

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/23/2024
NAME OF PROVIDER OR SUPPLIER  Bronx Park Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3845 Carpenter Ave Bronx, NY 10467	
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)		
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50010</p> <p>Based on record review and interview conducted during the Recertification survey from 09/16/2024-09/23/2024, the facility did not ensure a resident, or their designated representative was provided appropriate notification at the termination of skilled services. Specifically, the facility did not provide the Notice of Medicare Non-Coverage for Medicare Part A at least two calendar days before Medicare covered services ended as required, did not ensure that notices were mailed on the same day telephone notification was made, and did not provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form for residents who were remaining in the facility after discharge from skilled services. This was evident for 2 (Resident #89 and Resident #14) of 3 residents reviewed for Beneficiary Notification out of 38 sampled residents.</p> <p>The findings are:</p> <p>The facility policy titled Medicare Beneficiary Notice for Non-Coverage of Service dated 2/18/23 states that the purpose is to have a notification process that complies with the Medicare regulations and the notification used was the Notice of Medicare Non-Coverage (NOMNC) CMS-10123. The policy also stated that residents/representatives are notified in writing when a decision of Medicare non-coverage is made a minimum of two days' notice before the last covered Medicare day. The policy did not include any reference to the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form.</p> <p>The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 states that the form must be delivered at least two calendar days before Medicare covered services end and included the requirement that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. The instructions also stated that if the provider is personally unable to deliver a Notice of Medicare Non-Coverage to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise them when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. The instructions also state that when direct phone contact cannot be made, the notice should be sent to the representative by certified mail, return receipt requested.</p> <p>(continued on next page)</p>		

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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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Form Instructions Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024) states that Medicare requires Skilled Nursing Facilities to provide the notice to original Medicare patients prior to providing care that Medicare usually covers but may not pay for because the care is not medically reasonable and necessary; or considered custodial.</p> <p>1. Resident# 89 was discharged from skilled services on 04/26/2024 with 66 days remaining and remained in the facility. The Notice of Medicare Non-Coverage form documented that the last day for Medicare Part A service was 04/26/2024. The Notice of Medicare Non-Coverage form also documented that Resident #89 was notified and their guardian received telephone notification of termination of coverage from the Social Services director on 4/25/24 which was one day before covered services were to end. There was no documented evidence that the notice was mailed on the same day that telephone notification was made. In addition, there was no documented evidence that the facility provided Resident #89 and/or their guardian with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage notice at the termination of skilled services.</p> <p>2. Resident #14 was discharged from skilled services on 8/15/24 with 44 days remaining and remained in the facility. The Notice of Medicare Non-Coverage form documented the last day for Medicare Part A service was 8/15/24. The Notice of Medicare Non-Coverage form also documented that Resident #14 was made aware, however was unable to sign. A telephone call was made to Resident #14's representative and a message was left on voicemail on 8/12/24. There was no documented evidence that the Notice of Medicare Non-Coverage form was sent by certified mail when direct telephone contact was not made. In addition, there was no documented evidence that the facility provided Resident #14 with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form at the termination of Medicare coverage.</p> <p>On 09/17/2024 at 3:23 PM, the Director of Social Services was interviewed and stated they work with the Rehabilitation Director to give the Notice of Medicare Non-Coverage notices to residents, families, or legal guardians. The Director of Social Services also stated that if the resident is confused, they will document it on the form and then inform the resident's family or legal guardian. The Director of Social Services further stated that they usually provide the letter two days before Medicare services are terminated and is not sure why one of the notices was given only one day before. The Director of Social Services Social Services Director stated they were not aware of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage notice and provides the notices that are given to them by the Director of Rehabilitation.</p> <p>On 09/17/2024 at 3:35 PM, the Director of Rehabilitation was interviewed and stated they prepare the Notice of Medicare Non-Coverage notices with the date included and then gives the letters to the Director of Social Services who then gives the notification to the resident, family member, or legal guardian. The Director of Rehabilitation also stated that the Notice of Medicare Non-Coverage notice must go out at least two to three days before Medicare services are terminated in order to allow the resident time to appeal the decision. The Director of Rehabilitation further stated that they were unaware that if a voicemail had been left for a family member that a copy of the notice should be sent by certified mail. In addition, the Director of Rehabilitation stated that they had no knowledge of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form.</p> <p>On 09/17/2024 at 3:59 PM, the Administrator was interviewed and stated that they are not involved in the beneficiary notification process as this is handled by the Director of Rehabilitation and the Director of Social Services.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10 NYCRR 415.3(g)(2)(i)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39136</p> <p>Based on record review and staff interviews conducted during the Recertification Survey from 09/16/2024 to 09/23/2024, the facility did not ensure that residents' and their representatives were provided with a summary of the baseline care plan. This was evident in 1 (Resident #76) of 3 reviewed for Urinary Catheter, 1 (Resident #92) of 1 resident reviewed for Pain, and 1 (Resident #220) of 2 residents reviewed for Behavioral/Emotional out of 38 total sampled residents. Specifically, residents or their representatives did not receive a copy of their baseline care plan.</p> <p>The findings include but are not limited to:</p> <p>The facility's policy and procedure titled Baseline Care Plan, last revised on 04/10/2024, documented that a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The resident and representative are verbally informed of their baseline care plan and provided with a written statement.</p> <p>1. Resident #76 was admitted to the facility with diagnoses that included Urinary Tract Infection and Acute Kidney Failure.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documented that Resident #76 had moderately impaired cognition. Section Q of the assessment documented that Resident #76 and family participated in the assessment and goal setting.</p> <p>On 09/18/2024 at 10:14 AM, Resident #76 was interviewed and stated that they did not remember if they received a copy of the baseline care plan.</p> <p>A Baseline Care Plan form dated 07/30/2024 and 07/31/2024 was completed for Resident #76 with signatures of interdisciplinary staff. There was no documented evidence that Resident #76 or a family representative was provided with a written copy of the baseline care plan.</p> <p>2. Resident #92 was admitted to the facility with diagnoses that included Malignant Neoplasm of the Tongue and Hypertension.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documented that Resident #92 had intact cognition. Section Q documented that Resident #92 participated in the assessment and goal setting.</p> <p>On 09/20/2024, at 11:47 AM, Resident #92 was interviewed and stated they had not received a copy of their baseline care plan.</p> <p>A Baseline Care Plan form dated 07/03/2024, 07/04/2024 and 07/07/2024 was completed for Resident #92 with signatures of interdisciplinary staff. There was no documented evidence that Resident #76 received a written copy of the baseline care plan.</p> <p>3. Resident #220 was admitted to the facility with the diagnosis that include Anxiety Disorder and Diabetes Mellitus.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Admission Minimum Data Set assessment dated [DATE] documented that Resident #220 has severely impaired cognition and never/rarely made decisions. Section Q documented that Resident #220 family participated in the assessment and goal setting.</p> <p>A Baseline Care Plan form dated 05/28/2024 and 05/29/2024 was completed for Resident #220 with signatures of interdisciplinary staff. There was no documented evidence that Resident #220's family representative was provided with a written copy of the baseline care plan.</p> <p>On 09/23/2024 at 11:04 AM, Unit Manager #1 was interviewed and stated that the baseline care plan is initiated on admission. Unit Manager #1 also stated that the former Assistant Director of Nursing was responsible for informing the family about the baseline care plan. Unit Manager #1 further stated that they did not know if a copy was provided to the residents and the family representatives.</p> <p>On 09/23/2024 at 8:51 AM, the Director of Social Service was interviewed and stated the baseline care plan is completed within 48 hours of admission. The Social Service staff reviews the baseline care plan and explains the care and goals to the family. The Director of Social Service also stated that nursing is responsible for providing a copy of the baseline care plan to the residents and family representatives. The Director of Social Service further noted that the previous Assistant Director of Nursing informed the family of the baseline care plan, and the facility had no evidence that a copy had been provided to residents or their representatives.</p> <p>On 09/20/2024 at 12:39 PM, the Director of Nursing was interviewed and stated that a baseline care plan is initiated for all new admissions. All departments are required to complete the baseline care plan in 48 hours. The Director of Nursing also stated that they discuss the baseline care plan with cognitively intact residents and family representatives but do not provide them with a copy. The Director of Nursing further stated that the facility policy states they must explain the baseline care plan to the resident and family and give them a copy. The Director of Nursing did not explain why this was not being done.</p> <p>10 NYCRR 415.11 (c)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842</b></p> <p>Based on observation, interview, and record review conducted during the Recertification Survey from 09/16/2024 to 09/23/2024, the facility did not ensure that food was served at an appetizing temperature during meal service. This was evident for 1 (Resident #203) of 3 residents reviewed for Food out of 38 total sampled residents. Specifically, food served during lunch meal service was not maintained at palatable and appetizing temperatures.</p> <p>The findings are:</p> <p>The facility's policy and procedure titled Hot Food Holding Policy dated October 2022, documented hot foods should be 135 degrees Fahrenheit or above at the time food is served to the residents.</p> <p>Resident #203 had diagnoses which included Diabetes Mellitus, Hypertension, and Heart Failure.</p> <p>The Quarterly Minimum Data Set, dated dated [DATE] documented that Resident #203 had intact cognition.</p> <p>On 09/16/2024 at 10:56 AM, Resident #203 stated meals are delivered to their room and the food is routinely served cold.</p> <p>On 09/23/2024 at 12:42 PM, the food delivery truck arrived on Unit 6. Staff distributed trays to residents located in the dining room and then distributed meal trays to residents located in their rooms.</p> <p>On 09/23/2024 at 12:59 PM, a test tray was conducted and revealed the following temperatures: soup 125.2 degrees Fahrenheit, jerk chicken 124.3 degrees Fahrenheit, rice 106 degrees Fahrenheit, and zucchini and squash 110.8 degrees Fahrenheit.</p> <p>On 09/18/24 at 10:37 AM, Certified Nursing Assistant #3 was interviewed and stated sometimes Resident #203 reports their grilled cheese sandwich is not warm enough and requests that staff heat it up. Certified Nursing Assistant #3 also stated that no other residents on the unit have complained of cold food.</p> <p>On 09/23/2024 at 1:09 PM, the Director of Dining Services was interviewed and stated the food temperatures should be above 135 degrees Fahrenheit. The Director of Dining Services also stated that test tray temperatures are monitored once per week, and they have found no issues. The Director of Dining further stated the food truck, and the insulated plate covers are supposed to keep the food temperatures above 135 degrees Fahrenheit.</p> <p>10 NYCRR 415.14(d)(1)(2)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876</b></p> <p>Based on observation, record review, and interviews conducted during the Recertification Survey from 09/16/2024 to 09/23/2024, the facility did not ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident for 2 (Resident #112 and Resident #181) of 3 residents reviewed for Skin Conditions (non-pressure) out of 38 sampled residents. Specifically, the Physician Assistant and Registered Nurse #5 failed to comply with infection control protocols during wound care.</p> <p>The findings are:</p> <p>The facility policy titled Wound Care, revised 01/31/2024, documented that the treatment in the facility of various types of wounds, is performed to ensure optimal healing and prevention of complications. The policy also documented that one key responsibility is to ensure compliance with infection control protocols and safety standards in wound care practices.</p> <p>The facility policy titled General Infection, revised 02/15/2024, documented that it is the policy of the facility to comply with the Center for Disease Control and other government agencies infection disease related recommendations as appropriate.</p> <p>1. Resident #112 was admitted to the facility with diagnoses that include Peripheral Vascular Disease and Diabetes Mellitus.</p> <p>The Minimum Data Set assessment dated [DATE], documented that Resident #112 had moderately impaired cognitive skills for daily decision making and one venous or arterial ulcer present.</p> <p>The Physician Treatment Order dated 09/13/2024, documented twice a day wound care as: Cleanse left foot and right leg abrasions with normal saline solution. Apply 1% Silvadene Cream topically to the left foot and right leg abrasions. Cover with bordered gauze dressing.</p> <p>During a wound treatment observation on 09/19/2024 at 11:03 AM, the Physician Assistant was observed performing wound care for Resident #112. The Physician Assistant used one cotton swab to apply 1% Silvadene cream to three separate wounds (left foot abrasion, and two right leg abrasions). After the Physician Assistant applied the cream, Registered Nurse #5, who was assisting the Physician Assistant, opened packages of gauze and placed the packages on the sheet of Resident #112's bed without first setting up a clean field. The gauze pads and bordered gauze dressings were then applied to Resident #112's left foot and right leg open wounds by the Physician Assistant.</p> <p>2. Resident #181 was admitted to the facility with diagnoses that include a Non-Pressure Chronic Ulcer of the Left Lower Leg and Non-Alzheimer's Dementia.</p> <p>The Minimum Data Set assessment dated [DATE], documented that Resident #181 had moderately impaired cognitive skills for daily decision making and one venous or arterial ulcer present.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physician Treatment Order dated 09/19/2024 documented twice a day wound care as: Cleanse left lower extremity with normal saline solution. Apply 1% Silvadene Cream topically to the left lower extremity and cover with Kerlix wrap.</p> <p>During a wound treatment observation on 09/19/2024 at 11:19 AM, Registered Nurse #5 was observed assisting the Physician Assistant. Registered Nurse #5 opened packages of gauze with kerlix rolls and placed the packages on the sheet of Resident #181's bed sheet without first setting up a clean field. The gauze and Kerlix dressings were then applied to Resident #181's left lower extremity wound by the Physician Assistant.</p> <p>On 09/19/2024 at 11:10 AM, the Physician Assistant was interviewed and stated that they had not done dressing changes for a while as they are usually assisted by a wound nurse who is no longer employed by the facility. The Physician Assistant also stated that they should have used a separate swab for each wound. The Physician Assistant further stated that Registered Nurse #5 did not set up a barrier before placing the gauze pads and bordered gauze on Resident #112's and Resident #181's bed sheet.</p> <p>On 09/19/24 at 3:33 PM, the Infection Control Nurse was interviewed and state that Registered Nurse #5 was recently hired and was not yet in-serviced on wound care. The Infection Control Nurse also stated that in-services had been rescheduled as the facility was being surveyed this week.</p> <p>On 09/19/2024 at 4:09PM, Registered Nurse #5 was interviewed and stated that they felt rushed while assisting the Physician Assistant and therefore they made many errors during the wound treatments for Resident #112 and Resident #181. Registered Nurse #5 also stated that they placed dressings on Resident #112's and Resident #181's bed and should have set up a clean field for dressings on the bedside table.</p> <p>On 09/19/24 at 04:33 PM, the Director of Nursing was interviewed and stated that the Physician Assistant cross contaminated the wound by not using a separate swab for each wound. The Director of Nursing also stated that the previous Assistant Director of Nursing would complete the wound care with the Physician Assistant, but they are no longer employed at the facility. The Director of Nursing further stated that Registered Nurse #5 will be the new wound care nurse, but they had not been oriented to that role yet and the Physician Assistant had been instructed not to have Registered Nurse #5 assist them with wound treatments until they were trained.</p> <p>10 NYCRR 415.19 (a)(1-3)</p>		