| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335381 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Schulman and Schachne Inst for Nursing & Rehab | 555 Rockaway Parkway<br>Brooklyn, NY 11212 |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350<br><br>Based on record review and interview conducted during the Recertification Survey from 06/26/2024 to 07/03/2024, the facility failed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals. This was evident for 3 (Residents #136, #44, and #291) of 35 total sampled residents. Specifically, an individualized discharge care plan was not developed for Residents #136, #44, and #291.<br><br>The findings are:<br><br>The facility's policy titled Planned Transfer and Discharge with a reviewed date of 02/2023 stated that the social worker documents the resident's/designated representative's plan/request to return home or to another skilled nursing facility in the medical record, the assessment section, the coordinated care plan and the progress notes.<br><br>The facility's policy titled Comprehensive Care Plan with a reviewed date of 12/2023 stated that every comprehensive care plan meeting must include a review and discussion of discharge planning.<br><br>1.) Resident #136 had diagnoses of Congestive Heart Failure, Hypertension, and Diabetes.<br><br>The Minimum Data Set assessment dated [DATE] documented that the Resident had intact cognition.<br><br>A review of Resident #136's comprehensive care plan revealed no documented evidence that a discharge care plan had been developed.<br><br>During an interview on 06/26/2024 at 3:42 PM, Resident #136 stated they requested the social worker for help to be discharged in an apartment and they were told that Resident #136's family had to look for the apartment.<br><br>During an interview on 07/03/2024 at 10:56 AM, Social Worker #4 stated Resident #136 had no active discharge plan because the Resident need homecare and had no housing. The Social Worker stated that there had been no discussion with Resident #136 about their discharge.<br><br>During an interview on 07/02/2024 at 11:51 AM, the Director of Social Services stated discharge planning for each resident begins on admission and that discharge options must be discussed and documented in the medical record. The Director of Social Services stated a discharge care plan must be initiated for every resident.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 45351<br><br>2.) Resident #44 had diagnoses of Seizure Disorder, Hyperlipidemia, and Hypertension.<br><br>The Minimum Data Set assessment dated [DATE] documented Resident #44 had intact cognition and that Resident participated in the assessment process and would like to talk about possibility leaving the facility and returning to the community.<br><br>A review of Resident #44's comprehensive care plan revealed no documented evidence that a discharge care plan had been developed.<br><br>3.) Resident #291 had diagnoses of Thyroid Disorder and Myotonic Dystrophy.<br><br>The Minimum Data Set assessment dated [DATE] documented resident had intact cognition.<br><br>The Social Services assessment dated [DATE] documented Resident #291 wanted to be transferred to another facility and gave a list of facilities.<br><br>The review of medical record revealed there was no documented evidence Resident #291's transfer request made on 11/14/2023 was ever submitted and follow up was ever made to inform resident on the progress of transfer request.<br><br>The Social Service assessment dated [DATE] documented Resident #291's goal was to remain in the facility and resident did not have active discharge planning occurring.<br><br>A review of Resident #291's comprehensive care plan revealed no documented evidence that a discharge care plan had been developed.<br><br>During an interview on 06/26/2024 at 9:52 AM, Resident #291 stated they requested a transfer to another facility some time last year, but Resident does not know if the application were submitted.<br><br>During an interview on 07/02/2024 at 11:50 AM, Registered Nurse #5 stated Resident #291 had requested a few times about transferring to another facility and that the social worker was aware of the request.<br><br>During an interview on 07/03/2024 at 10:49 AM, the Social Worker Assistant stated Resident #291 requested a transfer and gave a list of potential facilities some time last year. They stated they sent Resident #291's information last year but they cannot recall if they followed up with the facilities. The Social Worker Assistant stated Resident #291 gave them another list of facilities this year where they would want to be transferred to but have not submitted the application to any of these facilities.<br><br>During an interview on 07/02/2024 at 3:34 PM, The Director of Social Services stated Resident #291 requested transfer to other facilities in November 2023 as per the medical record, but the Resident's transfer request was never carried out by the social work assistant. The Director of Social Services stated they were not able to locate the discharge care plan for Resident #291 and Resident #44 upon review of their medical record. They stated that the social worker who is assigned to the resident is responsible for initiating a discharge care plan.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10 NYCRR 415.11(d)(3) |

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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** 48711<br><br>Based on observation, interviews, and record review conducted during the Recertification and Complaint (NY00340955) Survey from 06/26/2024 to 07/03/2024, the facility did not ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene. This was evident for 1 (Resident # 69) of 35 total sampled residents. Specifically, Resident #69 did not receive staff assistance for nail trimming and was observed with thick, long, discolored fingernails.<br><br>The findings are:<br><br>The facility policy titled Activities of Daily Living with a revised date of 06/2024 documented that a program of activities of daily living (ADL) is provided to residents to prevent disability and promote resident's function at maximum level of independence. The ability of each resident to meet the demands of daily living is assessed by a registered nurse, occupational therapist, and/or physical therapist. Hygiene was included in the policy explanation and compliance guidelines.<br><br>Resident # 69 had diagnoses of Cerebral Vascular Accident and Dementia.<br><br>The Minimum Data Set assessment dated [DATE] documented that Resident #69 had moderately impaired cognition and required partial/moderate assist with toileting, personal hygiene, and grooming.<br><br>On 6/26/2024 at 12:30 PM, Resident #69 was observed sitting in the dining room eating lunch. Resident's left hand was contracted, with long, thick and brownish/yellowish nails observed curled into resident's left hand.<br><br>The Comprehensive Care Plan Titled Self Care Deficit- Dressing and Grooming that was initiated on 04/05/2024 documented that Resident #69 required assistance with personal hygiene associated with grooming. The facility interventions include to clip and clean nails regularly in accordance with preference and safety.<br><br>The Certified Nursing Assistant Accountability Records from April 2024 to May 2024 had no documentation about nail care for Resident #69.<br><br>The nursing progress notes dated 11/01/2023 to 06/26/2024 had no documentation that Resident # 69's fingernails were cleaned and trimmed.<br><br>During an interview on 06/28/2024 at 12:16 PM, Certified Nurse Assistant #5 stated Resident #69 needs total care. They stated that Resident #69's nails need to be trimmed by a podiatrist because they are too long. They stated they did not report to the nurse that Resident #69's nails need to be trimmed.<br><br>During an interview on 06/28/2024 at 12:10 PM, Licensed Practical Nurse #2 stated that Resident #69 requires total care and that they were not aware of Resident #69's long nails.<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 | During an interview on 06/28/2024 at 12:20 PM, Registered Nurse # 3, who was the nursing supervisor, stated they were not aware of Resident #69's long nails. They stated that the Certified Nursing Assistants are supposed to cut the resident's nails unless it is beyond their training to cut the nails, then a podiatry consult is placed.<br><br>10 NYCRR 415.12(a)(3) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709<br><br>Based on observation, record review, and interview conducted during the Recertification and Complaint Survey (NY00341538), the facility did not ensure that the resident environment remains as free of accident hazards as is possible; and received adequate supervision to prevent accidents. This was evident for 1 (Resident #237) of 5 residents investigated for Accidents, out of 38 total sampled residents. Specifically, on 05/07/2024, Resident #237 sustained a fall when Certified Nursing Assistant #11 transferred Resident #237 using a mechanical lift without assistance from another staff.<br><br>The findings are:<br><br>The facility policy titled Mechanical Lift with a last reviewed date of 02/2020 documented that all residents must be lifted or transferred according to the determined procedure as stated in the resident care plan. A mechanical lift shall be used appropriately to facilitate transfers of residents as required. At least 2 people shall be present during transferring with the lift.<br><br>Resident #237 had diagnoses of Hypertension, Hyperkalemia, and Non-Alzheimer's Dementia.<br><br>The Minimum Data Set assessment dated [DATE] documented that Resident #237 had moderately impaired cognition. The assessment further documented that Resident #237 had impairment in both upper and lower extremities and was dependent for transfers, toileting, and bathing activity.<br><br>A care plan for self-care deficit inability to transfer was initiated on 12/27/2023 for Resident #237. The care plan documented that Resident had impaired ability to move independently secondary to wheeled, chair fast, inability to shift weights, loss of voluntary movements. The facility interventions include providing passive range of motion, and to provide a supportive and safe environment.<br><br>The Certified Nursing Accountability Record for Resident #237 dated May/June 2024 documented that the Resident required assistance of two persons for assistance using a mechanical lift for transfers.<br><br>The nursing progress notes dated 05/07/2024 at 7:00 PM by Registered Nurse #7, documented that at approximately 6:25 PM, the nurse went to the unit to assess Resident #237. Upon arrival Resident was observed on the floor supine next to bed with the mechanical lift next to the Resident. Resident #237 was noted with a 2 centimeter laceration to the forehead. Resident was unable to give account of occurrence secondary to cognitive impairment. The note documented that as per staff, Resident #237 slid from the canvas during transfer with a mechanical lift. The doctor was informed and ordered to transfer the resident to the hospital. The laceration was cleaned with normal saline and cold compress was applied.<br><br>The nursing progress notes dated 05/08/2024 at 8:15 AM documented that Resident #237 returned to the facility. The Resident was status post fall, laceration to their left forehead remained intact with no bleeding, mild swelling noted, denied pain.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The hospital emergency room after visit summary dated 05/07/2024 documented that Resident #237 had a diagnosis of unspecified fall, with forehead laceration, closed with glue. The computed tomography scan showed no evidence of cervical spine fracture or subluxation and no acute findings in the head/brain.<br><br>A written statement by Certified Nursing Assistant #11 dated 05/07/2024 documented that they were preparing Resident #237 to transfer from recliner chair back to bed. The written statement documented, Certified Nursing Assistant called for help and while waiting, raised the Resident up from the recliner chair and the Resident shifted and slid from the canvas.<br><br>The facility Internal Investigation Report form completed by the Director of Nursing documented that on 05/07/2024, the supervisor was called to the unit to assess a resident post fall. Resident was unable to give an account due to cognitive impairment. Staff reported that while waiting for help, they transferred Resident #237 with a mechanical lift from the chair and the resident slid off the canvas. The investigation concluded that the staff was made aware of the dangers of using a Hoyer Lift without assistance and most important of calling for help, and waiting until help arrives. The facility investigation report also documented that the incident was an accident which could have been avoided.<br><br>On 07/02/2024 at 09:47 AM, Resident #237 was interviewed and stated they remember they had a fall when 1 staff transferred them and that they hit their head and went to the hospital.<br><br>On 07/01/24 at 03:45 PM, an interview was conducted with Certified Nursing Assistant #11. They stated that Resident #237 was on their assignment on the evening shift of 05/07/2024. The stated they took Resident #237 to their room and called for help to transfer the resident. The Certified Nursing Assistant was not able to specifically say who they asked for assistance. They stated that they were setting up the Resident for transfer by placing the recliner close to the bed. Certified Nursing Assistant #11 stated they did not try to transfer Resident #237 alone with a mechanical lift, and that Resident #237 had a canvas underneath and was moving and shaking and fell out of the chair on their left side.<br><br>On 07/03/2024 at 12:52 PM, the Director of Nursing Services was interviewed and stated<br><br>that the incident that occurred on 05/07/2024 was an accident that could have been avoided if the staff followed the plan of care of having two staff for mechanical lift transfer.<br><br>10 NYCRR 415.12 (h)(2) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351<br><br>Based on observation, interview, and record review conducted during the Recertification and Complaint (NY00311959) Survey from 06/26/2024 to 07/03/2024, the facility did not ensure that food were served at an appetizing temperature during meal service. This was evident for 2 units observed during dining observation. Specifically, food served during lunch meal service were not maintained at palatable and appetizing temperatures.<br><br>The findings are:<br><br>The facility's policy and procedure titled Dining and Meal Policy dated 11/2023 documented it was the policy of the facility to serve meals to meet the nutritional needs of residents.<br><br>The facility's policy on Food and Nutrition Service dated 11/2023 documented it is the policy of the facility to provide meals to residents as scheduled to meet their nutritional requirements and to develop a mechanism that will ensure safe and accurate preparation and distribution of food products. The meal service time for lunch is 12:00 PM to 1:00 PM.<br><br>1. Resident #27 was admitted to the facility with Coronary Artery Disease, Hypertension and Hemiplegia. The Annual Minimum Data Set, dated dated dated [DATE] documented resident had intact cognition.<br><br>On 06/27/2024 at 10:43 AM, Resident #27 stated meals are delivered to their room. The food is often served unappetizing and not hot enough.<br><br>2. Resident #261 was admitted to the facility with Depression, Respiratory Failure and Diabetes Mellitus. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that resident had intact cognition.<br><br>On 06/26/2024 at 11:07 AM, Resident #261 stated the meals were often served late and food is cold.<br><br>On 06/28/2024 at 12:38 PM, Resident #261 was observed in the room, waiting for their lunch meal.<br><br>On 07/01/2024 from 12:06 PM to 12:59 PM, food delivery cart arrived on Unit 2 North. The staff distributed the trays in the dining room and then distributed meal trays to residents in their room.<br><br>On 07/01/2024 at 12:59 PM, test tray was conducted and revealed the following temperatures: chicken noodle soup 146.5 degrees Fahrenheit, a cup of hot water for tea 117.8 degrees Fahrenheit, spaghetti with sauce 148.5 degrees Fahrenheit, baked chicken 132.9 degrees Fahrenheit, broccoli 118.8 degrees Fahrenheit.<br><br>On 7/2/2024 from 11:40 AM to 12:32 PM, food delivery cart arrived on Unit 3 North. The staff distributed the trays to the residents in the dining room and residents' rooms.<br><br>On 07/02/2024 at 12:32 PM, test tray was conducted on Unit 3 North. The food temperatures were: meatloaf 115.5 degrees Fahrenheit, stuffing 154.4 degrees Fahrenheit, and mustard greens 147 degrees Fahrenheit.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/03/2024 at 11:35 AM, the Food Service Director stated the food temperatures measured on 7/1/2024 and 7/2/2024 were inconsistent and some items were below the optimal temperature for hot foods. Food Service Director stated some hot foods depending on the density are harder to maintain the temperature; however, the temperature should be at least above 135 degrees Fahrenheit. Food Service Director stated the food cart is delivered to dining room at 11:45 AM, starts meal delivery around 12:00 PM and should not take no longer than 30 minutes from start time. Food Service Director stated the staff took about 1 hour which is longer than expected to deliver the meals to the residents. When foods are kept long on the food cart, the temperature and quality may not be maintained. Food Service Director stated they have been using this food delivery system for more than [AGE] years; therefore, the equipment may also need maintenance to ensure they are working properly.<br><br>On 7/3/2024 at 1:31 PM, Administrator stated they were made aware of the food temperature issue yesterday. Administrator further stated the facility will need to review the current food delivery system and look further into improving the food quality and temperature for the residents.<br><br>10 NYCRR 415.14(d)(1)(2) |