiance) was not available and when they asked the nurse about it, the nurse told them that they did not have it and did not come back to the room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/24 at 04:33 PM, the Medical Doctor stated they were not made aware that Resident #261 ran out of Jardiance, The Medical Doctor stated the nurses could have electronically reordered the medication a few days in advance to prevent the resident from missing a dose. During an interview on 08/06/24 at 08:46 AM, Registered Nurse Supervisor #6 stated they were scheduled to supervise on 7/27/24, but had to pass medications because they did not have a nurse. Registered Nurse #6 stated the medication cart was missing a lot of medications. Registered Nurse Supervisor #6 stated they could not remember if Resident #261 received Jardiance on that date or if they notified the physician that the medication was unavailable. During an interview on 08/06/24 at 08:55 AM, the Director of Nursing stated that Resident #261 was unable to receive the Jardiance dose because it had been reordered on 7/27/24, and was not delivered until late in the evening on 7/27/24. During a follow up interview on 08/06/24 at 10:00 AM, the Director of Nursing stated they spoke with the pharmacy and that due to insurance purposed pharmacy had only sent 14 days of Jardiance. The Director of Nursing stated that was all the more reason the nurses should reorder the medication timely. The Director of Nursing stated the physician should have been notified that the Jardiance was not available for administration. During an interview on 08/06/24 at 10:31 AM, the Pharmacy Director stated that only 14 days of Jardiance was delivered to the facility for Resident #261 because the insurance would only cover 14 days at a time because of the brand name. The Pharmacy Director stated that the facility must reorder medications timely. The Pharmacy Director stated that the medication was first ordered on 7/10/24, and again ordered on 7/27/24 at 3:41 PM. The Pharmacy Director stated that the Jardiance was delivered to the facility on [DATE] at 10 PM . The Pharmacy Director stated that the Jardiance should have been reordered by 7/24/24 to ensure timely delivery During an interview 08/06/24 at 01:35 PM. Licensed Practical Nurse #15 stated that they worked on 7/26/24 and when they gave the last dose of Jardiance to Resident #261, they reordered the medication the same day. Licensed Practical Nurse #15 stated that it should have been reordered a few days ahead of time, but they were not working with Resident #261 prior to 7/26/24. Licensed Practical Nurse #15 stated that the pharmacy was far away and sometimes it took a while for medications to be delivered. 10NYCRR 415.12(m)(2) Based on observation, record review, and interview conducted during the Recertification Survey from 7/31/24 to 8/07/24, the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, Resident #48 did not receive requested pain medication Hydromorphone (Dilaudid) on 7/30/24 as per physician order. Subsequently Resident #48 refused wound care treatment/s due to the medication not being available. The findings are: The facility policy titled Medication Administration-General dated 12/2018 documented that medications were to be administered to resident/s in a timely and accurate manner. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #48 was admitted with the following diagnoses including chronic pain, polyneuropathy, stage 3 and 4 pressure ulcers of the sacral region, and a stage 3 pressure of the right lower back. The 7/8/24 Quarterly Minimum Data Set Assessment documented that Resident #48 was cognitively intact, had frequent pain, received scheduled and as needed pain medications, and received opioids. The 7/18/24 Physicians order documented Hydromorphone (Dilaudid) 4 mg tablet by oral route, every 4 hours as needed. The 7/2/24 Care Plan titled Pain documented history of chronic pain, multiple wounds, decreased mobility as evidenced by change in gait or behavior, eating poorly, vocal complaints of pain and nonverbal sounds. Interventions included assess nature, intensity, location, duration, and frequency of pain, and offer as needed medications as ordered. The 7/24/24 care plan note documented Resident #48 was seen by psychiatry and Dilaudid 4 mg every 4 hours as needed for severe pain only should be continued. The Controlled drug record for Resident #48 documented Hydromorphone (Dilaudid) 4 mg tablet (quantity 90) was delivered to the facility on [DATE], and the last dose was given on 7/29/24, There was no documented evidence in the Medication Administration Record that Resident #48 received requested Hydromorphone (Dilaudid) prior to wound treatment/s on 7/30/24. There was no documented evidence that the Pixus Medication Reorder list (Pixus) contained Hydromorphone(Dilaudid). The Controlled drug record for Resident #48 documented the Hydromorphone (Dilaudid) was reordered and delivered on 7/30/24. The 7/31/23 Care Plan titled Non Compliance written by Licensed Practical Nurse #7 documented that Resident #48 refused wound care from the prior nurse because they did not have Hydromorphone (Dilaudid). During an interview on 08/05/24 at 09:40 AM, the Director of Nursing stated that medications should never run out and that Dilaudid was not in the Pixus. The Director of Nursing stated that if a medication ran out, specifically controlled medications, the nurses must call the physician for a new prescription, timely to ensure the resident received the next dose. The Director of Nursing stated that the medications should never run out and that was why there was a blue line on the blister packs indicating when the pills should be reordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/24 at 12:11 PM, Licensed Practical Nurse #16 stated that on 7/30/24, prior to wound care, Resident #48 requested Dilaudid, and the medication was not in the medication cart. Licensed Practical Nurse #16 stated that when they went to locate the medication, they could not find it. Licensed Practical Nurse #16 stated that they reported to the supervisor that the medication was not available, and that the supervisor stated that they would follow up with physician and the pharmacy. Licensed Practical Nurse #16 stated that they should have followed up with the physician and the pharmacy themselves, and that because the Dilaudid was not available, the resident refused wound care. Licensed Practical Nurse #16 stated that medications should not run out and medications should be reordered when the blue line on the blister pack was reached. Licensed Practical Nurse #16 stated that when they told Resident #48 that the medication was not available, Resident #48 stated that it was not the first time that medications had run out. During an interview on 08/05/24 at 02:51 PM, the Pharmacy Director stated that the medication was never on backorder and should have been ordered a few days prior to running out to ensure prompt delivery. The Pharmacy Director stated that the medication Dilaudid for Resident #48 was ordered and had not been delivered until the night of 7/30/24. During an interview on 08/05/24 at 04:23 PM, Licensed Practical Nurse #11 stated that on 7/29/24, they took over the high side medication administration at approximately 10 PM. Licensed Practical Nurse # 11 stated that when they were administering Resident #48's Dilaudid, they realized there was only one Dilaudid left in the blister pack, and the Medical Doctor was notified via text message. Licensed Practical Nurse #11 stated that medications should be reordered when the medication gets to the last blue row on the blister pack. During an interview on 08/05/24 at 04:33 PM, the Medical Doctor stated the nurses usually text them when they are running low on medications and stated that a resident should never run out of medications. The Medical Doctor stated that Licensed Practical Nurse #11 texted them on 7/29/24 at 10:32 PM to request a refill on Resident #48's Dilaudid and that they did not reorder the medication because they were already in the bed. The Medical Director stated that the Nurse Practitioner reordered the medication the next day. The Medical Doctor stated that they were not informed until late evening on 7/29/24 that Resident #48 was out of Dilaudid and expected the nurse to let them know at least 3-4 days prior to medications running out. During an interview on 08/07/24 at 02:09 PM, the Director of Nursing stated Resident #48 always requested their Dilaudid and that it should have been available. 10NYCRR 415.12

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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. 49255 Based on observation and interview conducted during the recertification survey from 7/31/24-8/7/24, the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, 1. the walk-in refrigerator contained an open container of Feta Cheese and one 64 oz jug of Cream o Land whole milk which were not dated when opened, 2. the cook's daily/ready to use refrigerator, contained one open/undated 64 oz jug of Cream O Land whole milk, 3. The walk-in freezer, contained unlabeled plastic bags of Tortellini and Croissants which were not dated when opened, and 4. The dry storage room, contained trays of [NAME] Rock diet ginger ale without expiration dates. Finding include: The revised May 12 2021 facility policy and procedures titled Storage of Food Appendix, documented all resident and staff food stored in facility refrigerators were to be properly wrapped, labeled and dated. Proper labeling would consist of received date, use by or expiration date. During an initial tour of the kitchen on 07/31/24 at 9:13 AM accompanied by the Director of Food Services the following were observed: 1. The walk-in refrigerator contained an undated Mamaris Feta Cheese container with an expiration date of 6/4/25. The container did not include the date the cheese had been opened. There was one open/undated 64 oz jug of Cream O Land whole milk. The jug did not include the date it had been opened. 2. The cooks daily/ready to use refrigerator contained one undated 64 oz jug of Cream O Land whole milk. The jug did not include the date the milk had been opened. 3. The walk-in freezer, contained one plastic bag of Tortellini and one plastic bag of Croissants stored outside of the original packaging. The packaging did not include the date/s the packages had been opened. 4. The dry storage room contained trays of [NAME] Rock diet ginger ale without expiration date/s. When interviewed on 07/31/24 at 09:31 AM, the Director of Food Services stated they were unaware that an opened Feta Cheese container, two 64 oz jugs of Cream O Land whole milk and frozen Tortellini and Croissants bags had not been dated when they were opened. They stated that any opened item/s must be dated and labeled, the bags of frozen Tortellini and Croissants must be kept in the original cardboard boxes and dated when they were opened. The Director of Food Services stated that both milk jugs would be discarded. The Director of Food Service stated they were unaware that the diet ginger ale did not have expiration dates. 10NYCRR 415.14(h)