STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335372	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vanderbilt Rehabilitation and Care Center, Inc	135 Vanderbilt Ave Staten Island, NY 10304

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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** 44842 Based on observation, interviews, and record review conducted during the recertification survey from 07/09/2024 to 07/16/2024, the facility did not ensure each resident was treated with respect and dignity. This was evident for 1 (Resident #344) of 1 residents reviewed for Dignity out of 39 total sampled residents. Specifically, the facility did not ensure privacy and dignity were provided when a licensed nurse performed blood glucose monitoring. The findings are: The facility's policy titled Resident Rights Overview dated 04/2023 documented it is the policy of this facility to protect and promote resident rights. It is the policy of this facility to create an environment that strongly emphasizes individual dignity and self-determination while promoting resident independence and a positive quality of life. Resident #344 had diagnoses which included Schizophrenia, Depression, and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented that Resident #344 had intact cognition. During an observation on 07/09/2024 at 12:39 PM, Licensed Practical Nurse #7 was observed collecting a fingerstick from Resident #344 in the Unit 3 Dining Room in front of other staff and residents while residents were eating lunch. During an interview on 07/09/2024 at 12:39 PM, Licensed Practical Nurse #7 stated they are instructed to collect the fingerstick from Resident #344 whenever they catch the resident. The Licensed Practical Nurse #7 further stated the fingerstick is usually done in areas where there is privacy. During an interview on 07/09/2024 at 2:32 PM, the Registered Nurse Supervisor #8 stated Licensed Practical Nurse #7 should have taken Resident #344 to their room for privacy and performed the fingerstick there. During an interview on 07/16/2024 at 1:50 PM, the Director of Nursing stated resident care is supposed to be provided with privacy, to maintain dignity. The Director of Nursing further stated Licensed Practical Nurse #7 should have taken Resident #344 back to their room for the fingerstick. 10 NYCRR 415.5

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on interview and record review conducted during the Recertification and Complaint survey (NY00335874) from 7/9/24 to 07/16/2024, the facility did not ensure that it promoted and facilitated resident self-determination through the support of resident choice for 1 (Resident #143) of 5 residents reviewed for Activities of Daily Living, and 2 (Resident #39 and #63) of 2 residents reviewed for Choices. Specifically, the preferred number of showers per week were not obtained and not provided in accordance with Resident #143, Resident #39's, and Resident #63's wishes. The findings are: The facility's policy and procedure titled Shower and Bath reviewed 2/2022 documented facility to cleanse and refresh the residents through showering and scheduled for two showers per choice weekly and as needed. 1. Resident #143 was admitted to the facility with diagnosis of Cerebrovascular Accident and Hypertension. The Quarterly Minimum Data Set, dated dated dated [DATE] documented resident had severely impaired cognition and required partial/moderate assistance for shower. The New York State Department of Health Complaint Intake (NY00335874) received 5/9/2024 documented that Resident #143's hygiene is poor, and they do not get their hair washed. During an interview on 7/10/2024 at 10:20 AM, Resident #143 stated they were showered once last week but they would like twice a week as per their shower schedule. The Comprehensive Care Plan for Activities of Daily Living/Rehabilitation Potential revised 12/22/2023 documented that resident's bathing type is shower. The Certified Nursing Assistant Documentation Record from 6/1/2024 to 7/10/2024 revealed Resident #143 was showered 3 (6/6/2024, 6/13/2024, and 6/25/2024) days out of 9 days in June 2024 and 2 (7/2/2024, 7/9/2024) days out of 3 days from 7/1/2024 to 7/10/2024. The review of Resident #143's medical record from 6/1/2024 to 7/10/2024 revealed resident refused shower once on 7/5/2024; therefore, bed bath was rendered instead. There was no documented evidence that Resident #143 refused shower on other scheduled days. On 7/11/2024 at 10:44 AM, Certified Nursing Assistant #14 was interviewed and stated that Resident #143 requires assistance and is scheduled to shower twice a week. Certified Nursing Assistant #14 also stated that Resident #143 is able to verbalize their needs and they did not recall Resident #143 ever refusing a shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/2024 at 11:39 AM, Licensed Practical Nurse #8 stated that all residents on the unit have a shower schedule and are showered twice a week. Licensed Practical Nurse #8 also stated that any refusal of care or treatment is documented in the resident's medical record and Resident #143 had refused a shower on 7/5/2024. Licensed Practical Nurse#8 further stated that they do not recall Resident #143 refusing any showers last month. On 7/16/2024 at 11:26 AM, Registered Nurse Supervisor #2 stated the unit nurse is responsible for ensuring that nursing staff is providing showers as per the schedule and document if it is not being done. Registered Nurse Supervisor #2 also stated they were not aware that Resident #143 was not getting shower consistently on their shower days. 50894 2. Resident #63 had diagnoses which included Cerebrovascular accident and hemiparesis. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #63 was cognitively intact, required moderate assistance with bathing and personal hygiene, and that there was no rejection of care. The Significant Change Minimum Data Set assessment dated [DATE] documented that it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. During an interview on 07/09/24 at 12:03 PM, Resident #63 stated that they received showers on Tuesdays and Saturdays. Resident #63 stated that they would like to take showers more often but if they request to shower on an alternate day, they are told by the Certified Nursing Assistants to wait until their designated shower day. During an interview on 07/15/24 at 09:46 AM, Certified Nursing Assistant #7 stated that Resident #63 is scheduled for showers during the event shift and that they work the day shift, so they do not assist with this resident's showers. Certified Nursing Assistant #7 stated that Resident #63 has not requested a shower during the day shift but requests a bed bath one to two times per week and they are able to accommodate this. 3. Resident #39 had diagnoses which included Renal Failure, Diabetes Mellitus, and Anxiety. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #39 was cognitively intact, required dependent-level assistance for bathing, tub/shower transfer, putting on and removing footwear, and lower body dressing. Resident #39 required moderate assistance for upper body dressing and personal hygiene. The Annual Minimum Data Set assessment dated [DATE] stated that it was very important to choose between a tub bath, shower, bed bath or sponge bath. During an interview on 07/09/24 at 11:33 AM, Resident #39 stated that their shower days are Wednesday and Saturday, but that they attend dialysis every Wednesday, so they are only able to shower on Saturdays. Resident #39 stated that they would like to shower three days per week, on days that they are not attending dialysis. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/12/24 at 09:13 AM, Resident #39 stated that they clean themselves in bed by mixing their own solution which they put on a rag because they do not feel like the staff cleans them thoroughly. Resident #39 also stated that they are rushed in and out of the shower by the Certified Nursing Assistant on their shower day and that there are times when the Certified Nursing Assistant is unable to wash their hair on their shower day because they are too busy. During an interview on 07/15/24 at 09:38 AM, Certified Nursing Assistant #7 stated that Resident #39 is scheduled for showers on Wednesday and Saturday. They stated that a bed bath is given on Wednesday instead of a shower due to the resident going to dialysis on Wednesdays. Certified Nursing Assistant #7 stated that they will wash the resident's body completely but that the resident sometimes wants to clean themself in addition to that, and Certified Nursing Assistant #7 will give the resident a washcloth to do so. Certified Nursing Assistant #7 stated that the nurse on the floor creates the shower schedule and that depending on how many other showers are scheduled for that day, they may be able to accommodate shower requests for non-scheduled shower days. During an interview on 07/15/24 at 02:57 PM, Registered Nurse #3 stated that showers are given twice a week based on the posted shower schedule which designates assigned shower days based on room number. Registered Nurse #3 stated that the schedule that is currently followed for the 2nd floor residents was created with day and room assignments prior to Registered Nurse #3 being assigned to the floor, but that they can edit it if needed. Resident Nurse #3 also stated that they have only had one or two requests for showers on alternate shower days by residents on the floor, and if the resident's assigned Certified Nursing Assistant has extra time, they will usually comply with extra shower requests unless they are chaotically busy and short staffed. Registered Nurse #3 stated that the social worker and Director of Nursing would be required to approve requests for a resident to be regularly scheduled for more than two showers per week, or to change the day of the scheduled two showers. During an interview on 07/16/24 at 11:28 AM, the Director of Social Work stated that residents are showered twice a week and that if residents want to change their shower day, the social service department would work with the nurses on the floor to assist with the resident's request. The Director of Social Work stated that they were unaware if anyone asks residents about their shower frequency preference or bathing preference and that that would likely be something the nursing department would do. During an interview on 07/16/24 at 11:45 AM, the Director of Nursing stated that showers are scheduled at least twice a week, or more if that is the resident's preference. The Director of Nursing stated that residents are told that they will get showers twice a week during their admission but that nurses on the floor should be telling residents that they can take showers more frequently than that if they would like. 10 NYCRR 415.5(b)(1-3)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48711 Based on observation, record review, and interviews conducted during the Recertification survey from 07/09/2024 to 07/16/2024, the facility did not ensure that residents are provided the option to formulate an advance directive and that advance directives are documented for each resident. This was evident for 2 (Resident #502 and Resident #233) of 6 residents reviewed for Advance Directives out of 39 sampled residents. Specifically, the facility failed to discuss and provide information concerning the resident's right and option to formulate an advance directive for newly admitted residents. The findings are: The policy and procedure titled Advanced Directives reviewed/revised 03/20/2024 documented that residents and/or health care representative will receive education regarding advanced directives on admission, re-admission, annually, with any change in condition, and as requested by the resident and/or healthcare representative. 1. Resident #502 had diagnoses which included Benign Prostate Hyperplasia and Diabetes Mellitus. The Admission Minimum Data Set assessment dated [DATE] documented Resident #502 was moderately cognitively intact, was understood and was able to understand others. A review of the physician orders, hard chart, and electronic medical record on 7/9/2024 reveal no orders for advanced directives and there was no Medical Orders for Life-Sustaining Treatment form located on the chart. There was no documented evidence in the Social Service notes or assessment that Advanced Directives had been reviewed with Resident #502. On 07/12/24 at 10:00 AM, Registered Nurse Supervisor #9 was interviewed and stated they were not sure of whose responsibility it is to put in the Medical Orders for Life Sustaining Treatment forms in the chart. Registered Nurse Supervisor #9 also stated that the nurses are supposed to ask on admission about the resident's advanced directives and put a Medical Life Sustaining Orders for Life Sustaining Treatment form on the chart. Registered Nurse Supervisor #9 further stated that they were not sure of why this had not been done for Resident #502. 50894 2. Resident #233 was admitted to the facility on [DATE] with diagnoses that included Cerebrovascular accident, Coronary Artery Disease, and Non-Alzheimer's dementia. The Admission Minimum Data Set assessment dated [DATE] documented that resident was cognitively intact and that the resident and resident's family participated in the assessment. The Comprehensive Care Plan titled Advance Directives dated 06/05/2024 stated Resident has the following advance directive orders in place with nine options, however none of the options had been selected and all were unchecked. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that advance directives were discussed with the Resident #23 or their designated representative, and no advance directives were noted in the medical record. On 07/15/24 at 03:06 PM, an interview was conducted with Registered Nurse #3 who stated that when a resident is admitted , the social worker will discuss and determine the resident's advance directives. Registered Nurse #3 also stated that the social worker completes a Medical Orders for Life-Sustaining Treatment form for every admitted resident and that it will be placed in their chart in case of a code. Registered Nurse #3 stated that they will then notify the doctor that the advanced directive order needs to be signed, or the Director of Social Work will get verbal consent from the doctor. On 07/16/24 at 11:28 AM, an interview was conducted with the Director of Social Work who stated that on admission, the social worker meets with the resident and their family and discusses advance directives. If a choice is made, it is initiated with an order. A Medical Orders for Life-Sustaining Treatment form is created if the resident would like to create one. If the resident does not decide to create a Medical Orders for Life-Sustaining Treatment form, they are documented as being full code by default. stated that this should be documented in the chart and there should be a care plan created for the advance directives. The Director of Social Work also stated that for Resident #233 and Resident #502, there is no Medical Order of Life Sustaining Treatment form and there is no documentation by Social Work about any conversations being conducted about advanced directives. On 07/16/24 at 11:57 AM, an interview was conducted with the Director of Nursing who stated that when a resident is admitted from a hospital, the admission nurse should check the discharge paperwork to see if the resident came with a Medical Orders for Life-Sustaining Treatment form. If so, they will ask the resident or resident representative if they would like to continue this advance directive and document that in the chart. The Director of Nursing also stated that if they are not admitted with a Medical Orders for Life-Sustaining Treatment form, the admission nurse will explain their advance directive options to them and will document this in their chart. The Director of Nursing further stated that if a resident does not opt to complete a Medical Orders for Life-Sustaining Treatment form, they will be defaulted to being full code and this will be documented in the chart. 10 NYCRR 415.3(e)(1)(ii)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on record review and interviews conducted during the Recertification survey from 7/09/2024 to 7/16/2024, the facility did not immediately inform the physician when a resident's blood sugar was below the parameter that needed to be reported. This was evident for 1 (Resident #344) of 1 resident reviewed for Dignity out of 39 total sampled residents. Specifically, Resident #344 had a physician's order to notify the physician when resident's finger stick blood sugar (method of drawing drops of blood from the finger for testing the blood glucose level) result was less than 70 milligrams per deciliter or more than 400 milligrams per deciliter. The licensed nurse failed to notify the physician when Resident #344's finger stick blood sugar was below 70 milligrams per deciliter on 07/09/2024. The findings are: The facility's policy titled Diabetic Management dated 01/01/2024 documented the Primary Medical Doctor will be notified when a resident exhibits any signs or symptoms of hypoglycemia, and the current diabetic management regime will be reviewed and revised, and the root cause of hypoglycemia will be identified. Resident #344 had diagnoses which included Schizophrenia, Depression, and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented that Resident #344 had intact cognition. A Comprehensive Care Plan for Diabetes was initiated on 01/04/2018 and revised 6/26/2024 and included interventions of monitor blood glucose level as ordered by the medical doctor and monitor for observable signs and symptoms of hyperglycemia (a condition when the blood sugar was higher than normal) or hypoglycemia (a condition when the blood sugar level was lower than normal). On 07/09/2024 at 11:30 AM, during a Dining Room observation, Licensed Practical Nurse was observed checking blood glucose for Resident #344. A physician's order dated 06/02/2024 documented Novolin 100 units per milliliter injection solution, inject subcutaneously every day at 7:30 AM, 11:30 AM, and 4:30 PM when finger stick blood sugar readings are as follows: Between 151 and 200 give 2 units, between 201 and 250 give 4 units, between 251 and 300 give 6 units, between 301 and 350 give 8 units, and between 351 and 400 give 10 units. If greater than 400 or below 70, call the physician. The electronic Medication Administration Record for 07/9/2024 at 11:30 AM documented a finger stick blood sugar result of 64 milligrams per deciliter. The nurses and medical progress notes dated 07/09/2024 through 07/10/2024 contained no documented evidence that the physician had been notified as per the order when Resident #344's finger stick blood sugar result was below 70 milligrams per deciliter. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 11:45 AM, Licensed Practical Nurse #7 was interviewed and stated they have Physician #2's personal cell number and sent a text to the physician with Resident #344's blood sugar result on 07/09/2024. During an interview on 07/16/2024 at 11:59 AM, Physician #2 stated they did not receive a text from Licensed Practical Nurse #7 on 07/09/2024 and was never notified of Residents #344's low blood sugar on 07/09/2024. The Physician #2 further stated they want to be notified when Resident #344's finger stick blood sugar is below 70. During an interview on 07/16/2024 at 1:50 PM, the Director of Nursing stated Licensed Practical Nurse #7 should have followed Physician #2's orders and notified the physician and their supervisor when Resident #344's blood sugar was below 70 milligrams per deciliter. 10 NYCRR 415.3(f)(2)(ii)(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review, and interview conducted during the Recertification Survey from 07/09/2024 to 07/16/2024, the facility did not ensure a safe, clean, comfortable, and homelike environment was provided to the residents. Specifically, maintenance services necessary to maintain a sanitary, orderly and comfortable interior were not provided to the residents. This was evident for 4 of 9 resident units (Unit 5, Unit 6, Unit 7, Unit 2, and Unit 8) during environmental observations. Specifically, 1) on Unit 5 a wooden closet was observed with scuff marks and scratches, and the lock on the closet was broken, 2) on Unit 6 name plaques were missing, there mismatched and scuffed paint on walls, scratched furniture, cracked armrests and missing parts on wheelchairs, rusted and scratched lockers, and black substance on shower room floor grout, 3) on Unit 7 there was mismatched paint, scuff marks in dining room and throughout unit, and scratched furniture, 4) on Unit 2 an active leak was observed in the ceiling of a resident's room, 2), and on Unit 8, mismatched pain, stained walls, chipped radiator, broken nightstand, scuffed walls, dusty furniture, and improperly hung privacy curtains were observed. The findings are: The facility's policy titled Safe, Clean, Comfortable, and Home-like Environment revised on 02/20/2023 stated that it is the policy of the facility to provide a safe, clean, comfortable homelike environment in such a manner to acknowledge and respect resident rights to the extent possible. The policy also documented that this included but was not limited to the provision of housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The New York State Department of Health Complaint Intake #NY00337577 dated 4/1/2024 documented the facility is dirty and there is broken furniture throughout the facility. 1. On 7/9/2024 at 10:58 AM and on 7/10/2024 at 9:05 AM, on Unit 5 in room [ROOM NUMBER] A, the wooden closet was observed with scuffs marks and scratches, and the lock on the closet was broken. 44842 During multiple observations from 7/9/24 to 7/16/24 the following were noted: 2) On Unit 6 a) Rooms 615/616/618-Name plaques were missing near bedroom doors leaving square area of mismatched, scuffed paint, b) Lock on 618A wooden closet was broken, c) a black-colored substance was noted along the floor/wall edge in shower room (lower side of unit), d) Resident #36's wheelchair armrests cracked and missing foam from right arm rest, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) Resident #102's left push handle grip missing and plastic part at end of left anti bar missing on wheelchair, f) Metal lockers and cabinet rusted and scratched (located in side hallway on unit), and g) Chipped paint, mismatched paint, scuff marks, and scratched furniture were observed throughout unit. 3) On Unit 7 a) Large chunk of paint peeled off lower door of dining/day room, b) Mismatched/scuffed paint throughout dining/day room, c) room [ROOM NUMBER] Large rectangular area of mismatched paint, d) room [ROOM NUMBER] About 8 chipped paint on wall by nightstand bed A, e) room [ROOM NUMBER] Large piece of the top layer of counter below sink was missing, wooden closet had scratches, and large square area of mismatched paint missing, f) Large area of mismatched paint near elevator, and g) Chipped paint, mismatched paint, scuff marks, and scratched furniture throughout unit. On 7/12/2024 at 11:10 AM, [NAME] #1 was interviewed and stated staff reports broken furniture in the maintenance book which is located at the nurse's station. Then we either fix the furniture or throw it out. On 7/16/2024 at 1:42 PM, the Director of Nursing was interviewed and stated we do weekly rounds with Administrator, Maintenance, and Housekeeping Director. The Director of Nursing stated they are putting together work orders for maintenance and housekeeping issues that need to be addressed and setting aside broken furniture in the facility alcove to be removed from the facility. 50894 4. On 07/11/24 at 11:24 AM, brown marks were observed on the ceiling of room [ROOM NUMBER]. A basin was observed on top of the air conditioning unit, positioned under some of the brown marks on the ceiling. On 07/11/24 at 11:24 AM, the resident who resides in room [ROOM NUMBER], was interviewed and stated that the ceiling had been leaking for a while on and off, most recently on 07/10/2024, and that it had been an ongoing issue. They were unable to identify an approximate date when it began. The resident also stated that all of the staff on the floor were aware of the issue, On 07/15/24 at 11:00 AM, the resident who resides in room [ROOM NUMBER] was re-interviewed and stated that maintenance had examined the leak on 07/12/2024 and told them that it was resolved. [NAME] marks on the ceiling remained present. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/15/24 at 2:48 PM, room [ROOM NUMBER] was observed with a ceiling actively leaking, with drops collecting in the basin placed on top of the air conditioning unit. [NAME] marks were observed on the ceiling where leak was occurring. On 07/16/24 at 09:31 AM, the basin in room [ROOM NUMBER] was observed to have two white cloths in it that were saturated in water. 5. On 07/10/2024 at 12:39 PM, the following observations were made on Unit 8 in room [ROOM NUMBER]: a) Paint on the ceiling and walls were mismatched, b) Stains and scuffmarks observed on walls, c) Radiator paint was chipped, d) Nightstand door was broken, e) Sink ledges were dusty, f) Brownish stains observed on remote control, g) Scuffmarks observed on dresser, h) Stains observed on floor, and i) Privacy curtain improperly hung with hooks missing, On 07/12/24 at 10:29 AM, Registered Nurse Supervisor #3 was interviewed and stated that the facility was aware of the leak in room [ROOM NUMBER], and that the leak is coming from the air conditioning unit in the room on the 3rd floor above room [ROOM NUMBER]. Registered Nurse #3 also stated that maintenance was aware of the leak and was working on fixing it. On 07/15/2024 at 09:46 AM, Certified Nursing Assistant #7 was interviewed and stated that on 07/12/2024, maintenance fixed the leak in Resident #63's ceiling. Certified Nursing Assistant #7 also stated that maintenance requests are managed via a computer ticketing system. On 07/16/24 at 12:20 PM, Housekeeper #1 was interviewed and stated that privacy curtains are cleaned when the Director of Housekeeping tells the housekeepers to clean them. The housekeeper will remove the curtain, wash them, and rehang them. Housekeeper #1 also stated that the housekeepers are not responsible for identifying when curtains need to be cleaned or fixed and that it would be up to the nurse on the floor to notify the Director of Housekeeping of concerns. Housekeeper #1 further stated that concerns like leaks would be handled by the maintenance department. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/24 at 12:30 PM, the Director of Housekeeping was interviewed and stated that they make daily rounds of the units to identify concerns, but that if there is a specific concern, nurses will let them know, and that housekeepers are not responsible for notifying the head of housekeeping of these concerns. The Director of Housekeeping stated that there may be torn curtains on Unit 2 but that they were not sure, and that if privacy curtains are torn, it is their responsibility to order new ones. On 07/16/24 at 12:42 PM, the Director of Maintenance was interviewed and stated that they make daily rounds on the units to identify any maintenance related concerns. The Director of Maintenance also stated that they were aware of the leak in room [ROOM NUMBER] and that it needs to be repaired. The Director of Maintenance further stated that there are only four other people working on the maintenance team so they cannot immediately repair things like this but try their best to get it done as quickly as possible. 10 NYCRR 415.5 (h)(2)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894 Based on record review and staff interviews, during the recertification survey from 07/09/2024 to 07/16/2024 the facility did not ensure Minimum Data Set (MDS) 3.0 comprehensive and non-comprehensive assessments were submitted and transmitted into the Quality Improvement Evaluation System Assessment Submission and Processing system in a timely manner. Specifically, admission, annual, and quarterly assessments were not submitted and transmitted within 14 calendar days after the assessments were completed. This was evident for 53 of 53 residents reviewed for the Resident Assessment facility task. The findings include but are not limited to: The facility policy and procedure titled Resident Assessment Using Minimum Data Set reviewed 01/01/2024 documented that the facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The Minimum Data Set assessments will be completed and submitted in accordance with regulatory time frames. The Minimum Data Set Assessments will be transmitted to CMS within 14 days after completion by the Minimum Data Set Coordinator/designee. The Centers for Medicare and Medicaid Services Resident Assessment Instrument Version 3.0 Manual Dated October documented that Assessment Completion refers to the date that all information needed has been collected and recorded and staff have signed and dated the assessment is complete. The manual also documented that Assessment Transmission refers to the electronic transmission of submission files to the Quality Improvement Evaluation System Assessment Submission and Processing system using the Medicare Data Communication Network. The Centers for Medicare and Medicaid Services Resident Assessment Instrument Version 3.0 Manual also documented that the Minimum Data Set completion date must be no later than 14 days after the Assessment Reference Date for all non-admission assessments. The Minimum Data Set completion date must be no later than 13 days after the entry date for admission assessments. Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date. All other Minimum Data Set assessments must be submitted within 14 days of the Minimum Data Set completion date. 1. Resident #202 was initially admitted to the facility on [DATE]. The Quarterly assessment with an Assessment Reference Date of 05/04/2024 was completed and signed on 05/18/2024 and submitted/transmitted on 07/08/2024. The assessment was submitted/transmitted 51 days late. 2. Resident #1 was initially admitted to the facility on [DATE]. The Quarterly assessment with an Assessment Reference Date of 04/30/2024 was completed and signed on 05/7/2024 and submitted/transmitted on 07/08/2024. The assessment was submitted/transmitted 48 days late. 3. Resident #136 was initially admitted to the facility on [DATE]. The Quarterly assessment with an Assessment Reference Date of 05/08/2024 was completed and signed on 05/16/2024 and submitted/transmitted on 07/08/2024. The assessment was submitted/transmitted 39 days late. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	4. Resident #167 was initially admitted to the facility on [DATE]. The Quarterly assessment with an Assessment Reference Date of 05/07/2024 was completed and signed on 05/14/2024 and submitted/transmitted on 07/08/2024. The assessment was submitted/transmitted 41 days late. 5. Resident #5 was initially admitted to the facility on [DATE]. The Quarterly assessment with an Assessment Reference Date of 04/16/2024 was completed and signed on 04/22/2024 and submitted/transmitted on 07/08/2024. The assessment was submitted/transmitted 63 days late. 6. Resident #59 was initially admitted to the facility on [DATE]. The Quarterly assessment with an Assessment Reference Date of05/10/2024 was completed and signed on 05/17/2024 and submitted/transmitted on 07/08/2024. The assessment was submitted/transmitted 38 days late. On 07/16/2024 at 10:31 AM, the Minimum Data Set/Rehabilitation Department head was interviewed and stated that their job responsibilities include overseeing the Minimum Data Set Secretary, who submits the Minimum Data Set assessment books. The Minimum Data Set/Rehabilitation Department head also stated that the Minimum Data Set assessment books were being submitted late because some of the interdisciplinary team members who conducted the assessments were completing the documentation of their assessments late. The Minimum Data Set/Rehabilitation Department head further stated that the Minimum Data Set system can show that the assessment was completed timely even though all members of the interdisciplinary team may not have completed their assessments. On 07/16/2024 at 10:37 AM, the Minimum Data Set Secretary was interviewed and stated that their job responsibilities include submitting the Minimum Data Set assessment books in the electronic medical record after they are completed. The Minimum Data Set Secretary also stated that once a Minimum Data Set book is completed, the Minimum Data Set/Rehabilitation Department head would move it to the ready to submit category in the electronic medical record. The Minimum Data Set Secretary further stated that they check the ready to submit section daily, and if an assessment was submitted late, it would be because it was not marked as ready to submit by the Minimum Data Set/Rehabilitation Department head. On 07/16/2024 at 11:13 AM, the Administrator was interviewed and stated that they are not certain who is signing the Minimum Data Set assessment books but that it would be someone in the Minimum Data Set department overseen by Minimum Data Set/Rehabilitation Department head. The Administrator also stated that they are aware that assessments are being submitted late and that the Minimum Data Set/Rehabilitation Department head has been discussing this with the involved interdisciplinary departments. On 07/16/2024 at 11:38 AM, the Director of Social Work was interviewed and stated that the social work department is heavily strained due to staffing issues and that assessments are sometimes submitted late due to these staffing issues.

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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** 44864 Based on record review and interviews conducted during the Recertification and survey from 7/09/2024 to 7/16/2024, the facility did not ensure services provided met professional standards. This was evident for 1 (Resident #193) of out of 39 total sampled residents. Specifically, Licensed Practical Nurse #5 was observed administering medications via gastrostomy tube by using the pistol syringe and forcing the medications through the gastrostomy tube. The findings are: The facility's policy titled Administering Medications through an Enteral Tube, last revised 1/1/24, documented to administer each medication separately and to administer medication by gravity flow by pouring diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion, then open the clamp and deliver medication slowly. Resident #193 was admitted to the facility with diagnoses that include Chronic Respiratory Failure and Dry eye Syndrome. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #193 had a feeding tube. The Physician's order last renewed 6/24/24 included Acidophilus capsule: give 1 capsule by feeding tube route 2 times per day, multivitamins -minerals: give 5millimeters by feeding tube route once daily, and Vitamin C 500 mg tablet: give 1 tablet by g-tube route 3 times a day. On 07/12/24 at 08:14 AM, an observation of medication administration was conducted with Licensed Practical Nurse #5. Licensed Practical Nurse#5 washed their hands and put on gloves, removed medications from the medication cart, then crushed the medications individually and proceeded into the Resident #193's room. Licensed Practical Nurse #5 then placed the medications on top of a clean field on the Resident 190's bedside table and picked up a pistol syringe. Licensed Practical Nurse #5 then put water in the pistol syringe and using the syringe, pushed the water into the tube to check for patency of the tube. Licensed Practical Nurse #5 then continued to push all the other medications into the tube and did not permit the medications to flow into the tube via gravity. Licensed Practical Nurse #5 then put away the pistol syringe and removed their gloves. On 07/12/24 at 08:34 AM, immediately after the medication administration observation, Licensed Practical Nurse #5 was interviewed and stated that they dilute the medications to ensure that all the medications are administered. Licensed Practical Nurse #5 also said that they were taught both methods for administering medications via a gastrostomy tube, either by gravity or by using the pistol syringe and forcing it through. Licensed Practical Nurse #5 stated that they were taught to use either technique. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 at 08:34 AM, Registered Nurse Supervisor #2 was interviewed and stated that they when a medication is administered via a gastrostomy tube, the medications can be pushed using the syringe. Registered Nurse Supervisor #2 later stated that they were not quite sure if the medications were to be administered via gravity or pushed. On 07/16/24 at 01:04 PM, the Director of Nursing was interviewed and stated that the Licensed Staff are in-serviced during orientation, competencies are done on administering medications via gastrostomy tubes, and that the Licensed Practical Nurse #5 was evaluated was on the proper way for the gastrostomy tube medications be administered. The Director of Nursing also stated that the nurses are monitored by the Registered Nursing Supervisors and reeducation is done by the Educator. Registered Nursing Supervisors do random medication pass observations to ensure that the nurses are using the correct measures. If there is an issue, they would be re- inserviced. 10 NYCRR 415.12

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review and staff interviews conducted during the Complaint (NY#00335874) and Recertification survey from 7/9/2024 to 7/16/2024, the facility did not ensure that a resident was provided with appropriate treatment and services to maintain or improve their ability to ambulate. This was evident for 1 (Resident #143) 5 residents reviewed for Activities of Daily out of 39 sampled residents. Specifically, Resident #143 was not provided with floor ambulation program as per physical therapy and in accordance with physician's order. The findings are: The facility's policy and procedure titled Restorative Nursing Services revised 1/1/2024 documented resident will receive restorative nursing care as needed to help promote optimal safety and independence. Resident #143 was admitted to the facility with diagnoses that included Cerebrovascular Accident, Hypertension, and Hyperlipidemia. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #143 had intact cognition, required supervision for walking 50 feet and walk of 150 feet had not been attempted, and resident used a walker and wheelchair for ambulation. The New York State Department of Health Complaint Intake received 5/9/2024 documented that Resident #143 can walk to the bathroom, but the staff will not let resident walk or provide any walking exercises. On 7/10/2024 at 10:20 AM, an interview was conducted with Resident #143 who stated they would like to be out of bed and out of the room more often to decrease further decline in their mobility. Resident #143 also stated they had not been doing any type of walking or ambulating with staff on the unit. The Physician's Order initiated 1/6/2024, revised 3/3/2024 documented Floor Ambulation Program resident to ambulate 100 feet using rolling walker with closer supervision and wheelchair to follow twice daily. The Physical Therapy Discharge Summary completed 3/4/2024 documented Resident #143 has reached maximum potential with skilled services and was being discharged from physical therapy. The discharge recommendation for Resident #143 was to continue restorative nursing program/floor maintenance program to maintain current level of performance and in order to prevent decline. The Physical Medicine and Rehabilitation Evaluation dated 3/13/2024 documented Resident #143 was evaluated for mobility/activities of daily living (ADL) dysfunction. The evaluation also documented resident's prior function was ambulating with rolling walker independently and the recommendation was to proceed with floor ambulation program for Resident #143. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan titled Activities of Daily Living/Rehabilitation Potential last revised on 12/22/2023 revealed no documented evidence a floor ambulation program was initiated for Resident #143. The Certified Nursing Assistant Documentation Record for Resident #143 dated 3/1/2024 to 7/10/2024 revealed task Walk in Corridor task for 150 feet were completed 26 (4/17, 4/18, 4/20, 4/23, 5/5, 5/9, 5/14, 5/15, 5/16, 5/18, 5/20, 5/21, 5/23, 5/25, 5/27, 5/28, 5/29, 5/30, 5/31, 6/1, 6/5, 6/17, 6/24, 6/25, 6/26 and 7/8) out of 132 opportunities for the 7 AM to 3 PM shift, 4 (3/20, 5/18, 6/7, 6/25) out of 132 opportunities for the 3 PM to 11 PM shift, and 5 (3/28, 5/17, 5/26, 5/27, 6/17) out of 132 opportunities for the 11 PM to 7 AM shift. There was no documented evidence that Resident #143 refused the floor ambulation program. On 7/11/2024 at 10:44 AM, Certified Nursing Assistant #14 was interviewed and stated Resident #143 is independent but mostly required supervision for their daily care. Resident #143 is able to verbalize their needs and asks for assistance especially when transferring for toileting. Resident #143 is assisted to the toilet by holding and walking with the resident to the toilet. Resident #143 uses a wheelchair to transfer from their room to dining room. Certified Nursing #14 stated they were not aware that Resident #143 was on a floor ambulation program, and so they had never done any ambulation with Resident #143. On 7/16/2024 at 3:51 PM, Certified Nursing Assistant #15 was interviewed and stated Resident #143 uses a wheelchair in transferring from their room to the dining room. Certified Nursing Assistant #15 also stated they would be notified by the nurse if a resident requires an ambulation program daily. Certified Nursing Assistant #15 further stated they were not made aware of an ambulation program for Resident #143. On 7/11/2024 at 11:39 AM, Licensed Practical Nurse #8 was interviewed and stated Resident #143 requires supervision for most of their care but does gets out of bed independently at their will and uses a wheelchair to go out of their room. Licensed Practical Nurse #8 also stated that any noncompliance or refusals will be documented in the medical record. Licensed Practical #8 further stated they were not aware that Resident #143 was on a Floor Ambulation Program because the floor ambulation program is usually done on the unit by the Rehab staff. On 7/11/2024 at 12:30 PM, the Director of Rehabilitation was interviewed and stated that Resident #143 completed Physical Therapy on 3/3/2024 and was discharged to the unit on a Floor Ambulation Program. Resident #143 was able to ambulate 100 feet using the rolling walker and a Floor Ambulation Program was ordered upon discharge to maintain functional ability and to prevent further decline. The Director of Rehabilitation also stated nurses are responsible for picking up the order and implementing the floor ambulation program with the nursing staff. The Director of Rehabilitation further stated that they were not aware that nursing staff did not perform the floor ambulation program for Resident #143 On 7/16/2024 at 11:26 AM, Registered Nurse Supervisor #2 was interviewed and stated the unit nurse is responsible for ensuring that nursing staff is doing the ambulation program with the residents. Registered Nurse Supervisor #2 reviewed Resident #143's medical record and stated that Resident #143 has an order for Floor Ambulation Program, but they did not know why the floor ambulation program was not implemented for Resident #143. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12(e)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observation, record review and interview conducted during the Recertification/ Complaint Survey from 07/09/2024 to 07/16/2024, the facility did not ensure that a resident with indwelling catheter receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bowel function to the extent possible. This was evident for 2 (Residents #20 and #160) of 3 residents reviewed for Catheter care out of a sample of 39 residents. Specifically, the Foley urinary collection bag was improperly positioned compromising the devices' ability to maintain gravity drainage and prevent reflux of urine. The findings are: The facility's policy and procedure titled Catheter Care, Urinary with a revision date of 12/2019, documented that the drainage bag should be positioned lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 1.Resident #20 was admitted to the facility with diagnoses that included Coronary Artery Disease, Neurogenic Bladder, and Cerebrovascular Accident (CVA. The Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident has intact cognitive status (Brief Interview for Mental Status score 15). The Minimum Data Set also documented that Resident #20 is dependent on staff for most activities of daily living including toileting hygiene, shower/bathe, upper body dressing, lower body dressing, and personal hygiene and had an indwelling catheter. The Comprehensive Care Plan titled Urinary Incontinence-Foley Catheter dated 3/14/24 documented that Resident #20 has alteration in urine elimination, with indwelling catheter in place, with goals that included resident will not experience complications of indwelling catheter as evidenced by no signs or symptoms of urinary infection. Interventions included monitor for signs/symptoms of urinary tract infection, and report abnormal findings to physician. The Physician's order dated 07/03/2024 documented Foley Catheter Care every shift and as needed. On 07/09/24 at 12:12 PM, Resident #20 was observed in the dining room, with a Foley catheter bag hanging on the left side of the resident's chair. On 07/10/24 at 09:21 AM, Resident #120 was observed in bed, and a Foley bag was hanging on the left upper side rail of bed, above the level of Resident #20's bladder. Resident #20 was interviewed and stated that they do not know where the catheter bag was positioned by the staff, and staff comes in to empty and position the bag. On 07/11/24 at 11:01 AM, Resident #20 was observed in bed, awake, with Foley catheter bag hanging on the left upper side of bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 at 11:00 AM, Resident #20 was observed seated in the reclining chair in the day room, with the Foley catheter placed on top of their thigh. Resident #20 stated that it was their assigned Certified Nursing Assistant that placed it there when they were taken out of bed and brought to the day room. 2.Resident #160 was admitted to the facility with diagnoses that included Neurogenic Bladder, Obstructive Uropathy, and Urinary Tract Infection. The Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident has moderate impairment in cognition; has clear speech, with distinct intelligible words, makes self-understood, and understands others. The Minimum Data Set also documented the resident is totally dependent on staff for toileting hygiene. The Comprehensive Care Plan titled Urinary Incontinence dated 9/14/2023 documented Resident #160 has Alteration in Elimination related to Urinary incontinence and indwelling catheter with goals that included resident will not experience complications of indwelling catheter as evidenced by no signs or symptoms of urinary infection. Interventions included monitor for signs/symptoms of urinary tract infection, and report abnormal findings to physician. The Physician's order revised date on 06/19/2024 documented Supra Pubic Catheter-Change every 6 weeks by Urology and as needed; Flush Suprapubic Catheter 30cc every day; Change urinary bag every week. On 07/09/24 at 11:47 AM, Resident #160 was observed wheeling themself in the hallway and their Foley catheter bag was observed hanging loosely to the left side of Resident's wheelchair. Resident #160 was interviewed and stated that staff assist in emptying and positioning of the bag every shift. On 07/11/24 at 08:36 AM, Resident #160 was observed in bed sleeping and the Foley catheter bag was hanging on the right upper side rail, above the level of Resident #160's bladder. On 07/12/24 at 11:03 AM, an interview was conducted with Certified Nursing Assistant #1 who stated that Resident #20's catheter bag was removed from the bed side rail and placed on the resident's thigh while transferring the resident from bed to chair. Certified Nursing Assistant #1 also stated that the catheter bag was to be repositioned properly to the Resident #20's chair, but they were busy doing other things and did not do it. On 07/12/24 at 11:08 AM, Certified Nursing Assistant #5 was interviewed and stated that they were trained on how to care for resident's Foley catheter, and Resident #160 is assisted with morning care, showers, and with Foley catheter care. Certified Nursing Assistant #5 also stated that the catheter bag is supposed to be placed above the resident's bladder at all times and was not able to explain why the bag was placed on the upper side rail when resident was in bed. Certified Nursing Assistant #5 further stated that resident's Foley bag is removed from the side rail and changed to a leg bag when Resident #160 is taken out of bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 11:35 AM, Registered Nurse Supervisor #1 was interviewed and stated that Certified Nursing Assistants are trained on how to drain the foley catheter drainage bag and to properly position the bag above resident's bladder to ensure free flow of urine. Registered Nurse Supervisor #1 stated that both the Licensed Practical Nurses and Registered Nurses are expected to monitor and ensure that the Certified Nursing Assistants are doing it correctly. Registered Nurse #1 was unable to explain why the Certified Nursing Assistants are not being properly monitored to ensure that they are positioning the bag properly below resident's bladder. Registered Nurse #1 stated that they just checked and noticed that residents' Foley bags were not properly placed, and they will get the staff re-educated. On 07/15/24 at 10:56 AM, an interview was conducted with the Director of Nursing who stated that staff were given in-service on Foley catheter care when they are newly hired, and if they are reported or observed not be providing proper care, they are sent to the classroom for re-training. The Director of Nursing also stated that Certified Nursing Assistants are supposed to be supervised and monitored by the nurses they work with to ensure proper care is provided to the residents as per their plan of care. The Director of Nursing stated that they are surprised that some the unit nurses and supervisors are not monitoring the certified nursing assistants well to ensure that residents were provided with proper care. 10 NYCRR 415.12(d)(1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864 Based on record review and staff interviews conducted during the Recertification survey conducted from 7/09/24 to 7/16/24, the facility did not ensure that a drug regimen review performed by the Consultant Pharmacist was reviewed and acted upon by the attending physician or medical director in a timely manner. This was evident for 1 (Resident #222) of 5 residents reviewed for Unnecessary Medications out of 39 sampled residents. Specifically, the attending physician did not address the consultant pharmacist's recommendations for Resident #222 as documented that they agreed and will do. The findings include: The facility's policy titled Consultation Review Policy, last revised 3/1/24, documented all consultation will be reviewed by the Medical Doctor/Nurse Practitioner upon consult completion to ensure that there is no delay in diagnosis, treatment, and service. Resident #222 was admitted to the facility with diagnoses that include Alzheimer's Disease and Anxiety Disorder. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident's 222 cognition as severely impaired-never/rarely made decisions, received 7/7 days of antipsychotics, antipsychotics were received on a routine basis only, and that gradual dose reduction has been documented by a physician as clinically contraindicated on 6/2/24. The Physician's Order renewed on 6/12/24 documented Divalproex (Valproic acid) extended release 250 mg tablet; extended release 24 hr. Give 1 tablet (250 mg) by oral route 2 times per day. The Pharmacy Drug Regimen Review dated 5/6/24 documented recommendations that resident is on Depakote, no serum level in chart, recommend 2 weeks after medication started. The Prescriber's response dated 5/6/24 on the Drug Regimen Review documented agree, will do. Review of the medical records and laboratory findings from 03/09/24 to 07/15/24, did not reveal any laboratory tests for Depakote levels. There is no documented evidence that the Depakote levels were ordered. On 07/15/24 at 10:38 AM, Registered Nurse Supervisor #5 was interviewed and stated that when labs are ordered, the requisition goes directly to the lab via the Electronic Medical Record. The night nurse then writes the names of the residents and the type of labs in the lab log. The technician then comes and documents when the lab is done or if the resident refuses. The Registered Nurse Supervisor #5 also stated that sometimes Resident #222 refuses to have their blood drawn for the labs, but they could not locate any documentation in the medical record that the Depakote level was ordered or that Resident #222 had refused to have it done. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 11:48 AM, Physician #1, who is Resident #222's primary physician, was interviewed and stated that they follow up with the Psychiatrist, since they do not want to adjust any medications or order any labs related to the resident's psychiatric history. Physician #1 also stated that if they check the resident's labs, and it not normal, they will leave it to the Psychiatry, and will go with the Psychiatry's response, since they do not want to do that by themselves. The Physician #1 further stated that although the Psychiatrist does not get a copy of the drug regimen review, they will follow what the Psychiatrist recommends. On 07/16/24 at 12:41 PM, the Medical Director was interviewed and stated that it is the expectation for the attending physician to get the labs done if they agree with the pharmacist's recommendations. The Medical Director also stated that the responsibility for the resident's care lies with the attending physician as the psychiatrist is a consultant. On 07/16/24 at 01:10 PM, the Director of Nursing was interviewed and stated that once Pharmacy Consultants makes a recommendation, it would be reviewed by the attending physician who would indicate whether they agree or disagree, then they would sign it, and give the order which would then be carried out by the nurses. The Director of Nursing also stated that the Registered Nurse Supervisors would review to see that orders are placed if the physician stated that they agreed with the recommendation. 10 NYCRR 415.18(c)(2)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review and staff interviews conducted during the Complaint (NY#00335874) and Recertification survey from 7/9/2024 to 7/16/2024, the facility did not assure that menus are developed/prepared/followed to meet resident choices including their nutritional, religious, cultural/ethnic needs. Specifically, 1) Resident #37 requested an ice cream during lunch service but was denied because of kosher dietary requirements, 2) Resident #143's alternative menu selection for lunch meal was not followed, and 3) Resident #58 stated the menus are developed with strict kosher dietary requirements and did not accommodating their cultural preferences. The findings are: The facility's policy and procedure titled Menus reviewed on 1/1/2024 documented menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs. Menu items and available snack reflect religious, cultural, and ethnic preferences of the residents and inputs from resident is considered in menu planning. 1.Resident #37 was admitted to the facility with diagnosis of Depression, Respiratory Failure and Hypertension. The Annual Minimum Data Set, dated dated dated [DATE] documented that Resident #37 has intact cognition. On 7/9/2024 at 12:29 PM, Resident #37 was observed eating a hamburger provided for a special barbecue event on the unit. Recreation Staff was observed calling the kitchen for a soda and ice cream as per Resident #37's request. Resident #37 was informed that thy would not be permitted to have ice-cream as dairy is not allowed to be served for this meal because meats were served for this event. Resident #37 was visibly upset and stated they do not follow a kosher diet. 2. Resident #143 was admitted to the facility with diagnosis of Cerebrovascular Accident, Hypertension and Hyperlipidemia. The Quarterly Minimum Data Set, dated dated dated [DATE] documented resident has severely impaired cognition. The New York State Department of Health Complaint Intake received 5/9/2024 documented that food is unpalatable, and Resident #143 does not get their choice. On 7/11/2024 at 10:44 AM, Certified Nursing Assistant #14 stated that Resident #143 did not like today's lunch option, so they ordered cheeseburger from the alternative menu. On 7/11/2024 at 12:01 PM, Certified Nursing Assistant CNA #14 was observed calling the kitchen for the missing cheese for the cheeseburger. On 7/11/2024 12:03 PM, Resident #143's hamburger was observed without cheese. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The review of alternative menu selected on 7/11/2024 for Resident #143 documented cheeseburger was ordered for Resident #143's lunch meal. 3. Resident #58 was admitted to the facility with diagnosis of Hypertension, Hyperlipidemia, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set, dated dated dated [DATE] documented cognition is intact. On 7/9/2024 at 11:50 AM, Resident #58 was interviewed and stated they have been residing in the facility for 4 years and are currently an active member of the Resident Council. Resident #58 also stated that the facility's regular menu strictly adheres to Kosher dietary law and so there is no cooked food served on Saturdays. Resident #58 further stated that the alternative menu is very limited, and they are forced to order alternative option daily. In addition, when the facility has special events, they are always challenged when ordering non-kosher foods such as cheeseburgers. Resident #58 stated that they are aware that this facility follows kosher law, however they are not kosher and feel that all residents' food choices are not accommodated. On 7/12/2024 at 11:00 AM, the Director of Activity stated that the Super Bowl Party is a pre-planned event with the menu items selected by residents and were approved for the event. On Super Bowl Day, some items were not ordered for the residents because the Rabbi did not approve them. The Director of Activity also stated that the residents complained and eventually the food items were ordered, however, a number of residents expressed dissatisfaction about the situation. On 7/16/2024 at 9:22 AM, the Food Service Director was interviewed and stated that the kitchen follows kosher dietary law, and so dairy and meat are not served together for all meals, and there is no raw meat cooked in the kitchen on Saturdays. The menus reflect these laws. The Food Service Director also stated that residents can always order alternative menu options such as battered fish, hamburger, baked chicken, spaghetti/sauce, meatballs, and cheeseburgers. These menu options are also offered for Saturday meals because some residents may not like the main option which is a salad. These foods can be cooked on Friday and can be reheated for the next day. The Food Service Director further stated the cheeseburger cannot be prepared together since it is a kosher kitchen therefore, hamburger and cheese are served separately for any request. The Food Service Director stated they are doing everything to accommodate residents' requests but they are also following the kosher dietary laws. 10 NYCRR 415.14(c)1-3

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observations and staff interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Specifically, 1) dairy walk-in refrigerator contained undated, unlabeled food items. 2) dry storage room was not maintained at appropriate temperature condition and was observed with expired items, and 3) cold food items were not held at the proper temperatures during tray line service. This was observed during the Kitchen Observation. The findings are: The facility's policy and procedure titled Food Safety and Sanitation dated [DATE] documented all local, state federal standards and regulations will be followed to assure a safe and sanitary food and nutrition service department. On [DATE] from 9:36 AM to 10:10 AM, the initial observation of the kitchen was conducted with the Food Service Director. The following were observed: 1. Dairy walk-in refrigerator contained a pan of leftover scrambled eggs and another pan with boiled eggs that were covered with aluminum foil without a date or a label. 2. The basement dry storage room storing non-perishable foods was observed and was humid with no ventilation and hot in temperature. Three bottles of unopened of salsa were observed with manufacturing label indicating to store in a cool place and to refrigerate after opening. The temperature of the dry storage room was checked immediately with the Maintenance Director and thermometer registered at 87.7 degrees Fahrenheit. Additionally, there were 2 bottles of sweet Chili sauce on the shelf with a manufacturing label documenting best by date of [DATE]. On [DATE] at 2:11 PM, Dietary Chef stated they are responsible for ensuring all prepared foods are labeled and dated. The Dietary Chef also stated that the items found were left-over foods from the breakfast line today and was probably put away by staff on the breakfast tray line. The Dietary Chef further stated that the items should have been labeled with dates, but it was missed. On [DATE] at 11:12 AM, a tray line observation was conducted with the Food Service Director and the temperature checks revealed the following: cheese sandwich was 59 degrees Fahrenheit, plate of lettuce/tomato at 64 degrees Fahrenheit, and tuna fish sandwich at 63.5 degrees Fahrenheit. On [DATE] at 9:33 AM, the Director of Maintenance was interviewed and stated that there are no windows or a ventilation system in the dry storage room, so the temperature tested higher than the ideal room temperature. The Director of Maintenance also stated that the temperature of the dry storage room seems to be higher due to the hot summer weather. The ideal temperature for food storage room should be below 75 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:22 AM, the Food Service Director was interviewed and stated that any left-over, prepared foods should be covered and labeled with dates before storing in the refrigerator/freezer. The dry storage room is also checked routinely for any expired items. The Food Service Director also stated that sandwiches are made daily in the kitchen around 9:30 AM daily and placed in the freezer for 2 hours. The sandwiches stored in the freezer are taken out right before lunch service and kept on ice to maintain proper internal temperature below 41 degrees Fahrenheit. The Food Service Director also stated that the freezer was not working properly on [DATE]. 10 NYCRR 415.14(h)

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 45351 Based on observation, record review and staff interviews conducted during the Recertification survey from 7/9/2024 to 7/16/2024, the facility did not ensure garbage and refuse was disposed of properly. Specifically, the garbage compactor door was observed ajar, and multiple flies were observed flying on top of garbage inside the compactor. The findings are: The facility's policy and procedure titled Proper Kitchen Trash Disposal dated 1/8/2024 documented all kitchen waste is disposed properly to the compactor. During an observation of the kitchen on 7/12/2024 from 10:02 AM to 10:16 AM, the Dietary Worker brought the garbage to the garbage disposal area located outside of the building. The garbage compactor was observed to be open and there were multiple flies flying on top of the garbage piles inside the compactor. On 7/12/2024 at 10:25 AM, the Dietary Worker #1 was interviewed and stated the compactor door should have been kept closed to keep garbage inside the compactor. On 7/16/2024 at 9:22 AM, the Food Service Director was interviewed and stated the compactor is used by housekeeping and food service staff. The Food Service Director also stated that all staff are expected to keep the compactor door closed after each use. On 7/16/2024 at 9:33 AM, the Director of Housekeeping was interviewed and stated that staff should not have left the compactor door open on 7/12/2024. The Director of Housekeeping also stated that they are working with the Food Service Director to ensure that all staff are educated on the garbage disposal process. 10 NYCRR 415.14 (h)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 44842 Based on observation, record review, and interviews conducted during the recertification survey from 7/09/2024 through 7/16/2024, the facility did not ensure a Quality Assurance and Performance Improvement (QAPI) program identified and prioritized problems and opportunities that reflect organizational process, functions, and services provided to residents. Specifically, there were 7 repeated deficiencies from the last survey conducted on 5/22/2023. (Refer to: F600, F609, F640, F655, F657, F758, and F880) for further information. The findings include but are not limited to: The facility policy titled QAPI Plan, dated January 01, 2024, documented the system to monitor care and services will continuously draw data from multiple sources. These feedback systems will actively incorporate input from staff, residents, families, and others, as appropriate. Performance indicators will be used to monitor a wide range of processes and outcomes and will include a review of findings against benchmarks and/or targets that have been established to identify potential opportunities for improvement and corrective action. The system also maintains a system that will track and monitor adverse events that will be investigated every time they occur. Action plans will be implemented to prevent recurrence. 1. Refer to F550 and F561 re: resident rights. 2. Refer to F578 re: Advance directives. 3. Refer to F580 re: notification. 4. Refer to F584 re: the environment. 5. Refer to F610 re: investigation of allegations. 6. Refer to F658 re: professional standards. 7. Refer to F676 and F677 re: activities of daily living. 8. Refer to F685 re: communication/maintaining hearing. 9. Refer to F690 re: catheter care. 10. Refer to F756 re: drug regimen review. 11. Refer to F803 and F812 re: food and nutrition services. 12. Refer to F814 re: garbage disposal. 13. Refer to F842 re: resident records. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Refer to F865 re: QAPI. 15. Refer to R0610, R0830, and R1022 re: criminal history record check. 16. Refer to I210 re: signage for COVID vaccine availability. 16. Refer to F600, F609, F640, F655, F657, F758, and F880 re: repeat deficiencies. On 07/16/24 at 4:05 PM, the Administrator was interviewed and stated when any deviation from expected performance, or a negative trend occurs the findings are brought to the attention of the Quality Assurance committee. Staff report quality concerns to the Quality Assurance committee through their chain of command, the compliance officer, or the hotline. The facility works on issues that trigger and issues that the department feels need improvements. Also, weekly rounds are done with the department heads and the findings are reported to the Quality Assurance and Performance Improvement Committee. The nursing team and department heads will give a report on whether the corrective actions are effective, and if improvement is occurring. Monthly Quality Assurance and Performance Improvement committee meetings have been implemented in order to fix the issues. They compare month to month from the monthly progress reports from the departments. They meet as a team and discuss the inputs and ideas on how to change and correct the deficiencies. The Administrator stated at the time of the last survey, the facility submitted a plan of correction, and they continue to work on Quality Assurance and Performance Improvement and provide in-service training for the staff. The Administrator stated the facility performs competencies on staff and measure improvements and are working on recruiting staff with enticements such as bonuses. The Administrator stated the facility tracks performance by bringing it up to the team and move on if effective, if not effective then they continue to do Quality Assurance and Performance Improvement until compliance. The Minimum Data Set assessments are being worked on and Abuse issues are being worked on also. The Administrator further stated the Director of Nursing is new at the facility and started a month ago and they took over as Administrator late last year. 10 NYCRR 415.27

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on observation, and interviews conducted during the Recertification survey from 07/09/2024 to 07/16/2024, the facility did not ensure infection control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, 1) Registered Nurse Supervisor #8 failed to practice hand hygiene and glove changes during wound care, 2), Licensed Practical Nurse #4 failed to practice appropriate infection control during wound care treatment, and 3). Licensed Practical Nurse #5 did not perform hand hygiene during Medication Administration for a resident with a gastrostomy tube This was evident for 2 (Resident #189 and Resident #167) of 7 residents reviewed for Pressure Ulcer/Injury and 1 resident (Resident #193) observed during Medication Administration out of 39 sampled residents. The findings are: The facility policy titled Pressure Sore Prevention Program & Wound Care Management reviewed June 2024 documented that for residents with existing pressure sores, treatment, evaluation and monitoring are needed to prevent the progression of existing wounds, the development of new breakdown and complications such as infections. The facility's policy titled Infection Prevention and Control Program with revised date of 06/09/2024 documented the facility will require staff to perform hand hygiene as indicated by Centers for Disease Control guidelines. 1. Resident #189 had diagnoses of Stage 4 pressure ulcer of sacral region, Paraplegia, and Peripheral vascular disease. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #189 had intact cognition and Stage 4 pressure ulcers. The Physician's Orders renewed on 06/02/2024 documented cleanse sacral ulcer with normal saline solution, pat dry, Skin Prep to outer wound edges, apply Silvasorb, and Calcium Silver Alginate Sheet to wound bed, cover with Silicone Border dressing every day and as needed. On 07/15/2024 at 10:51 AM, wound care observation was conducted for Resident #189 with Registered Nurse Supervisor #8 performing wound care. Registered Nurse Supervisor #8 entered the room, placed the supplies, and washed their hands. Registered Nurse Supervisor #8 then donned gloves and removed Resident #189's soiled dressing from the wound on their sacrum. Registered Nurse Supervisor #8 then changed their gloves without washing their hands and cleansed the wound, applied the treatment, and placed the clean dressing on the wound. Registered Nurse Supervisor #8 then removed their gloves and performed hand hygiene. Registered Nurse Supervisor #8 did not change their gloves or wash their hands after removing the soiled dressing, cleaning the wound, and before applying the treatment and clean dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/15/23 at 11:40 AM, Registered Nurse Supervisor #8 was interviewed and stated they were instructed to wash their hands during dressing change or use hand sanitizer if soap is not available. Registered Nurse Supervisor #8 further stated they used sanitizing wipes instead of washing their hands. However, surveyor did not observe the Registered Nurse Supervisor #8 using hand sanitizer wipes when performing wound care. On 07/16/2024 at 1:55 PM, the Director of Nursing who is also serving as the Infection Preventionist was interviewed and stated that hand hygiene is supposed to be performed in between changing gloves when performing wound care. The Director of Nursing further stated the Registered Nurse Supervisor #8 was supposed to change gloves and wash their hands after removing the soiled dressing, then again after cleaning the wound, and also before applying the treatment and clean dressing. 50894 2. Resident #167 was admitted to the facility with diagnoses that included an Unstageable pressure ulcer, Diabetes Mellitus, Alzheimer's disease, and Malnutrition. The Admission Minimum Data Set assessment dated [DATE] documented Resident #167's cognition as moderately impaired, and that the resident was at risk of developing pressure ulcers and had one Stage 3 pressure ulcer that was present upon admission/reentry to facility. The Nursing Progress Note dated 07/8/24 documented that Resident #167 had a sacral ulcer which measured 2.5 cm x 4cm x 0.1 cm, 100% granulation, scant serous exudate. Treatment was documented as: cleanse area with NSS, pat dry, apply calcium alginate, cover with foam dressing daily & PRN. The Physician's Order renewed 7/09/2024 documented cleanse with normal saline solution, pat dry, apply calcium alginate, and cover with foam dressing daily. On 07/15/2024 at 10:42 AM, a wound care observation was conducted with Licensed Practical Nurse #4. Licensed Practical Nurse #4 entered the room of Resident #167 wearing a gown and gloves, with a tray containing wound care supplies that they placed on Resident #167's overbed table. Licensed Practical Nurse #4 performed hand hygiene and donned gloves. Licensed Practical Nurse #4 removed the dressing from Resident #167's sacral region and disposed of it in the trashcan positioned next to the bed. Licensed Practical Nurse #4 removed and disposed of their gloves in the trashcan and walked to the sink in Resident #167's room to perform hand hygiene. Licensed Practical Nurse #4 asked Certified Nursing Assistant #6 to kick the trashcan at the bedside over to the sink, which Certified Nursing Assistant #6 did. Licensed Practical Nurse #4 completed hand hygiene and kicked the trashcan back to the resident's bedside. Licensed Practical Nurse #4 donned gloves and picked up a piece of dry gauze from a multipackage of gauze and poured saline onto it. Licensed Practical Nurse #4 then rubbed the wet gauze horizontally across the wound to clean it. Licensed Practical Nurse #4 then disposed of the gauze in the bedside trash can, picked up a piece of calcium alginate, and placed it on gauze, then applied it to the wound before applying a foam dressing. Licensed Practical Nurse #4 returned to the sink and completed hand hygiene. Licensed Practical Nurse #4 took the multipack of gauze from the resident's bedside table and returned it to the medication cart positioned outside of Resident #167's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335372	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vanderbilt Rehabilitation and Care Center, Inc	135 Vanderbilt Ave Staten Island, NY 10304

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #4 did not sanitize the bedside table or place a drape on the table before placing supplies down, did not clean the wound from inner to outer aspects, did not perform hand hygiene after cleaning the wound, and did not maintain infection control standards when returning the opened multipack of gauze to the medication cart. On 07/15/2024 at 02:34 PM, an interview was conducted with Licensed Practical Nurse #4 who stated that they forgot to use the drape because they were nervous. Licensed Practical Nurse #4 also stated that they typically use single-use gauze for wound care but used the multipackage of gauze during Resident #167's observation because they were nervous. Licensed Practical Nurse #4 further stated that they have been observed doing wound care in an in-service earlier this year, and also completed an infection control in-service earlier this year. On 07/15/2024 at 02:49 PM, an interview was conducted with Registered Nurse Supervisor #3 who stated that they have done wound care twice since beginning employment at the facility around seven months ago. Registered Nurse Supervisor #3 also stated that the Wound Care Nurse is responsible for monitoring the wounds and reporting concerns during their weekly wound care rounds. Registered Nurse #3 failed to identify the steps for performing wound care appropriately, including the need to perform hand hygiene after cleaning a wound and before performing the ordered treatment. On 07/16/2024 at 09:52 AM, an interview was conducted with the Staff Educator who stated wound care observations are conducted upon hire and then yearly for all staff providing wound care in the facility. The Staff Educator stated that it was their responsibility to conduct the observation upon hire, and that the Wound Care Nurse conducts the yearly in-service wound care observations. If a staff member is identified as needing an additional in-service, the Staff Educator stated that they would do that with the assistance of the Wound Care Nurse. When asked about hand hygiene during wound care, the Staff Educator stated that after cleaning the wound and before applying treatment, they would remove the soiled gloves and put on new ones but failed to identify the need to perform hand hygiene after removing the soiled gloves. On 07/16/2024 at 10:08 AM, an interview was conducted with the Wound Care Nurse who stated that they do an initial skin check on admitted patients, and weekly wound rounds with the doctors. They will also assist the Licensed Practical Nurses on the floor with complex wound care, such as wounds requiring wound vac treatment. When asked for the steps on providing wound care, the Wound Care Nurse failed to identify the need to perform hand hygiene after cleaning a wound and before performing the ordered treatment. The Wound Care Nurse stated that most wound care competencies are completed by the Staff Educator and that they try to do some but have not been able to complete many due to their current workload. On 07/16/24 at 11:49 AM, an interview was conducted with the Director of Nursing who was able to accurately outline how wound care should be completed while maintaining infection control standards. The Director of Nursing stated that the Staff Educator was responsible for completing the upon-hire and annual wound care competencies for staff members providing wound care. 44864 3. Resident #193 was admitted to the facility with diagnoses that include Chronic Respiratory Failure and Dry eye Syndrome. (continued on next page)

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	335372	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vanderbilt Rehabilitation and Care Center, Inc	135 Vanderbilt Ave Staten Island, NY 10304

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #193 had a feeding tube. The Physician's Orders last renewed 6/24/24, documented Artificial tears 1.4% eye drops, apply 1.4 drops by eye route in each eye 2 times per day. On 07/12/24 at 08:14 AM, an observation of medication administration was completed with Licensed Practical Nurse #5. Licensed Practical Nurse #5 entered Resident #193's room, washed their hands, and put on a pair of gloves. Licensed Practical Nurse #5 then administered the medications via the gastrostomy tube. Licensed Practical Nurse #5 then removed their gloves, donned a clean pair of gloves and proceeded to instill eye drops to both of Resident #193's eyes. Licensed Practical Nurse #5 did not perform hand hygiene between glove changes. On 07/12/24 at 08:34 AM, immediately after the medication administration observation for Resident #193, Licensed Practical Nurse #5 was interviewed and stated that they were taught to wash their hands between glove changes, but that they did not clean their hands after they changed their gloves to administer the eye drops. Licensed Practical Nurse #5 also stated that they were nervous and forgot to wash their hands after taking off the gloves when they administered medications via the gastrostomy tube. On 07/16/24 at 01:04 PM, the Director of Nursing was interviewed and stated that the staff is taught to wash their hands after every glove changes. The Licensed Staff are in-serviced during orientation, competencies are also done yearly, and Licensed Practical Nurse #5 was evaluated and knew the correct way to do glove changes. The Director of Nursing said that the nurses are monitored by the Registered Nursing Supervisors and reeducation is done by the Educator. The Registered Nursing Supervisors do random medication pass observations to ensure that the nurses are using the correct measures. If there is an issue, they would be re-in-serviced. 10 NYCRR 415.19(b)(4)