STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335387	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peninsula Nursing and Rehabilitation Center	50 15 Beach Channel Drive Far Rockaway, NY 11691

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50820 Based on interviews and record review conducted during the Recertification survey from 06/26/2024 to 07/03/2024, the facility did not ensure a resident, or their designated representative was provided appropriate notification at the termination of Medicare Part A benefits. This was evident for 2 (Residents #166 and 428) of 3 residents reviewed for Beneficiary Notification out of 37 total sampled residents. Specifically, the Notice of Medicare Non-Coverage were not mailed out to Resident #166 and #428 designated representatives on the same day as telephone notification. The findings are: The facility policy titled Medicare Determination for SNF (Skilled Nursing Facility) with an effective date of 1/2021 states that the facility is required to provide notification of termination of services/Medicare coverage at least 2 business days before the last covered day. Notices mailed are certified and the receipt of certified mail is stapled to a copy of the letter and maintained in the MDS office for file. 1. Resident #166 was discharged from skilled services on 5/28/2024 with 59 days remaining and remained in the facility. The Notice of Medicare Non-coverage form with heading Telephonic notification documented that on 5/24/2024 at 10:50 am, Resident #166 representative was made aware that last coverage date would be 5/28/2024 and copy of Notice of Medicare Non-coverage was sent via certified mail. The United States Postal Service Tracking number from the Certified Mail Receipt addressed to resident's representative indicated that the mail arrived at the post office on May 29, 2024, at 8:05pm and was not mailed on 5/24/2024, the same day the telephone notification was made. 2. Resident #428 was discharged from skilled services on 1/5/2024 with 32 days remaining and remained in the facility. The Notice of Medicare Non-coverage form with heading Telephonic notification documented that on 1/3/2024 at 1:06 pm, Residents #428 representative was made aware that last coverage date would be 1/5/2024, and a copy of Notice of Medicare Non-Coverage was sent via certified mail. The United States Postal Service Tracking number from the Certified Mail Receipt addressed to resident's representative indicated that the mail arrived at the post office on January 5, 2024, at 9:31pm and was not mailed on 1/3/2024, the same day the telephone notification was made. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/03/24 at 12:04 PM, the Minimum Data Set Assessor #1 was interviewed and stated that if a resident is not alert, the resident's family will be contacted regarding resident's discharge from skilled services. The Minimum Data Set Assessors call the residents family two days prior to discharge from skilled services and the Notice of Medicare Non-Coverage form would be mailed out the same day. A copy of the certified mail showing that it was sent out the same day would be stored in the resident's file. The Minimum Data Set Assessor #1 stated that the Notice of Medicare Non-Coverage was dropped off at the front desk the same day as telephone notification to Resident #166's family member on 5/24/2024, but they were unsure when the mail man picked up the mail. On 07/03/24 at 12:10 PM, the Minimum Data Set Assessor #2 was interviewed and stated in case resident is not alert or oriented, the family representative or emergency contact would be informed regarding resident's date of discharge from skilled services. Usually, the family representatives would request that the Notice of Medicare Non-Coverage be mailed through certified mail. The Notice of Medicare Non-Coverage is mailed the same day that the conversation with family representative took place which usually occurs 2-3 days before resident is discharged from skilled services. The Minimum Data Set Assessor #2 also stated that the form is left at the front desk where the mail man picks them up, however they are unsure what time they come to pick it up. The Minimum Data Set Assessor #2 further stated that no one usually checks to see if mail was picked up but wait for the receipt to come back to confirm it was delivered. On 07/03/24 at 12:30 PM, the Minimum Data Set Coordinator was interviewed and stated that as per the policy the Notice of Medicare Non-Coverage should be signed by resident and family within 2 days to 48 hours before the last covered day. The last covered day may fall on a Monday or Tuesday so the Minimum Data Set Assessor will call the family on Friday and mail the letter out after confirming the address. The Minimum Data Set Coordinator stated that the Notice of Medicare Non-Coverage should be mailed out the same day and that the Minimum Data Set Assessors will drop the form to the front desk to be mailed on the same day of telephone conversation with the family representative. The mail man then picks up the forms from the front desk. 10 NYCRR 415.3(g)(2)(i)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 48876 Based on observation, interview and record review conducted during the Recertification Survey from 06/24/2024 to 07/03/2024, the facility failed to ensure that the physician reviewed the resident's total program of care. This was evident for 2 residents (Resident #50 and Resident #377) observed for Medication Administration. Specifically, there were no physician orders specifying care and treatment for the maintenance of intravenous catheter lines. The findings are: The facility policy titled Care and Treatment of the Resident -Physician Orders Monthly Review, effective 06/2017, documented that to ensure appropriate ordering of medications, treatments, and services, it is the policy of the facility that the medical provider shall review and renew the monthly medication and treatments for the resident. The facility's policy titled Care and Treatment of the Peripherally Inserted Central Catheter, Maintenance and Care, documented that it is the policy of the facility to provide intermediate to long-term venous access in a safe, aseptic manner: General Guidelines Include - Lines should be flushed on a routine basis to maintain patency of the device. Lines should be flushed before and after the administration of any medication or solutions. The dressing change for the line is completed every 7 days or as needed. 1. On 06/26/24 at 09:32 AM, during the Medication Administration task, Registered Nurse #3 was observed performing dressing change for a Peripherally Inserted Central Catheter (An indwelling catheter that is inserted through a peripheral vein into a central vein for intravenous treatment) and administering intravenous antibiotic for Resident #377. The soiled dressing that was removed was observed to be dated 6/18/2024, which was 8 days since the dressing was last changed. last changed. Registered Nurse #3 was interviewed immediately, and they stated that they changed the dressing at this time because it was applied on 6/18/2024, 8 days ago, and should have been on changed 6/25/2024, the 7th day. A Physician Order dated 6/23/2024, documented that Resident #377 received Vancomycin intravenous solution every 12 hours for Osteomyelitis until 7/10/2024. There was no documented evidence of physician orders specifying the frequency of dressing changes for Resident #377's Peripherally Inserted Central catheter site. 2. On 6/27/2024 at 10:36 AM, during the Medication Administration task, Registered Nurse #4 was observed performing a dressing change for a Midline (an indwelling catheter that is inserted into a large peripheral vein in the upper arm for intravenous treatment) for Resident #50 and administering intravenous antibiotic. A Physician Order dated 6/17/2024, documented that Resident #50 was to receive Ceftriaxone Sodium Solution intravenously one time a day for osteomyelitis for 14 Days. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence of physician orders specifying the frequency of dressing changes for Resident #50's Midline Catheter site. On 07/02/24 at 12:09 PM, an interview was conducted with the Director of Nursing who stated Peripherally Inserted Central Catheters and Midlines (an indwelling catheter that is inserted into a large peripheral vein in the upper arm for intravenous treatment) site dressings should be changed every 7 days. On 07/03/24 at 12:42 PM, an interview was conducted with the Director of Nursing who stated physician orders are given in person or by phone. The Registered Nurse should enter orders in the computer system for intravenous line care and maintenance, monitoring for signs/symptoms of infection and dressing changes. The Director of Nursing further stated that for Resident #50 there is no order for dressing change and that they are working on determining if there is an order for Resident #377. On 07/03/24 at 02:53 PM, an interview was conducted via telephone with the Medical Director who stated that there should be documentation of the physician conversation with the nurse for orders requested and the physician should check that the order was entered in the computer system and signed off afterwards. On 07/03/24 at 3:21 PM, an interview was conducted with the Attending Physician who stated that when they place a telephone call to the nurse or speak to them in person when they request an order, they will enter the orders themselves if they are in the building. The Attending Physician also stated that if they are not in the building, the nurse should enter the order. After the nurse enters the order, the Attending Physician will verify and sign the order. The Attending Physician further stated that they did not check for a dressing change order for Resident #50. The Attending Physician stated that if there is an issue with an order for the resident the Director of Nursing would let them know. 10 NYCRR 415.15(b)(2)(iii)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50820 Based on observation, record review, and interviews conducted during the Recertification survey completed from 6/26/2024 to 7/3/2024, the facility did not ensure that a resident was promptly referred for annual dental evaluation and care. This was evident for 1 (Resident #92) of 4 residents reviewed for Dental out of a sample of 37 residents. Specifically, an annual dental evaluation was not performed for Resident #92. The facility policy titled Dental and Oral Health Services dated 11/2017 states that it is the policy of the facility to make routine and 24-hour emergency dental care available to its resident and that the dentist shall perform an annual re-evaluation for reach resident. A record of dental services and evaluations will be maintained in the resident's medical chart. Resident #92 was admitted with diagnoses that included Alzheimer's Disease, Non-Alzheimer's Dementia, and Seizure Disorder. The Annual Minimum Data Set, dated dated dated [DATE] documented that Resident #92 was moderately cognitively impaired, did not reject care, and required supervision assistance for oral hygiene and set-up/clean up assistance for eating. The Minimum Data Set assessment also documented that Resident #92 and had no concerns with swallowing and oral/dental status. On 06/26/2024 at 11:46 AM, Resident #92 was interviewed and stated that they told staff that they needed dentures to help chew their food, but no one had followed up on it. The Order Details dated 4/30/2023 documented orders for initial dental consult and follow up as needed. The Dental Consult dated 5/25/2023 located in the facility's Electronic Medical Record documented that Resident #92 was asymptomatic, has no complaints and is functional with present oral condition. There was no documented evidence in the Electronic Medical Record or physical chart on the unit that Resident #92 had been evaluated by the dentist after 5/25/2023. The Point Click Care Clinical Forms List for April, May and June 2024 did not document that a dental consult was placed for Resident #92. The Dental Orders and Progress Notes form documented that Resident #92 refused to be seen on 5/23/2024 and dentist unable to do exam. The Dental Orders and Progress Notes form also documented that on 5/30/2024, Resident #92 stated that they did not want to be seen now. On 7/2/2024 the Dental Orders and Progress Notes documented that resident is missing teeth but feels good without any problems. There was no documented evidence in the Electronic Medical Record or the physical chart that Resident #92 refused to be seen on 5/23/2024 and on 5/30/2024 or was seen on 7/2/2024. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/03/2024 at 11:28 AM, Registered Nurse #4 was interviewed and stated that they report to nursing supervisors if the resident has issues with dentures, tooth ache or loose teeth but the floor supervisor is responsible for scheduling annual dentist appointments. On 07/03/2024 at 11:33 AM, Nursing Supervisor #1 was interviewed and stated that dental consults are scheduled annually every 6 months. Nursing Supervisor #1 also stated that the floor supervisors schedule the dental consults and that the last dental consult for Resident #92 was performed on 5/25/2023. Nursing Supervisor #1 further stated that charts are checked manually to see which residents needs to be seen and who is due, then consults are put into the system by the supervisor where the dentist can view it. Nursing Supervisor #1 states they are unsure on how the scheduling of the annual dentist consult was missed for Resident #92. On 07/03/2024 at 01:08 PM, the Director of Nursing was interviewed and stated that dental consults are done annually and as needed. The Director of Nursing stated that the contracted dental company tracks annual consults, and the Director of Nursing will receive emails regarding when the consults are due for residents. If consults are due, then the supervisor on the floor will place orders for the dental consults. The Director of Nursing further stated they are unsure regarding the process and did not know whether emails regarding specific dental annuals had been received. The Director of Nursing stated they are unsure if there are other methods on following up with annual dental consults aside from notification from the dental provider. 10 NYCRR 415.17 (a-d)

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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** 48876 Based on observation, record review, and interviews conducted during the Recertification survey from 06/24/2024 to 07/03/2024, the facility did not ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, 1). Enhanced Barrier Precautions were not implemented for 2 residents (Resident #377 and Resident #50) with indwelling medical devices and 1 resident (Resident #23) during a wound care observation, and 2). A Certified Nursing Assistant did not perform hand hygiene while assisting multiple residents in the dining room. The findings are: The Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memorandum titled Enhanced Barrier Precautions in Nursing Homes, Ref: QSO-24-08-NH dated 03/20/2024 documented that effective 04/01/2024, Centers for Medicare and Medicaid Services is issuing a new guidance for long term care facilities on the use of enhanced barrier precautions to align with nationally accepted standards. Enhanced Barrier Precautions recommendations now include use of enhanced barrier precautions for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. The new guidance related to enhanced barrier precautions is being incorporated into F880 Infection Prevention and Control. The facility policy and procedure titled Enhanced Barrier Precautions, with a revision date of 05/2024, stated that the facility will utilize Enhanced Barrier Precautions which entails the use of gown and gloves during high-contact resident care activities for residents with wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with Multidrug Resistant Organisms (germs that are resistant to many antibiotics and can cause infections). The policy also stated that high-contact resident care activities include care and use of devices including central lines and wound care. Enhanced Barrier Precautions protocols are to be followed to inhibit opportunities for transfer of Multidrug Resistant Organisms to staff hands and clothing during high-contact resident care activities. 1(a). On 06/26/2024 at 09:32 AM, during the Medication Administration task, Registered Nurse #3 was observed performing dressing change for a Peripherally Inserted Central Catheter (An indwelling catheter that is inserted through a peripheral vein into a central vein for intravenous treatment) and administering intravenous antibiotic for Resident #377. Registered Nurse #3 was observed wearing gloves and a mask however was not wearing a gown. There was no signage that Resident # 377 was on Enhanced Barrier Precautions. Order Details dated 6/28/2024 documented that Resident #377 required Enhanced Barrier Precautions during high-contact care activities for the PICC (Peripherally Inserted Central Catheter) Line every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1(b). On 6/27/2024 at 10:36 AM, during during the Medication Administration task, Registered Nurse #4 was observed performing a dressing change for a Midline (an indwelling catheter that is inserted into a large peripheral vein in the upper arm for intravenous treatment) for Resident #50 and administering intravenous antibiotic. Registered Nurse #4 was observed wearing gloves and a mask however was not wearing a gown. There was no signage that Resident #50 was on Enhanced Barrier Precautions. A facility document titled Enhanced Barrier Precautions List, dated 6/28/2024, documented a list of residents who were maintained on Enhanced Barrier Precautions. Resident #377 was included on the list, and Resident #50 was not. On 06/27/24 at 03:08 PM, Registered Nurse #3 was interviewed and stated that at the time of the dressing change they did not know that Enhanced Barrier Precautions were needed. Registered Nurse #3 also stated that subsequently they learned that the resident had a Peripherally Inserted Central Catheter line and not a midline catheter, and that they were supposed to maintain Enhanced Barrier Precautions. On 06/28/24 at 11:48 AM, Registered Nurse #4 was interviewed and stated that there was no Enhanced Barrier Precaution notice posted on Resident #50's door although Resident #50 has a midline. Registered Nurse #4 also stated that they did not wear a gown when administering the intravenous antibiotic because they did not know a gown was needed. On 07/01/2024 at 10:02 AM, the Infection Control Preventionist/Assistant Director of Nursing, was interviewed and stated when care is provided for a resident with a Peripherally Inserted Central Catheter, Enhanced Barrier Precautions should be maintained. The Infection Control Preventionist/Assistant Director of Nursing also stated that Registered Nurse #3 should have worn a gown. On 07/02/24 at 12:09 PM, the Director of Nursing was interviewed and stated Enhanced Barrier Precautions are to be maintained for dressing changes and any care needs for a Resident with a Peripherally Inserted Central Catheter. The Director of Nursing further stated that Registered Nurse #3 did not use the gown as an Enhanced Barrier Precaution. 50820 1(c). Resident #23 was admitted with diagnoses of Non-Alzheimer's Disease and Cerebrovascular Accident. The Admission Minimum Data Set, dated dated dated [DATE] documented Resident #23 was moderately cognitively impaired and had one Stage 3 pressure ulcer and one unstageable pressure ulcer. The Order Details dated 5/1/2024 documented Enhanced Barrier Precautions during high contact resident care activities (Wounds). The Order Details dated 5/28/2024 discontinue use of Enhanced Barrier Precautions. The Order Details dated 6/4/2024 document to cleanse left heel wound, pat dry, apply sting free skin prep to peri-wound, allow to dry, pain with betadine, cover with abdominal pad and loosely wrap with rolled gauze. Every night shift for wound care and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Order Details dated 6/25/2024 documented to clean sacral area wound, pat dry, apply sting free skin prep to peri-wound. Allow to dry, apply treatment every day shift every Monday, Wednesday, Friday for wound care. The Wound Care Consult done on 6/4/2024 documented that resident has sacrum to bilateral buttocks pressure ulcer Stage 3 measuring 7cm x 8cm x 0.3cm, 100% granulation tissue, moderate serous drainage, peri-wound intact. The Interdisciplinary Team Weekly Wound Documentation done on 6/4/2024, 6/13/2024, 6/18/2024 and 6/25/2024 by wound care nurse documented that Resident #23 has Stage 3 pressure ulcer to the sacrum. On 07/01/24 at 11:39 AM, Registered Nurse #5 was observed performing wound care for sacral pressure ulcer for Resident #23 with assistance of Certified Nursing Assistant. There was no signage indicating Enhanced Barrier Precautions on Resident #23's door. Registered Nurse #5 did not don a gown or face mask before entering the room. Wound care was performed with no concerns and Registered Nurse #5 performed hand hygiene and exited the room. On 07/02/24 at 02:35 PM, the Registered Nurse #5 was interviewed and stated that Enhanced Barrier Precautions are for residents who have intravenous devices, feeding tubes and wounds. Registered Nurse #5 also stated that Resident #23 is not on Enhanced Barrier Precautions currently because Resident #23's wound has been healing and currently, they only have excoriation to the sacrum. Registered Nurse #5 stated that Enhanced Barrier Precautions has not been used because of current wound status and cannot recall if they have ever used Enhanced Barrier Precautions for Resident #23 since they started working on the unit one month ago. Registered Nurse #5 stated there are two residents on Enhanced Barrier precautions due to feeding tubes. Registered Nurse #5 stated it is necessary to wear gown, gloves and mask before entering the room of those residents. On 07/03/24 at 10:13 PM, the Certified Nursing Assistant #3 was interviewed and stated that Resident #23 was on Enhanced Barrier Precautions before but is currently off it now. If resident was currently on Enhanced Barrier Precautions, it would show up in the Electronic Medical Record which it does not. Certified Nursing Assistant #3 stated that resident has a dressing on sacrum which the nurse changes. On 07/03/24 at 10:19 AM, the Nursing Supervisor #1 was interviewed and stated that Resident #23 was on Enhanced Barrier Precautions from 5/1/2024-5/28/2024 and is currently not on precautions. Nursing Supervisor #1 also stated that residents are usually placed on Enhanced Barrier Precautions when they have chronic wounds, peripherally inserted central catheters or foley catheters. Nursing Supervisor #1 further stated Resident #23 may have been taken off precautions as the wound was either healing or healed. Nursing Supervisor #1 stated that the current ulcer staging in the Electronic Medical Record is a Stage 3 pressure ulcer to the sacrum. Nursing Supervisor #1 also stated that the wound care doctor evaluates resident with wounds 2-3 times a month and puts in the final order to discontinue use of Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/03/24 at12:53 PM, the Assistant Director of Nursing and Infection Preventionist #1 was interviewed and stated that newly admitted residents are assessed for the need to be on Enhanced Barrier Precautions. If applicable, residents are placed on Enhanced Barrier Precautions particularly if have multi drug resistant organisms, foley catheters, feeding tubes, peripherally inserted central catheter lines. If a wound is healing which is determined by assessing the size, drainage, slough and drainage, then the Enhanced Barrier Precautions are lifted. The wound care nurse does daily assessments of wounds and will report it the doctor. The doctor will also evaluate the wound. The Wound care doctor makes the final decision on lifting Enhanced Barrier Precautions after consultation with the Infection Preventionist. If there is normal progression of healing from a 3-month period, then the wound is considered as healing and the Enhanced Barrier Precautions are lifted. If not, the resident would continue to be on precautions. Wound care nurse will continually assess resident and if wound is not healing, resident would continue to be on Enhanced Barrier Precautions. 42101 2. The facility policy titled Hand Hygiene Protocol effective 11/2017 documented the facility follows hand hygiene protocol in preventing the spread of potential pathogens on the hands. All personnel must perform hand hygiene as per standard guidelines. Alcohol based soaps are the most effective product for effective hand hygiene. Soap and water should be used if hands are visibly soiled. Guidelines for hand hygiene before and after eating. Resident hand hygiene should be performed before meals. The facility policy titled Meal Service-Assistance of Residents effective 4/2016 documented the facility will provide each resident a nourishing, palatable diet at proper temperature to meet the dietary needs of each resident. Certified Nursing Assistant wash resident's hands or offer handwipes. Offer and/or assist resident to cleanse their hands with a hand wipe. During an observation on 06/27/2024 at 11:46 AM, Certified Nursing Assistant #4 was observed in the dining room handing out hand wipes for residents to clean their hands for lunch meal. Certified Nursing Assistant #4 assisted Resident #37 with hand hygiene, removed Resident #37 used oral supplement and giving hand wipe to Resident #133, Resident #158, Resident #168, Resident #54, and Resident #5. Certified Nursing Assistant #4 collected hand wipes from some residents and asked some of them to put it in a plastic cup for used hand wipes. Certified Nursing Assistant #4 discarded the plastic cup with dirty hand wipes in the trash and wiped their own hands with hand wipes after. On 06/27/2024 at 11:50 AM, Certified Nursing Assistant #4 stated that they discarded the plastic cup with dirty wipes in the trash and cleaned their hands. They used the plastic cup to collect used wipes that needed to be disposed of. Certified Nursing Assistant #4 also stated that they thought they cleaned their hands with wipes in between residents, and it may have slipped their mind that they did not clean their hands. Certified Nursing Assistant #4 further stated that resident's hands may have bacteria and they do not want to spread any bacteria to other residents. On 07/03/2024 at 10:40 AM, Registered Nurse #7 stated that they monitored the dining room this past week. Staff should wash their hands first for 20 seconds. Certified Nursing Assistants should use hand wipes to clean their hands or wash their hands when it is visibly soiled. The Certified Nursing Assistants should stop and clean hands, so we do not have cross contamination. Registered Nurse #7 also stated that they have not noticed any issues with hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335387	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peninsula Nursing and Rehabilitation Center	50 15 Beach Channel Drive Far Rockaway, NY 11691

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.19 (b)(4)