STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335350	A. Building B. Wing	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sutton Park Center for Nursing and Rehabilitation	31 Lockwood Avenue New Rochelle, NY 10801

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observations, interviews, and record review during the Recertification Survey from 11/7/23-11/14/23, the facility did not ensure residents were treated with dignity for 2 of 4 residents (#71 and #119) reviewed for dignity. Specifically, 1) staff were not seated when feeding Resident #71; and 2) staff were observed entering Resident #119's room without knocking on the door. The findings are: The facility policy for Feeding Assistance Program dated 3/2023 documented, staff will be seated when feeding a resident. 1) Resident# 71 was admitted with diagnoses of metabolic encephalopathy, Alzheimer's disease and abnormal weight loss. The Minimum Data Set (MDS) dated [DATE] documented Resident #71 required assistance with eating. During an observation on 11/08/23 at 12:41 PM, Licensed Practical Nurse (LPN) #5 was observed standing while assisting Resident # 71 with their meal. During an interview with LPN #5 on 11/08/23 at 12:55 PM, they stated they knew they should have been seated while feeding the resident, but they did not sit while assisting Resident #71. 2) Resident #119 was admitted with diagnoses of diabetes mellitus, cerebral vascular accident (CVA, stroke) and peripheral vascular disease. The MDS dated [DATE], documented Resident #119 was cognitively intact. During an interview on 11/8/23 at 10:16 AM, Resident #119 stated some staff knocked and some did not. Resident #119 stated it got uncomfortable at times and privacy was important to them. They worried someone might hear them while they were on the phone. During an observation on 11/8/23 at 11:11 AM, Activity Aide #1 entered Resident #119's room without knocking on the door and/or asking for permission to enter. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/08/23 at 11:11 AM with Activity Aide #1 who stated they forgot to knock because it slipped their mind. 10NYCRR 415.3

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673 Based on record review and interviews conducted during the Recertification Survey from 11/7/2023 through 11/14/2023 the facility did not ensure that resident and/or resident representative were notified in writing of the reason for the transfer/discharge to the hospital in a language that they understood, and the facility did not notify the Ombudsman for 1 of 5 residents (Residents # 109) reviewed for hospitalization . Specifically, the resident was transferred to the hospital and the facility could not provide evidence that a written notice of transfer/discharge was provided to the resident, or the resident representatives and that notification was sent to the State Ombudsman. The findings are: The policy and procedure titled Admission, transfer discharge revised 1/2022 documented the resident or representative will be informed of the resident transfer discharge. The state Ombudsman will be notified of all facilities-initiated discharge. Resident # 109 was admitted to the facility with diagnoses of schizoaffective disorder, major depressive disorder, and hypertensive heart disease. The Minimum Data Set (MDS-a resident assessment tool) annual assessment dated [DATE] documented Resident #109 had moderately impaired cognition. Review of the electronic medical record documented Resident #109 had three hospitalization s, 10/5/2023 through 10/6/2023, 10/7/2023 through 10/7/2023, and 10/26/2023 through 10/28/2023. The facility was unable to provide documented evidence that Resident #109 or their representative had been notified in writing of the resident's transfers/discharges from the facility and the reasons for the transfers/discharges or that notices were sent to the Ombudsman. During an interview on 11/14/2023 at 11:00 AM, Resident #109's representative stated they had not received written notification regarding hospital transfer and/or discharge. During an interview on 11/14/2023 at 11:10 AM, the Director of Nursing stated they did not know if Resident #109 was given transfer and/or discharge notification or if the Ombudsman was notified of the residents hospital transfer and/or discharge. During an interview on 11/14/2023 at 11:15 AM, the Director of Social Work stated they did not give Resident #109 or the family representative the transfer/discharge notices. The Director of Social Work further stated they did not notify the Ombudsman when Resident #109 was transferred and/or discharged to the hospital. 10NYCRR 415.3(l)(3)(i)(a)

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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** 45478 Based on observation, record review and interview during the recertification and abbreviated surveys (NY00325370) conducted from 11/6/2023 to 11/14/2023, the facility did not ensure the development and implementation of comprehensive person-centered care plans to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #120) reviewed for accidents, 1 of 3 residents (Resident #10) reviewed for hospitalization and 1 of 4 residents (Resident #46) reviewed for dignity. Specifically, 1) the facility did not ensure a person-centered care plan was developed for Resident #120 to be able to self-administer medications. 2) Staff did not implement interventions as per care plan for Resident #10 with a history of falls. 3) Staff did not develop a care plan to address Resident #46's refusal to wear clothes. The findings are: Review of the facility policy and procedure (P&P) titled Medication Administration-General dated 04/2018, documented medications are administered to resident/patients in a timely and accurate manner and to never leave medication at the bedside for a resident to self-administer. 1. Resident #120 was first admitted on [DATE] and last admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), anxiety disorder, and agoraphobia with panic disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented Resident #120 was cognitively intact. Physician orders dated 10/31/2023 documented to administer albuterol sulfate HFA 90 mcg/actuation aerosol inhaler, one puff by inhalation route every six hours as needed for COPD. On 11/14/2023 at 4:32 PM, Resident #120 was observed with the prescribed albuterol sulfate inhaler in their room located in the nightstand. When interviewed on 11/14/2023 at 4:32 PM, licensed practical nurse (LPN) #1 stated the resident was in possession of the albuterol sulfate inhaler because they self-administered their medication. When interviewed on 11/14/2023 at 4:33 PM, Resident #120 stated they were given the albuterol inhaler by the nurses and kept it in their possession to be able to self-administer. Resident #12 stated when the inhaler runs out, the nurse replaces it. When interviewed on 11/14/2023 at 4:55 PM, the Assistant Director of Nursing (ADON) stated the resident should not be carrying their own medication due to safety concerns and regardless of cognitive status. The ADON stated it was the policy of the facility that nurses administered all medications to residents and not to leave medications at bedside for a resident to self-administer. 2. Resident #10 was admitted to the facility with diagnoses including Alzheimer's disease, bipolar disorder, and a history of falling. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented the resident had severely impaired cognition and required extensive assist of one for bed mobility, eating, toileting, and transfers. The falls care plan dated 6/1/2023 and updated on 6/2/2023, documented the resident was at risk for falls with potential for injury related to the Morse scale assessment with diagnoses of gait disturbance and abnormality. Interventions included keeping the call bell within reach, providing a clutter free environment, and providing adequate lighting while avoiding glare. On 11/09/2023 at 12:04 PM, Resident #10 was observed in their room sitting in wheelchair unsupervised with their door closed. The call bell was observed on the floor on the opposite side of the bed and the lights in the room were off. On 11/09/2023 at 12:07 PM, Resident #10 was observed sitting in their room, with the door closed and was heard from the hallway banging on the door. Certified Nurse Aide (CNA) #6 was observed walking past the room while the door was closed and did not open the door to check on the resident. On 11/09/2023 at 12:12 PM, Resident #10 was observed in their room with the door closed. Upon opening the door, the resident was observed sitting in their wheelchair. The call bell was not in reach, and lights were off in the room. When interviewed on 11/09/2023 at 12:21 PM, CNA #6 stated that Resident #10 was placed in their room because they were in the hallway running their wheelchair into other residents' wheelchairs and the other residents were complaining. CNA #6 stated that Resident #10 was at risk for falls and should not have been in the room alone with the door closed due to safety concerns. CNA #6 stated the call bell should always be within the residents reach. When interviewed on 11/14/2023 at 10:58 AM, Licensed Practical Nurse (LPN) #1 stated that Resident #10 should not be in the room with the door closed, and if the door was closed, staff should open door to check on the resident. 3. Resident #46 was admitted to facility on 10/10/2022 with diagnoses including fibroid neurofibromatosis, malnutrition, and low back pain. The annual Minimum Data Set (MDS, an assessment tool) dated 8/28/2023 documented Resident #46 was cognitively intact, there were no behaviors and Resident #46 required extensive assist of one person for bed mobility, transfer, eating and toileting. The behavior care plan initiated 10/13/2022 documented Resident #46 had alteration in mood and behavior pattern due to diagnosis of depressive disorder and history of insomnia. The interventions documented to use the resident's name and explain purpose upon approach during care, psychiatric or psychological consult and follow up as ordered, provide routine daily caregivers as much as possible, maintain safety measures during periods of behavior disruptions. The behavior care plan had no documented evidence of resident having behaviors regarding not wearing clothing and/or not wanting the curtain closed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence in the electronic medical record (EMR) of any behaviors regarding not wanting to wear clothing. During observation on 11/07/2023 at 12:13 PM, 11/10/2023 at 1:16 PM and 11/14/2023 at 1:47 PM, Resident #46 was in their bed laying down, wearing an adult brief with no clothes on and visible from hallway During an interview with certified nurse aide (CNA) #14 on 11/14/2023 at 1:30 PM, CNA #14 stated the resident was supposed to be wearing clothes but was informed the resident always took their clothes off. During an interview on 11/14/2023 at 1:33 PM, CNA #4 stated Resident #46 did not like to wear clothes. CNA #4 stated they offered Resident #46 a gown, but they refused to wear the gown and refused to put a blanket on. CNA #4 stated they did not know if this behavior was discussed with the family or social worker. During an interview with licensed practical nurse (LPN) #6 on 11/14/2023 at 1:36 PM, LPN #6 stated Resident #46 refused to wear clothes and believed the resident had the right to refuse clothing. LPN #6 stated the resident did not want to have their bed side curtain drawn. LPN #6 stated they never thought to change the resident's bed position in the room as to make the resident not visible from the hallway. LPN #6 stated there were no care plan meetings held about Resident #46 not wearing clothes. 10NYCRR 415.11(c)(1) 48847

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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** 41666 Based on observation, record review, and interviews during the Recertification Survey 11/7/2023-11/14/2023 the facility did not ensure medications were provided to meet the needs of each resident for 2 of 2 residents (#119 and #116) reviewed for insulin. Specifically, long-acting insulin was not administered consistently as per physician order for Residents #119 and #116. The findings are: The facility policy for Administration of Medication dated 1/2023, documented before starting medication pass, check the physician order book for changes in medication orders against the Medication Administration Record (MAR). 1. Resident #119 was admitted with diagnoses including diabetes mellitus type II, cerebral vascular accident (CVA, stroke) and peripheral vascular disease. The 9/15/2022 nursing care plan for diabetes documented to provide medications as ordered. The 10/12/2022 physician order documented insulin glargine (U-100) 100u/ml (3 cc), inject 12 units by subcutaneous route once daily at bedtime. The Minimum Data Set Assessment (MDS) dated [DATE] documented Resident #119 was cognitively intact. The September 2023 medication administration record (MAR) documented insulin glargine (U-100) 100u/ml (3 cc), inject 12 units by subcutaneous route once daily at bedtime, hold if blood sugar equals 126, if greater than 400 or below 60, call physician. The MAR documented: - on 09/16/2023 at 9:00 PM glargine insulin was not administered. The reason documented, blood sugar (143) was below normal parameters. - on 09/24/2023 at 9:00 PM glargine insulin was not administered. The reason documented, blood sugar (240) was below normal parameters. The October 2023 MAR documented: - on 10/21/2023 at 9:00 PM glargine insulin not administered. The reason documented the resident was sleeping. - on 10/30/2023 at 9:00 PM glargine insulin not administered. The reason documented the blood sugar was (144). Upon further review of physician orders and the MAR, there were no clear documented parameters as when to hold the insulin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #119 on 11/08/2023 at 10:05 AM, they stated they were not sure if they were getting their insulin on time. Resident #119 stated sometimes they get only pills and no insulin. 2. Resident #116 was admitted with diagnoses including of diabetes type II, hypertension and major depressive disorder. The 6/24/2022 nursing care plan for Diabetes documented to administer medications as ordered. The 9/12/2023 MDS documented Resident #116 was cognitively intact. The current physician order documented Levemir flex pen 100/ml (3 ml), inject 20 units daily in the morning and Levemir flex pen 100/ml (3 ml), inject 30 units daily at bedtime. The September 2023 MAR documented: - on 9/4/2023 at 9:00 PM Levimir 30 units not administered. The reason documented within normal range. The October 2023 MAR documented to administer Levemir flex pen 100/ml (3 ml), inject 20 units daily in the morning with protocol for blood sugar monitoring. The MAR documented: - on 10/10/2023 at 8:00 AM Levimir 20 units was not administered. The reason documented the blood sugar (118) was below normal parameters. - on 10/15/2023 at 8:00 AM Levimir 20 units was not administered. The reason documented the blood sugar (131) was below normal parameters. - on 10/19/2023 at 8:00 AM Levimir 20 units was not administered. The reason documented the blood sugar (96) was within normal parameters. - on 10/27/2023 at 8:00 AM Levimir 20 units was not administered. The reason documented the blood sugar (119) was within normal parameters. - on 10/31/2023 at 8:00 AM Levimir 20 units was not administered. The reason documented the blood sugar (99) was within normal parameters. Upon further review of physician orders and the MAR, there were no documented parameters as when to hold the insulin. During an interview on 11/10/2023 at 12:56 PM Charge Nurse #1 stated it did not make sense to not give the insulin because the sugars were within range or below normal parameters as documented on the MAR. Charge Nurse #1 further stated they did not do audits or even check MARS for completion. Charge Nurse #1 stated they follow up behind the physician to make sure medications were picked up correctly, but they were not sure what happened with the two residents (#119 and #116) not receiving their insulin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/10/2023 at 1:12 PM the Pharmacy consultant stated their role was to review new admissions and existing residents' medications, review orders, review labs, and review notes. The Pharmacy consultant stated nursing should be involved to find out why the insulin was not being given because of a parameter. The Pharmacy consultant stated as far as parameters, there were no parameters for Levemir insulin because it was long acting and it was a standing order. The Pharmacy consultant stated the MD needed to be involved/called if medications were not being given. During an interview on 11/10/2023 the Director of Nursing (DON) stated if insulin was ordered as a standing order as in this case, it should have been given that way. The DON stated there were no parameters for long-acting insulins. The DON stated they did not know why blood sugar testing was performed. The DON stated the pharmacy consultant reviewed medications and would notify them if there was a concern. The DON stated medication errors were part of quality assurance, but it had not been addressed because the facility did not have medication errors. 10NYCRR 415.12

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 48847 Based on record review and interview during the recertification survey from 11/6/2023 to 11/14/2023, the facility did not ensure certified nurse aide (CNA) performance reviews were completed at least once every 12 months or that they provided regular in-service based on outcomes of such reviews for 5 of 5 reviewed for staffing (CNA #8, 9, 10, 11,and 12). Specifically, there were no performance evaluations provided when requested. Findings include: There was no documented evidence that CNA #8, 9, 10, 11, and 12 had performance reviews completed at least once every 12 months. During an interview on 11/09/2023 at 2:03 PM, the Assistant Director of Nursing (ADON) stated that staff performance reviews had not been done and that the facility did not have a policy in place. During an interview on 11/09/2023 at 2:45 PM, CNA # 8 stated that had been employed at the facility for many years and had not had a performance review. During an interview on 11/13/23 at 9:58 AM, the Administrator stated the facility did not provide staff performance evaluations. 10NYCRR 415.26

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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. 48849 Based on observation and interview conducted during the recertification survey from 11/8/23 to 11/16/23, the facility did not ensure that food was stored in accordance with acceptable standards for food safety practice. Specifically, perishable foods in kitchen freezer #1 and freezer #2 were not labeled and/or dated properly. The findings are: The 10/2023 facility food service policy titled Food Receiving/storage, procurement/Labeling documented foods will be labeled with a best-by date and use by that date or discarded; foods that do not have either a best-buy date or expiration date will be labeled with the date received and discarded within 6 months. 1. Observations during the initial tour of the kitchen on 11/7/2023 at 10:48 AM revealed the following unlabeled and/or undated foods were stored in walk-in freezers # 1 and freezer #2: -Freezer #1, had one (1) box of frozen manicotti, which was opened and unsealed without a use by date. -Freezer # 2, had one (1) box of frozen chicken wings, which was open and unsealed with a handwritten illegible use by date of either 10/18/2023 or 10/18/2025. During an interview on 11/7/2023 at 10:48 AM the Dietary Supervisor stated that the box of manicotti should have had a use by date. The Dietary Supervisor stated the use by date on the box of chicken wings was 10/18/2025. They added that the manufacturers were supposed to put a use by date and a received/prepared date on their products, and if there was no use by date, the director was supposed to call the manufacturer to obtain a use by date for the items. During the same initial tour on 11/7/2023 the Dietary Director was interviewed and stated if there was no manufacturer use by date, they would use the food within 3 months. The Dietary Director further stated that they should have called the manufacturer and also stated Dietary Aide #1, who received the food items from the delivery truck, was responsible for labeling the food items. During an 11/13/2023 at 10:30 AM follow up interview Dietary Aide # 1 (receiver) stated the frozen items should have a received/prepared date on the box and a use by date. If there was no use-by date on the box, they tell the supervisor or the director, and they should contact the manufacturer to obtain a use-by date to label the items. They added that all new frozen foods were supposed to be dated and rotated. 10NYCRR 415.14