STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris Park Rehabilitation and Nursing Center	1235 Pelham Parkway North Bronx, NY 10469

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on observation, record review, and interviews during the Recertification and Abbreviated Survey (NY00365258) conducted from 01/26/2025 to 01/31/2025, the facility did not ensure that sufficient nursing staff was consistently provided to meet residents' needs in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care. Specifically, 1.) Several residents reported the facility was short staffed of Certified Nursing Assistants which resulted in lack of timely staff response to residents who needed assistance, 2.) Multiple nursing staff members reported lack of sufficient staffing, 3.) Facility's staffing levels were repeatedly below facility assessed levels, and 4.) Excessively low weekend staffing was triggered in the Payroll Based Journal Staffing Data Report. The findings include but are not limited to: 1.) The facility's policy titled Staffing Coverage with a last reviewed date of 12/01/2024 documented each unit will be staffed according to the facility's 24-hour nurse staffing guidelines. The use of agency/contractual staff and mandatory overtime may be used as an alternative to meet staffing needs. The total daily number of Certified Nursing Assistants needed during the weekdays on the day shift are 22 and 21 are needed on the evening shift for 5 resident units. The Daily Staffing Schedule for 12/16/2024 documented that Resident #89's unit (3rd Floor) had a census of 37, and 3 Certified Nursing Assistants on schedule for both day and evening shifts. Resident #89 had diagnoses of Morbid Obesity, Contracture of Right Hand, and Peripheral Vascular Disease. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #89 had intact cognition and was dependent on staff for toileting and hygiene. On 01/29/2025 at 10:18 AM, Resident #89 was interviewed and stated that on the day they made the complaint, no one responded to their call bell on both the day and evening shifts. The night shift aide responded to their call bell at the start of their shift. Resident #89 stated this happens often and the situation improved when they notified Registered Nurse #2 of the incident. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/30/2025 at 2:23 PM, the Staffing Coordinator was interviewed and stated they were short of Certified Nursing Assistants on 12/16/2024 on the 3rd floor for both the day and evening shifts. The Staffing Coordinator stated 3rd floor should have 4 Certified Nursing Assistants scheduled for both the day and evening shifts. On 01/30/2025 at 3:36 PM, Certified Nursing Assistant #2, who worked the evening shift on 12/16/2024, was interviewed and stated there should be 4 Certified Nursing Assistants scheduled for the day and evening shifts. They stated some days there are only 3 Certified Nursing Assistants working which makes it challenging to complete all their work and showers especially with residents requiring 2 staff for personal care. Certified Nursing Assistant #2 stated Resident #89 requires 2 aides, and the Resident recently made a complaint about not receiving incontinent care from the previous shift because they were working short. On 1/30/2025 at 3:44 PM, Certified Nursing Assistant #4, who worked the day shift on 12/16/2024, was interviewed and stated that residents receive delayed incontinent care when there are only 3 Certified Nursing Assistants on the unit. Certified Nursing Assistant #4 stated they try their best to get all the showers done when they are short but sometimes showers have to be rescheduled for the following day. 43350 2.) The Payroll Based Journal Staffing Data Report for 4th Quarter of 2024 (07/01/2024 - 09/30/2024) documented that excessively low weekend staffing was triggered. The Facility assessment dated [DATE] documented the facility's average daily census ranged from 175 - 180. The facility assessment documented the following facility resources to provide competent resident support and daily and during emergencies are as follows: Day shift - 5 Unit Managers, 5 Licensed Practical Nurses, and 22 Certified Nursing Assistants Evening shift - 2 Registered Nurse Supervisors, 5 Licensed Practical Nurses, and 20 Certified Nursing Assistants Night shift - 1 Registered Nurse Supervisor, 5 Licensed Practical Nurses, and 11 Certified Nursing Assistants The facility's policy titled Staffing Coverage (Nursing Department Par Levels) dated 11/01/2020 with reviewed dates of 10/01/2023 and 12/01/2024 documented the total daily number of nursing staff needed for each shift on weekends are as follows: Day and Evening shifts - 2 Registered Nurses, 5 Licensed Practical Nurses, and 20 Certified Nursing Assistants Night shift - 1 Registered Nurse, 5 Licensed Practical Nurses, and 10 Certified Nursing Assistants On 01/27/2025 at 9:27 AM, Resident #2 was interviewed and stated some days the facility is really short of staff, and they had to wait a long time for help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/27/2025 at 9:36 AM, Resident #144 was interviewed and stated the residents are not getting the care they need due to not having enough staff. On 01/27/2025 at 9:51 AM, Resident #37 was interviewed and stated there was no point ringing the call bell because staff ignore it especially on weekends. The actual staffing schedule documented the following: On 07/06/2024, Saturday, documented 17 Certified Nursing Assistants worked on the evening shift (par level of 20) On 07/07/2024, Sunday, documented 17 Certified Nursing Assistants worked on the evening shift (par level of 20) On 07/13/2024, Saturday, documented 18 Certified Nursing Assistants worked on the day shift (par level of 20), and 16 Certified Nursing Assistants worked on the evening shift (par level of 20) On 07/14/2024, Sunday, documented 17 Certified Nursing Assistants worked on the day shift (par level of 20), and 16 Certified Nursing Assistants worked on the evening shift (par level of 20) On 07/20/2024, Saturday, documented 17 Certified Nursing Assistants worked on the evening shift (par level of 20) On 07/21/2024, Sunday, documented 8 Certified Nursing Assistants worked on the night shift (par level of 10) On 07/27/2024, Saturday, documented 14 Certified Nursing Assistants worked on the day shift (par level of 20), and 15 Certified Nursing Assistants worked on the evening shift (par level of 20) On 08/11/2024, Sunday, documented 15 Certified Nursing Assistants worked on the day shift (par level of 20), and 16 Certified Nursing Assistants worked on the evening shift (par level of 20) On 08/17/2024, Saturday, documented 16 Certified Nursing Assistants worked on the day shift (par level of 20) On 08/31/2024, Saturday, documented 15 Certified Nursing Assistants worked on the evening shift (par level of 20) On 09/08/2024, Sunday, documented 17 Certified Nursing Assistants worked on the day shift (par level of 20), and 14 Certified Nursing Assistants worked on the evening shift (par level of 20) On 09/21/2024, Saturday, documented 15 Certified Nursing Assistants worked on the day shift (par level of 20), and 14 Certified Nursing Assistants worked on the evening shift (par level of 20) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/30/2025 at 9:53 AM, Certified Nursing Assistant #8 was interviewed and stated there are usually 2-3 aides in the unit on the weekends. They stated that male aides are only allowed to care for male residents, so if there are 2 male aides in the unit, most of the residents which are female are left for the single female aide to take care of. Certified Nursing Assistant #8 stated it is very hard and stressful, and they cannot do a good job when they are short of staff. On 01/30/2025 at 11:17 AM, Certified Nursing Assistant #7 was interviewed and stated when they work on weekends, the unit is usually working short. The aide stated when they start to fall behind, they sometimes take it into their own hands to phone colleagues who have the day off and beg them to come in to assist. On 01/30/2025 at 3:36 PM, Certified Nursing Assistant #2 was interviewed and stated there were as few as 3 aides on the evening shift in their unit despite some of the residents requiring 2 assists for care. The aide stated it can be challenging. On 01/30/2025 at 3:43 PM, Certified Nursing Assistant #4 was interviewed and stated there will be times when there are a lot of last-minute call outs and the nursing supervisor who is sometimes working alone would be assisting with care as well. Certified Nursing Assistant #4 stated that incontinent care may be delayed until the end of the shift and showers may have to be postponed until the following day when more staff are scheduled. On 01/31/2025 at 9:18 AM, Registered Nurse #2 was interviewed and stated it is very stressful on the weekend because they had to assist the aides with resident care because of short staffing and at the same time had to do their supervisory tasks. On 01/30/2024 at 2:24 PM, the Staffing Coordinator was interviewed and stated that because of short staffing, they schedule home health aides to assist in the units, and while home health aides are not permitted to provide direct patient care, they can make beds, serve meals, and answer call bells to lighten the load for other staff. The Coordinator stated the facility offers cash bonuses to any nursing personnel who are working so hard that they miss their lunch or their break. On 01/30/2025 at 11:52 AM, the Director of Nursing was interviewed and stated that the facility is hiring continuously and currently uses several agencies as well, but the agency workers can pick and choose which facilities they go to by comparing hourly rates and accepting only the highest. This leaves the permanent staff doing constant overtime or taking just one day off a week instead of two. The Director of Nursing stated they tried to retain agency staff by giving them a permanent floor assignment so they can feel some sense of ownership of the workload on that unit as well as providing continuity of care for the residents, but that the nursing staff typically like the flexibility of agency work and seldom stay at the facility for very long. On 01/31/2025 at 9:33 AM, the Administrator was interviewed and stated that the facility uses several strategies to attract nursing staff. The facility advertises available nursing positions on its website and posts a large sign outside the building that says they are hiring. Four new agency contracts have been added, sign-in bonuses are offered, and 5 televisions were awarded to staff members who had no call-outs. The Administrator stated 90 certified nursing assistants were hired in the past nine months, but currently only thirty of them remain on staff. As for the rest, many were let go because they were consistently no-call-no-show, particularly on the weekends. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10 NYCRR 415.13(a)(1)(i-iii)

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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. 48876 Based on observation, record review, and interviews during the Recertification Survey conducted from 01/26/2025 to 01/31/2025, the facility did not ensure drugs and biologicals were stored in accordance with professional standards of practice. This was evident in 2 of 5 units observed. Specifically, 1.) Unit 4 emergency drug box contained expired medications, and 2.) Unit 5 medication cart was observed with insulin pens that were not properly and sanitarily stored and were not marked with the dates they were opened. The findings are: The facility's policy titled Storage of Medications with a revised date of 10/20/2023 documented that the facility shall store all drugs and biologicals in a safe, secure and orderly manner. All medications will be stored, distributed, and administered, in compliance with all applicable laws and regulations. The nursing staff shall be responsible for maintaining medication storage. The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy for destruction. The facility's policy titled Emergency Medications with a revised date of 09/15/2024 documented that the facility shall maintain a supply of medications typically used in emergencies. The emergency medication box will include medications and biologicals that are essential in providing emergency treatment. Each nurses' station will store an emergency medication kit in the medication room. The contents of each emergency medication kit will be clearly listed. The Consultant Pharmacist shall inspect the emergency medication kits monthly and record the findings on the record maintained with each kit. The facility's policy titled Role of the Consultant Pharmacist with a reviewed date of 10/01/2024 documented that the consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility, including regular review of the emergency medication supply, review of medication storage areas at least monthly, and medication carts at least quarterly, for proper storage and labeling of medications, cleanliness, and expired medications; and providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. 1.) On 01/30/2025 at 10:28 AM, an observation of the 4th floor unit medication storage room was conducted with the Assistant Director of Nursing. Emergency Box #1794 was labeled with a medication list with a delivery date of 05/2024. The emergency box contained the following expired medications: 1.) Diphenhydramine vial 50 milligram/milliliter with expiration date of 11/2024, 2.) Two 1 milliliter ampules of Epinephrine 1:1000 with expiration date of 12/2024. The 24-hour Report form documented that the emergency box in 4th floor were checked by each nurses on all shifts on 01/30/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/2025 at 10:40 AM, The Assistant Director of Nursing was interviewed and stated that the nurses in each shift are responsible to check the emergency drug box for expired medications. They stated they do not document when the nurses complete the checks. 01/30/2025 at 2:28 PM, Licensed Practical Nurse #1 was interviewed and stated that the charge nurse is responsible for checking if there are expired medications in the box. On 01/30/2025 at 11:08 AM, the Director of Nursing was interviewed and stated that emergency drug boxes are provided by a contracted pharmacy and nurses in each shift and the Assistant Director of Nursing are responsible for ensuring that the medications are not expired. They stated that the Pharmacy Consultant audits the emergency drug box 2-3 times in a year. 44842 2). On 01/29/2025 at 12:37 PM, an observation of the 5th Floor medication cart was conducted with Licensed Practical Nurse #2. The following were observed: Two insulin pens for 2 different residents were stored in the same plastic bag, 6 opened insulin pens were not marked with the dates they were opened, 1 insulin pen with an open date of 12/16/2024 with no resident name, and 2 unopened insulin pens stored in resealable bags labeled Refrigerate. On 01/29/2025 at 12:39 PM, Licensed Practical Nurse #2 was interviewed and stated insulin pens are supposed to be labeled, dated when opened, and each resident's insulin pen should be kept in a separate bag to prevent contamination. They stated unopened insulin pens are supposed to be in the refrigerator and not stored in the medication cart until opened. Licensed Practical Nurse #2 further stated they were busy administering medications and did not inspect the cart and could not explain the findings. On 01/29/2025 at 3:19 PM, Registered Nurse #1 was interviewed and stated the insulin pens that are delivered from the pharmacy are supposed to be kept in the refrigerator until opened. The pharmacy sends the insulin pens in separate bags for the individual residents. Registered Nurse #1 also stated they frequently remind the unit nurses to check their carts every shift for undated, unlabeled, expired medications, and to date medications when opened. On 01/30/2025 at 4:16 PM, the Director of Nursing was interviewed and stated that medication nurses are responsible for the upkeep of the medication cart, such as dating medications when opened, keeping cart locked when not in use, keeping cart clean, and disposing of expired medications. The Director of Nursing further stated insulin pens delivered from the pharmacy should be placed in the refrigerator until opened and then once opened they must be dated and kept in the medication cart. 10 NYCRR 415.18 (e)(1-4)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review, and interviews during the Recertification Survey conducted from [DATE] to [DATE], the facility did not ensure food were stored in accordance with professional standards for food service safety. This was evident during kitchen and dining observation. Specifically, 1.) The kitchen walk-in refrigerator and freezer contained opened and undated food items. 2.) The 5th floor unit refrigerator contained unlabeled and undated food items. The findings are: 1.) The facility's policy titled Stock Rotation/Dated Items and Safe Defrosting of Nutritional Items with a revised date of [DATE] documented that items received from the meat and chicken company will be placed in a plastic bin with a cover. The bins will be labeled with date arrived, date pulled for defrosting, and the date to be used. On [DATE] at 11:33 AM, kitchen observation revealed the following: the freezer was observed with 6 plastic bins containing frozen meats that were not labeled/dated. The walk-in refrigerator was observed with 4 plastic bins containing thawed meat and an opened container of tartar sauce that were not labeled and had no date indicating the use by date. On [DATE] at 12:39 PM, the Food Service Director was interviewed and stated when food products are delivered on Thursdays, the staff unpacks the meat from the original box, put them inside the plastic bin, and label the items to include product delivery date, date taken out of the box, use by date. The Food Service Director stated the meat found in the freezer were just delivered over the weekend and must have been put in the freezer by staff without labeling. 44842 2.) The facility's policy titled Food Safety Requirements-Outside Food dated [DATE] documented that resident and or person bringing in the food will be notified that perishable food will only be kept for 48 hours. All non-perishable food will be kept for 72 hours once package is opened. Food that requires refrigeration must be placed in pantry refrigerator, labeled with resident name and date received. Nursing staff will monitor resident's room, unit pantry, and refrigeration units for food and beverage disposal. On [DATE] at 11:03 AM, the 5th Floor pantry refrigerator was observed with an unlabeled and undated package of smoked salmon, unlabeled and undated container with fruit salad, and an unlabeled and undated container of unknown food in a Chipotle paper bag. On [DATE] at 11:05 AM, Licensed Practical Nurse #2 was interviewed and stated staff are supposed to label any food with resident's name and the date it was brought in and remind residents when it has to be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:34 AM, Registered Nurse #1 was interviewed and stated the unit nurses on every shift are supposed to make sure food is labeled and dated in the pantry refrigerator and that expired food are thrown after 72 hours. On [DATE] at 4:13 PM, the Director of Nursing was interviewed and stated that food must be labeled and dated before storing in the pantry refrigerators and are only kept for ,d+[DATE] hours. The Director of Nursing further stated that nursing staff are responsible to check the pantry refrigerators on the units to make sure staff are following this policy. 10 NYCRR 415.14(h)