STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335401	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentum at South Bay for Rehab and Nursing	340 East Montauk Highway East Islip, NY 11730

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observation, record review, and interviews during the Recertification Survey and Abbreviated Survey (Complaint #NY 00330563) initiated on 06/04/2024 and completed on 06/11/2024 the facility did not ensure Intravenous antibiotics were administered consistent with professional standards of practice and in accordance with physician's orders and the comprehensive person-centered care plan. This was identified for one (Resident #98) of one resident reviewed for Peripheral Intravenous Catheter. Specifically, Resident #98 was observed with a Peripheral Intravenous Catheter in their right arm. There were no physician orders for the placement of the Peripheral Intravenous Catheter and monitoring of the Peripheral Intravenous Catheter site. The finding is: The Facility's policy for Administration, Monitoring, and Maintenance of Intravenous Therapy dated January 2022, documented that the nursing staff must document an assessment of the Peripheral Intravenous Catheter site for phlebitis, infection, or infiltration at least once per shift. The Facility's policy for Medication Management Administration-Intravenous General dated January 2019, documented checking the Peripheral Intravenous Catheter for signs of infection, cleaning the Peripheral Intravenous Catheter with an alcohol wipe, and flushing the line as per the Physician's order. Resident #98 was admitted with diagnoses of Chronic Obstructive Pulmonary Disease, Lymphedema, and Acute and Chronic Respiratory Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The Comprehensive Care Plan for Risk for Infection related to Intravenous Access dated 6/10/2024 documented that the resident was at risk for infections related to Peripheral Intravenous Catheter use. The interventions included: the Registered Nurse was to change the dressing to the Intravenous site weekly and as needed, flush the Intravenous access line with 10 milliliters of Normal Saline after each medication and every shift when not in use or as per Physician order, monitor for signs and symptoms of infection such as redness, edema, warmth, and pain at the Intravenous site, and notify the Physician of abnormal findings. The Comprehensive Care Plan for Intravenous Therapy/Antibiotic Therapy dated 6/10/2024 documented interventions to monitor the Peripheral Intravenous Catheter site every shift and as needed. (continued on next page)

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 6/10/2024 documented to administer Rocephin 1-gram (Antibiotic) Intravenous Solution, infused by Intravenous route once daily for seven days for Acute Upper Respiratory Infection. The Medication Administration Record for June 2024 indicated that Resident #98 received Rocephin 1 gram Intravenously which started on 6/10/2024 at 9:00 AM once a day for seven days. There was no documentation on the Medication Administration Record or Treatment Administration Record for the placement of the Peripheral Intravenous Catheter and assessment of the Peripheral Intravenous Catheter site. Resident #98 was observed on 6/10/2024 at 10:09 AM resting in bed with a Peripheral Intravenous Catheter in their right arm. Resident #98 stated they were getting a new medication via the newly placed Peripheral Intravenous Catheter. Registered Nurse Manager #1 was interviewed on 6/11/2024 at 8:04 AM and stated there should be a physician's order for the placement and assessment of the Peripheral Intravenous Catheter. Registered Nurse Manager #1 stated on 6/10/2024 they received a verbal order for the Intravenous Antibiotic and the placement and assessment of the Peripheral Intravenous Catheter for Resident #98. The physician's order related to the use and assessment of the Peripheral Intravenous Catheter should have been transcribed onto the Medication Administration Record. Registered Nurse Manager #1 stated they forgot to write the physician's order for the insertion or monitoring of the Peripheral Intravenous Catheter, therefore, the physician's order did not get transcribed onto the Medication Administration Record. The Director of Nursing Services was interviewed on 6/11/2024 at 8:50 AM and stated there should be an order for the placement and the assessment of Peripheral Intravenous Catheter. The Director of Nursing Services stated whoever obtained the order from the Physician should have ensured the orders were entered into the Medication Administration Record. Physician #1 was interviewed on 6/11/2024 at 9:39 AM and stated they expect the nursing staff to follow the physician's orders and ask questions if needed. Physician #1 stated the nursing staff should check the Peripheral Intravenous Catheter site on all shifts and document their observations. The Peripheral Intravenous Catheter site should be checked each shift for redness, leaking, swelling, and signs and symptoms of infections. 10 NYCRR 415.12(k)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 6/4/2024 and completed on 6/11/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #90) of three residents reviewed for Infection Control. Specifically, Resident #90 had a physician's order for Contact Enteric Isolation due to Clostridium Difficile (C-Diff-bacteria that causes inflammation of the colon) infection. On 6/7/2024, Certified Nursing Assistant #4 was observed providing perineal care to Resident #90 after a bowel movement. When the perineal care was completed, Certified Nursing Assistant #4 removed their dirty gloves and put on a new pair of gloves without performing hand hygiene. Certified Nursing Assistant #4 then removed the used water basin from the overbed table, cleansed the overbed table, and exited the room wearing the same gloves. The finding is: The facility's policy and procedure titled Transmission-Based Precautions last revised on 3/28/2024, documented that while caring for a resident, change gloves after having contact with infective material, fecal material, and wound drainage. Remove gloves before leaving the room and perform hand hygiene. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. Resident #90 was admitted with diagnoses of Acute Respiratory Failure, Irritable Bowel Syndrome, and Unstageable Pressure Ulcer to the Sacral Region. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated the resident had severely impaired cognition. The Minimum Data Set assessment documented that Resident #90 had an Unstageable (full-thickness tissue loss in which the actual depth of the wound is obscured) wound on the sacrum. A Comprehensive Care Plan (CCP) for Isolation and Contact Precaution dated 5/29/2024 documented interventions that included Isolation Precautions as per the physician's order and to maintain contact precautionary measures as per facility protocol which included Personal Protective Equipment use. A Comprehensive Care Plan (CCP) for Clostridium Difficile (C-Diff) dated 5/29/2024 documented interventions to monitor signs and symptoms of Clostridium Difficile (C-Diff) (such as watery, smelling, and blood-tinged stool and abdominal pain), stool cultures as per the physician's order, and to provide protective skin care. A physician's order dated 5/29/2024 documented Contact Precaution secondary to Clostridium Difficile (C-diff). A physician's order dated 5/29/2024 documented to apply honey gel to the Coccyx (sacral) area after normal saline cleanses followed by a Calcium Alginate (wound fabric that absorbs water) dressing and cover with border gauze daily 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 - Few	During an observation on 6/7/2024 at 10:00 AM, Certified Nursing Assistant #4 was observed inside the resident's room with Certified Nursing Assistant #5. A sign posted outside the room read Contact Enteric Isolation. The sign included instructions that all staff and visitors must wash hands with soap and water before and after care and use Personal Protective Equipment (PPE) including wearing a gown and gloves. Certified Nursing Assistant #4 and Certified Assistant #5 were both wearing gowns and gloves and were providing perineal (area between the anus and genitalia) care for Resident #90. An open wound, without a dressing, was observed on the Coccyx (tailbone-sacral) area. Resident #90 was continuously having loose bowel movements while Certified Nursing Assistant #4 was wiping the perineal area. Certified Nursing Assistant #4 discarded their gloves after the perineal care was completed and put on a new pair of gloves without performing hand hygiene. Certified Nursing Assistant #4 then cleaned and wiped the overbed table which was used to hold the water basin and other supplies during the perineal care and exited the resident's room, to discard the garbage bag, wearing the same gloves. Certified Nursing Assistant #4 was interviewed on 6/7/2024 at 10:39 AM and stated they forgot to perform handwashing after discarding the dirty gloves. Certified Nursing Assistant #5 was interviewed on 6/7/2024 at 11:00 AM and stated they were helping to position Resident #90 during care because the resident was very combative. Certified Nursing Assistant #5 stated when the wound dressing came off, they should have called a nurse because the wound was exposed to fecal material; however, the resident was getting very anxious and combative, and they wanted to complete the care. The Infection Preventionist was interviewed on 6/7/2024 at 2:28 PM and stated staff must follow the isolation precaution instructions before and after entering the resident's room. Resident #90 was placed on a Contact Isolation precaution secondary to the Clostridium Difficile infection. The staff must perform handwashing to minimize the spread of contamination. Certified Nursing Assistant #4 should have washed their hands after discarding the dirty gloves and before putting on the new gloves. The Director of Nursing Services was interviewed on 6/10/2024 at 2:02 PM and stated that because of Resident #90's continued symptoms of loose feces, the dressing on the sacral wound will always be saturated and prone to cross-contamination. The Director of Nursing Services stated that Certified Nursing Assistant #4 and Certified Nursing Assistant #5 should have alerted a nurse when the sacral wound dressing came off. The exposed wound bed could have gotten feces on it and become infected. The Director of Nursing Services stated handwashing is of utmost importance, especially with a diagnosis of Clostridium Difficile (C-diff). Certified Nursing Assistant #4 should have washed their hands after discarding their dirty gloves. 10 NYCRR 415.19(a)(1-3)