| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335363 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ozanam Hall of Queens Nursing Home Inc | 42 41 201st Street<br>Bayside, NY 11361 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>33315<br><br>Based on observations, and interviews conducted during the Recertification survey from 09/26/2024 to 10/03/2024, the facility did not ensure that residents are treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. This was evident for 6 (Residents #239, 106, 164, 160, 245 & 166) residents observed during the Dining Observation Task on Unit 6 and Unit 4. Specifically, 1). staff members were observed feeding residents (Residents #239, 106, 164, 160 & 245 ) while standing, and 2.) a resident (Resident #166) was observed in the dining room sitting at a table where another resident was served their lunch, and they were not served for an additional 30 minutes while the other resident ate at the table.<br><br>The findings are:<br><br>The facility policy titled Resident Rights-Promoting and Maintaining Resident Dignity During Mealtimes dated 03/16/2023, updated 03/21/2024 documented that it is the practice of this home to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. The policy also stated that all staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes; residents should be served one table at a time and all staff will be seated, if possible, while feeding a resident.<br><br>1.On 09/26/24 between 12:00 PM and 12:48 PM, on Unit 6, Resident #239 was observed seated in a Geri-chair in the hallway. Registered Nurse #3 was observed standing over Resident #239 while feeding them their lunch in the hallway.<br><br>On 09/26/24 at 12:11 PM, Resident #106 was seated in a wheelchair in the Dining Room and Certified Nursing Assistant #1 was observed standing while feeding Resident #106. In addition, Certified Nursing Assistant #2 was also observed standing while feeding Residents #164 who was also seated in a wheelchair in the Dining Room.<br><br>On 09/26/24 at 12:30 PM, Certified Nursing Assistant #3 was observed feeding Resident #160 while standing, and the Registered Nurse #3 was also observed standing and feeding Resident #245 in the Dining Room.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 09/26/24 at 12:35 PM, an interview was conducted with Certified Nursing Assistant #1 who stated that they always stand while feeding residents because the resident's chairs are too high. Certified Nursing Assistant #1 also stated that standing while feeding the residents will enable them to see the residents in case they are experiencing choking.<br><br>On 09/26/24 12:43 PM, an interview conducted with Certified Nursing Assistant #2 who stated that they were aware that they have to sit to feed the residents, however they cannot sit because the resident's chairs are too high, and some of those chairs cannot be lowered. Certified Nursing Assistant #2 concluded by saying that maybe the facility needs to provide them higher chairs. Certified Nursing Assistant #2 could not recall if they had asked for another chair or complained to anyone at the facility about the chairs.<br><br>On 09/26/24 at 12:48 PM, an interview was conducted with Registered Nurse #1 who stated that they have to elevate the resident's head and they supposed to sit down to feed residents. Registered Nurse #1 also stated that when elevating the head of the resident's chair they sometimes found it difficult to reach the residents. Registered Nurse #1 further stated that they did not see this as a concern as all the other staff was doing it.<br><br>40565<br><br>2. On 09/26/24 at 01:02 PM, Resident #166 was observed sitting at the table with another resident who had been served their lunch meal and was already eating, Resident #166 became angry after watching the other resident complete their meal while Resident #166 had still not been served their meal. Resident #166 stated that they had been waiting for their tray since 12 o'clock and had not yet been served so wanted to be taken out of the Dining Room.<br><br>On 09/26/24 at 01:05 PM, Licensed Practical Nurse #2 was interviewed and stated that they were not aware that Resident #166 had not been served before they started feeding other residents in the dining room.<br><br>On 09/26/24 at 01:10 PM, Registered Nurse #8 was interviewed and stated that they did not know what happened to Resident #166's ticket, but they will call for another ticket to ensure Resident #166 receives the correct meal. Registered Nurse #8 also stated that they did not observe that Resident #166 had not been served their meal while Registered Nurse #8 was monitoring the dining room.<br><br>On 10/02/24 at 10:03 AM, the Director of Nursing was interviewed and stated that staff should not be standing up feeding residents and they have been trained that it is a matter of dignity to be at the same level with the resident to interact with them while feeding them. The Director of Nursing also stated that it is the responsibility of the nurses on the unit to ensure that staff are monitored to give appropriate care to the residents. There are also supervisors that make rounds to check them- The Director of Nursing stated that they were not sure why Resident #166's ticket was missing, but the staff could have removed Resident #166 from the dining room while their tray was being prepared.<br><br>On 10/03/24 at 12:38 PM, the Administrator was interviewed and stated that they hold the dignity of the residents very high, and staff should not be standing when feeding the resident. The administrator stated that both agency staff and facility staff were given training when hired on how to respect the dignity of the resident.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10 NYCRR 415.5(a) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565<br><br>Based on observations, record review, and interviews conducted during the Recertification survey from 09/26/2024 to 10/03/2024, the facility did not ensure that residents were afforded the opportunity to participate in their care planning process This was evident for 1 (Resident #103) of 2 residents reviewed for Care Planning out of 38 total sampled residents. Specifically, Resident #103 or their representative were not invited to attend care planning meetings.<br><br>The findings are:<br><br>The facility policy titled Comprehensive Care Plan dated 02/09/2024, updated 03/21/2024 stated that the home will provide the resident and resident representative, when applicable, with advance notice of care planning conferences to enable resident/resident representative participation.<br><br>Resident #103 was admitted with diagnoses that included Non-Alzheimer's Dementia, Malnutrition, and Psychotic disorder.<br><br>The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had severe impairment in cognition and was dependent on staff for Activities of Daily Living. The Minimum Data Set assessment also documented that resident and family participated in assessment and goal setting.<br><br>On 09/26/24 at 12:52 PM, Resident #103's representative was interviewed and stated that they had not been invited to any care plan meetings after the initial meeting in December 2023.<br><br>On 10/02/24 at 09:37 AM, Registered Nurse #8 was interviewed and stated that the Social Worker is responsible for inviting residents and family members to the care plan meetings.<br><br>On 10/02/24 at 11:42 AM, an interview was conducted with Social Worker #1who stated that they meet with residents and their family members only during initial, significant change and annual care plan meetings, and that residents and their family members are not invited to the quarterly meetings. Social Worker #1 also stated that they meet with the resident only during their quarterly review, and do not invite residents and their family for the quarterly care plan meeting.<br><br>On 10/02/24 at 11:42 AM, the Director of Social Work was interviewed and stated that they invite resident and the family to initial, Significant change, annual, and discharge care plan meetings if it is separate from initial care plan meetings. The Director of Social Work stated that they only speak with the family over the phone for the quarterly review.<br><br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/03/24 at 12:10 PM, an interview was conducted with the Director of Nursing who stated that resident's care plan meetings are usually handled by Social Services, and when the resident's care plan meeting is due Social Services staff will notify the resident and the family members. The Director of Nursing stated that they do not know which care plan meetings the residents and their family members are invited to as it is the Social Services department that handles and organizes the meetings. The Director of Nursing further stated that they were of the impression that resident and resident family are invited to all care meetings, and they did not know that they were not being invited for the quarterly meetings.<br><br>On 10/03/24 at 12:23 PM, the Administrator was interviewed and stated that resident and their families are invited for the initial, significant change and annual care plan meetings, but they have been having conversations with them for the quarterly assessment review since the COVID-19 pandemic. The Administrator also stated that they thought that family members would prefer this option, and they would meet with the residents and family if that is what they wanted.<br><br>10 NYCRR 415.3(f)(1) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315<br><br>Based on observation, record review, and interviews conducted during the recertification survey from 09/26/24 to 10/03/24 the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain grooming, and personal hygiene. This was evident for 1 (Resident #43) of 6 residents reviewed for Activities of Daily Living out of 38 sampled residents. Specifically, Resident #43 was observed unkempt with brown, dirty looking clothing and also noted with a strong urine odor.<br><br>The finding is:<br><br>The facility policy and procedure titled Completing the Activity of Daily Living Support created 5/6/2022 stated that residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. The policy also stated that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene.<br><br>Resident #43 had diagnoses which included Dementia, Anxiety Disorder and Depression.<br><br>The Minimum Data Set assessment dated [DATE] documented Resident #43 had impaired cognition and required partial or moderate assistance during shower/bathe, and also required supervision assistance during toileting. The Minimum Data Set assessment further documented that Resident #43 was incontinent of bowel and bladder.<br><br>The Comprehensive Care Plan related to self-care performance deficit(s) limited mobility, communication deficits, Dementia with impaired cognition last updated on 08/06/2024, documented that the resident required partial and moderate assistance with bathing/showering, personal hygiene, and toileting. Interventions included bathing/showering and as necessary.<br><br>The Registered Nurse progress note dated 07/20/24 documented that Resident #43 was alert and verbally responsive, assisted with some activity of daily living, refused shower this morning despite some encouragement from staff.<br><br>The Registered Nurse Plan of Care progress note dated 08/06/24 documented that Resident #43 was confused, had activity of daily living functional deficit(s) related to limited mobility and unsteady gait. The progress notes also documented that Resident #43 refused showers.<br><br>The Certified Nursing Assistant Task dated 09/01/24 to 10/02/24 documented that showers were provided two times a week. The Certified Nursing Assistant Task also documented Showering/Bathing prefers shower; Tuesday and Friday on 7-3 shift including fingernail care and shaving as needed. There was no documentation on the Certified Nursing Assistant Task that Resident #43 had refused shower.<br><br>On 09/26/24 at 11:21 AM, during the initial tour of Unit 6, Resident #43 was observed in the room, unkempt with brown, dirty looking clothing and also noted with a strong urine odor. Resident #43's room was also noted with strong, stale smelling urine odor. Resident #43 was confused and unable to answer questions.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 09/26/24 at 12:08 PM, Resident #43 was also observed in a wheelchair in the hallway, and a strong urine odor was detected as Resident #43 passed by. The assigned Certified Nursing Assistant #5 was also passing by and was asked about Resident #43's strong odor. Certified Nursing Assistant #5 stated that Resident #43 always refused shower and would not let anyone enter their room. Certified Nursing Assistant #5 also stated that Resident #43 was last showered on Friday 09/20/24, and that the family member is aware of this behavior. Certified Nursing Assistant #5 further stated and there is nothing they can do about it when Resident #43 refuses to shower.<br><br>On 09/27/24 at 09:53 AM, Resident #43 was observed in their room. The room was clean, and Resident #43 was observed to be wearing clean clothes. There was no urine odor detected.<br><br>On 09/27/24 at 10:00 AM, a follow-up interview was conducted with Certified Nursing Assistant #5 and stated Resident #43 received shower this morning after they encouraged them to shower. Certified Nursing Assistant #5 also stated that they brought Resident #43 out of the room and had housekeeping staff clean the room. Certified Nursing Assistant #5 further stated that Resident #43 is scheduled to shower twice per week during the day shift, however Resident #43 had not been receiving shower due to Resident #43 refusing to shower.<br><br>On 09/27/24 at 10:01 AM, an interview was conducted with Certified Nursing Assistant #9 who stated that they had been assigned to care for Resident #43 in the past and Resident #43 always refused care, especially showers. Certified Nursing Assistant #9 also stated that when Resident #43 was showered and given clean clothes, Resident #43 would remove clothing and put back on dirty clothing. The Certified Nursing Assistant #9 further stated that Resident #43 is very aggressive and always does not want people in their room.<br><br>On 09/27/24 at 11:45 AM, an interview was conducted with Registered Nurse #2 who stated that Resident #43 refused care, and their child was aware of this behavior. Registered Nurse #2 also stated that Resident #43 will not let anyone in the room, has some psychiatric issues and is being followed up by the psychiatrist. Registered Nurse #2 further stated that Resident #43 will not cooperate with staff attempts to shower them despite all efforts.<br><br>On 09/30/24 at 10:20 AM, Resident #43 was again observed in their room; the room was clean, and Resident #43 was also observed wearing clean clothes.<br><br>On 10/01/24 at 12:23 PM, an interview was conducted with the Director of Nursing who stated that they were not aware that Resident #43 was not receiving showers as scheduled. The Director of Nursing also stated that Certified Nursing Assistants need to communicate and notify nursing supervisor if activity of daily living care cannot be provided. The Director of Nursing further stated that it is the unit nursing supervisor's responsibility to ensure that care is provided in accordance with the plan of care.<br><br>10 NYCRR 415.12(a)(3) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18881<br><br>Based on observation, record review and staff interview conducted<br><br>during the Recertification survey from 09/26/2024 to 10/03/2024, the facility did not provide an ongoing program to support residents in their choice of activities based on the comprehensive assessment and care plan and the preferences of each resident, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident. This was evident for 2 (Resident #347 and Resident #408) reviewed for Activities out of a sample of 38 residents. Specifically, Resident #347 and Resident #408 were observed on multiple occasions not engaged in any activity programs.<br><br>The findings are:<br><br>The facility policy and procedure titled Recreational Activities with a revision date of November 2022 stated that it is the policy of the facility to provide a comprehensive recreational program as part of the multidisciplinary care approach. The policy also stated that the programming, both facility-sponsored group and individual activities and independent activities is geared for the enhancement of the social, emotional, intellectual, physical, creative, and spiritual well-being of the resident population, in accordance with the psychosocial assessment of the resident. The policy further stated that activities are individualized and customized based on the resident's previous lifestyle.<br><br>1. Resident #347 was admitted to the facility with diagnoses that included Non-Alzheimer's Dementia and Cataracts.<br><br>The Significant Change Minimum Data Set assessment dated [DATE] documented that Resident #347 had moderately impaired cognition and was dependent on staff for most activities of daily living and used a wheelchair for mobility. Section F Preferences for Customary Routine and Activities documented that it was very important for Resident #347 to listen to music they like and be around pets, and not very important to participate in religious services or practices.<br><br>On 09/27/2024 at 10:15 AM, Resident # 347 was observed seated in a wheel chair asleep, positioned against the wall facing the Nursing station in on open hallway along with four other residents. A television on the wall on was playing a Catholic mass service.<br><br>On 09/30/2024 at 2:30 PM, Resident #347 was observed in the Activity room seated on a wheel chair positioned against the wall facing the Nurses station, with no clear view of the program playing on the television.<br><br>On 10/01/24 at 11:47 AM, Resident #347 was observed in the Activity Room seated in a wheel chair with several other residents watching news on the television. Resident #347 was positioned behind a wall which blocked the view of the television. In addition, the television volume was lowered making it difficult for anyone to hear or understand what was being said in the program.<br><br>The Activities Admission assessment dated [DATE] documented that Resident #347 was interested in music, television movies and does not participate in spiritual activities.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Comprehensive Care Plan with focus resident is independent on staff for meeting emotional, intellectual, and social needs initiated 7/15/2024 included a goal of Resident will attend and participate in activities of choice when not in therapy. Interventions included invite the resident to scheduled activities and provide a program of activities that is of interest and empowers the resident by encouraging, allowing choice, self-expression, and responsibility.<br><br>There was no documented evidence that Resident #347 had been engaged in any activities on the unit or provided with 1:1 visits from Recreation staff.<br><br>2. Resident #409 was admitted to the facility with diagnoses that include Atrial Fibrillation, Renal Insufficiency and Non -Alzheimer's Dementia.<br><br>The Admission Minimum Data Set assessment dated [DATE] identified Resident #409 with moderately impaired cognition and required supervision and assistance from staff for Activities of Daily Living. The Admission Minimum Data Set assessment also documented in Section F Preferences for Customary Routine and Activities that it was very important for Resident #409 to have books, newspapers, and magazines to read, to listen to music they like, to do things with groups of people and do their favorite activities.<br><br>On 09/27/2024 at 12:01 PM, Resident #409 was observed on Contact Isolation in a single bedded room. Resident #409 was observed seated in a Geri chair facing a television set on the wall that was not turned on. There was no radio available in the room.<br><br>On 09/30/2024 at 01:37 PM, Resident #409 was interviewed and stated that they would like to receive newspapers, magazines, or books to read. Resident #409 also stated that no one had visited them or offered them newspapers or books to read. The television in the room was observed to be turned on at this time.<br><br>The Activity Admission assessment initiated on 08/28/2024 documented that Resident #409 wishes to participate in activities in the facility, including group and independent activities.<br><br>The Comprehensive Care Plan related to resident is independent for meeting emotional, intellectual, and social needs but dependent on staff for physical needs dated 09/02/2024 included a goal of resident will attend/participate in activities of choice when not in therapy. Interventions included introduce to other residents with similar background, interest and encourage and facilitate interaction, invite the resident to scheduled activities, provide a program of activities that is of interest and empowers the resident by encouraging, allowing choice, self-expression, and responsibility.<br><br>There was no documented evidence that Resident #409 had been engaged in any activities on the unit or provided with 1:1 visits from Recreation staff.<br><br>The Activity Calendars dated July 2024, August 2024, September 2024, and October 2024 included no activity program scheduled to occur on the 10th floor.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/01/2024 at 12:18PM, the Activity Director was interviewed and stated that the unit has no activity leader because this is a Rehabilitation unit, and residents are independent and can go to other units, stay in their rooms, or go to in the activity room on the unit where there is a television on. The Activity Director also stated that residents on this unit are asked if they want to attend any ongoing activities on other units. The Activity Director was asked for and was not able to provide any documentation that Resident #347 and Resident #409 had attended or participated in any activity programs.<br><br>On 10/01/2024 at 12:40 PM, Registered Nurse #9 was interviewed and stated that there were no structure activities on Unit 10 and no recreational leader comes to the unit. Registered Nurse #9 also stated that this is a rehabilitation unit, and residents go to therapy and when they return they either stay in the Activity room and watch television, go to their rooms, or family members may visit, and they may bring them downstairs to the garden.<br><br>On 10/02/2024 at 02:10 PM, Certified Nursing Assistant #13 was interviewed and stated that there are no activities on this floor; residents go to therapy in the morning and stay in the activity room when they come back to the unit. Certified Nursing Assistant #13 also stated that there is a television on all day for residents to watch if they so desire and there is a radio, but it is not always on.<br><br>10 NYCRR 415.5(f)(1) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315<br><br>Based on observations, record reviews and interviews conducted during the Recertification Survey-09/26/2024 to 10/03/2024 facility did not ensure that residents received proper treatment and assistive devices to maintain hearing abilities. This was evident for 1 (Resident #287) of 1 resident reviewed for Communication/Sensory out of a sample of 38 residents. Specifically, Resident #287 with a hearing impairment did not receive an audiology consultation or assistive devices to improve hearing ability.<br><br>The finding is:<br><br>Upon request, the Director of Nursing stated that the facility does not have a policy and procedure related to consultation, and that resident care is based on an individual plan of care.<br><br>Resident #287 was admitted to the facility with diagnoses that included End Stage Renal Disease, Hypertension, benign prostatic hyperplasia.<br><br>The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #287 was moderately cognitively impaired, does not have hearing problems and no hearing aid or other hearing appliance was used.<br><br>On 09/26/24 at 11:17 AM, Resident #287 was met in the room, alert and awake. Resident #287 was greeted repeatedly but was not able to hear the surveyor's questions and asked the surveyor to repeat self. Resident #287 stated they were not able to hear because they had an impairment to their left ear. Resident #287 was unable to recall if they had a hearing aid and asked the surveyor to speak to their child.<br><br>The Comprehensive Care Plan titled Communication Problem dated 11/11/22, last updated 11/03/23 documented that the resident had a communication problem related to being hard of hearing. Interventions included staff need to increase speaking volume when talking to the resident, anticipate and meet resident's needs, speak on an adult level, speaking clearly and slower than normal, and validate resident's message by repeating aloud.<br><br>The Physician orders since Resident #287's admission contained no documented evidence that an audiology consult was provided, or that Resident #287 had been seen by an audiologist.<br><br>On 10/02/24 at 10:56 AM, an interview was conducted with the assigned Certified Nursing Assistant #5 who stated they have been taking care of the resident for over 5 months. Certified Nursing Assistant #5 also stated that Resident #287 is hard of hearing, and they need to speak louder when talking to them. Certified Nursing Assistant #5 further stated that Resident #287 has never had a hearing aide.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335363 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ozanam Hall of Queens Nursing Home Inc | 42 41 201st Street<br>Bayside, NY 11361 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/02/24 at 11:28 AM, an interview was conducted with Resident #287's child who stated that Resident #287 used to have hearing problems when they were at home before being admitted into the nursing home. Resident #287's child also stated that they could not recall if anyone at the facility had ever discussed any hearing concerns of their parent or whether their parent had been seen by an audiologist.<br><br>On 10/02/24 at 11:55 AM, an interview conducted with the Director of Minimum Data Set assessments who stated that they reviewed the previous Minimum Data Set assessments and found that the hearing problem of Resident #287 was not identified however it was identified on the upcoming assessment dated [DATE] that was not yet submitted.<br><br>On 10/02/24 at 12:42 PM, an interview was conducted with the Attending Physician who stated that all resident care needs should be followed up during their visits. The Attending Physician also stated that a resident with a hearing impairment should be accommodated to ensure that assistive devices, such as hearing aids are provided if required. The Attending Physician further stated that Resident #287 should have been seen since the audiologist comes regularly to the facility and as needed.<br><br>On 10/02/24 at 02:18 PM, an interview was conducted with the Director of Nursing who stated that residents with hearing problems will first have their ears cleaned of any wax. If the hearing problem persists, then they will be referred to the audiologist who comes to the facility frequently. The Director of Nursing also stated that they were not aware that Resident #287 was hard of hearing. The Director of Nursing further stated that the audiologist comes a couple of times a month, and the nurses are supposed to identify a problem and get an order for the resident to be seen by the audiologist if needed.<br><br>10 NYCRR 415.12(3)(b)(1-3) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50820<br><br>Based on observations, record review and interviews conducted during the Recertification Survey from 9/26/2024 to 10/03/2024, the facility did not ensure that residents who needed respiratory care was provided such care consistent with professional standards of practice. This was identified for 2 of 4 Residents (Resident #58 and Resident #127) reviewed for Respiratory Care out of a sample of 36 total sampled residents. Specifically, Resident #58 and Resident #127 who received continuous oxygen did not have pulse oxygen saturations appropriately monitored and there was no date on their nasal cannula/ tubing date indicating when the tubing was last changed.<br><br>The findings are:<br><br>The facility policy titled Oxygen Administration dated 02/27/2024 states that it is the policy to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated, date tubing when changed. The policy also stated that staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.<br><br>1. Resident #127 was admitted to the facility with diagnoses that included Heart Failure, Hypertension, and Shortness of breath.<br><br>The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #127 was cognitively intact and was receiving oxygen therapy.<br><br>The Physician orders dated 01/08/2024 stated Oxygen inhalation per nasal cannula at 2 liters per minute every shift every day.<br><br>On 09/30/2024 at 10:17 AM, Resident #127 was interviewed and stated that it had been more than a week since oxygen tubing was last changed.<br><br>On 09/30/2024 at 10:17 AM, Resident #127 was observed receiving 2 liters of oxygen via nasal cannula. There was no date observed on the tubing.<br><br>On 09/30/2024 at 12:03 PM and on 10/01/24 at 10:05 AM, Resident #127 was observed receiving 2 liters of oxygen via nasal cannula. There was no date observed on the tubing.<br><br>The Vitals Summary documented that an Oxygen saturation of 97% was last recorded on 06/11/2024.<br><br>A Nursing progress note dated 07/15/2024 documented that Resident #127 had an Oxygen saturation of 96%.<br><br>A Nursing Progress Note dated 08/02/2024 documented that Resident #127 refused to have their oxygen saturation assessed.<br><br>Review of the Electronic Medical Record contained no documented evidence that Resident #127's oxygen saturation had been recorded after 08/02/2024.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | There was no documented evidence of when oxygen tubing was last changed for Resident #127.<br><br>2. Resident #58 was admitted with diagnoses that included Pneumonia and Chronic Obstructive Pulmonary Disease.<br><br>The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #58 was cognitively intact, was admitted with oxygen therapy and was receiving oxygen currently.<br><br>The Physician orders dated 07/01/2024 stated oxygen inhalation per nasal cannula at 2-3 liters per minute every shift for shortness of breath.<br><br>On 09/27/2024 at 10:50 AM, Resident #58 was interviewed and stated that oxygen tubing was last changed weeks ago.<br><br>On 09/27/2024 at 10:50 AM, Resident #58 was observed receiving oxygen 2 liters via nasal cannula. There was no date on the oxygen tubing.<br><br>On 09/30/2024 at 12:03 PM, Resident #58 was observed resting in bed with nasal cannula in place, oxygen running at 2 liters per minute. There was no date on the oxygen tubing.<br><br>On 10/01/2024 at 10:40 AM, Resident #58 was observed with Registered Nurse #8 receiving 2 liters of oxygen. There was no date on the nasal cannula tubing.<br><br>The Vital Signs Summary last documented an oxygen saturation of 97% was recorded for Resident #58 on 07/26/2024.<br><br>Review of the Electronic Medical Record contained no documented evidence that Resident #58's oxygen saturation had been recorded after 07/26/2024.<br><br>There was no documented evidence of when oxygen tubing was last changed for Resident #58.<br><br>On 10/02/2024 at 10:58 AM, Licensed Practical Nurse #5 was interviewed and stated that Licensed Practical Nurses on the units usually change the oxygen tubing twice a week, if it is dirty or noted to be on the floor. Licensed Practical Nurse #5 also stated that the tubing must have a label with a date to indicate when it was last changed. If there is no date on the tubing, then it poses a risk of infection control. Licensed Practical Nurse #5 stated that Oxygen saturation level should be recorded under vital signs and while the nurses check the oxygen saturation for residents on oxygen, it is not being recorded appropriately. Licensed Practical Nurse #5 also stated that they could not locate any documentation for the past couple of weeks regarding oxygen saturation levels for Resident #58 and Resident #127, and there was no other oxygen monitoring system in place for them. Licensed Practical Nurse #5 further stated that if oxygen levels are not monitored continuously there is risk of residents going into respiratory distress.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/01/2024 at 10:12 AM, Registered Nurse #8 was interviewed and stated that oxygen tubing is supposed to be changed weekly, is done mostly on the overnight shift, and staff are supposed to place a piece of tape on the tubing with the date that the tubing was changed. Registered Nurse #8 also stated that if the tubing is not changed it creates an infection control risk and the tubing also gets harder and is not as patent. Registered Nurse #8 was unable to locate a date on the tubing indicating when it was last changed and stated that there are no notes documenting when it was last changed either. Registered Nurse #8 stated that the charge nurses are responsible for monitoring oxygen saturation adequately as residents can go into respiratory distress if it is not properly monitored.<br><br>On 10/02/2024 at 02:32 PM, the Registered Nurse #1 was interviewed and stated that if a resident is on continuous oxygen the pulse oxygen saturation should be monitored every shift. Registered Nurse #1 also stated that oxygen saturation levels had not been checked today for Resident #127 and Resident #58, both Licensed Practical and Registered nurses are responsible for checking the pulse oxygen saturation of residents. Registered Nurse #1 stated that they were not sure why this had not been or documented for several weeks. Registered Nurse #1 also stated that they are not sure how often nasal cannula tubing should be changed and did not know why there were no dates on the tubing.<br><br>On 10/02/2024 at 03:05 PM, the Director of Nursing Service was interviewed and stated that there should be an order for oxygen saturation to be checked once a shift and typically it should be checked once ever shift. Monitoring needs to be done for resident on continuous oxygen to ensure that they are on the right concentration of oxygen and licensed staff should be monitoring oxygen use. The Director of Nursing Service also stated that the nasal cannula tubing should be changed weekly as per protocol as this creates an infection control issue if not changed appropriately. The protocol is that night shift nurses are supposed to change tubing every Tuesday night and label it with the date it was changed. The Director of Nursing Services stated that there are supervisors on each floor who are supposed to oversee staff and identify issues that required correction or education, however, these two issues were not noted to be a concern and is something that should have been followed by all staff as it is normal protocol. The Director of Nursing also stated that all nursing staff on been inserviced on the protocol regarding oxygen use.<br><br>10 NYCRR 415.12(K)(6) |