

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Little Neck Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 19 Nassau Blvd Little Neck, NY 11362	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37787</p> <p>Based on observation and staff interviews conducted during the Recertification Survey from 8/21/24 to 8/28/24, the facility did not ensure that a resident was cared for in a manner that maintained or enhanced dignity. This was evident for 1 (Resident #3) of 4 residents reviewed for Catheter out of a sample of 25 residents. Specifically, Resident #3's Foley catheter bag and tubing were not covered with a privacy bag.</p> <p>The findings are:</p> <p>The facility policy titled Care of the Resident with a Foley Catheter last reviewed 1/2024 documented that a drainage bag cover should be utilized for privacy.</p> <p>Resident #3 was admitted to the facility with diagnoses which include Multiple Sclerosis, Neuromuscular Dysfunction of Bladder and Type 2 Diabetes Mellitus with Chronic kidney Disease.</p> <p>The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #3 had moderate cognitive impairment, required extensive assistance of 2 staff members for bed mobility, transfer, dressing, toilet use and personal hygiene, and had a catheter.</p> <p>During multiple observations on 08/21/2024 at 10:12 AM, 08/22/2024 at 3:12 PM and 08/23/2024 at 2:36 PM, Resident #3 was observed lying in bed watching television. Resident #3's Foley catheter drainage bag and catheter tubing were observed with amber urine draining into the bag was visible from the hallway as it was not contained in a privacy bag.</p> <p>The Physician order dated 7/26/2024 documented monitor urine output and document amount in every shift for neuromuscular dysfunction of bladder.</p> <p>On 08/23/2024 at 2:15 PM, Licensed Practical Nurse #1 was interviewed and stated that the catheter bag is supposed to be in a privacy bag.</p> <p>On 08/23/2024 at 2:34 PM, Certified Nursing Assistant #5 was interviewed and stated that the privacy bag must be on every day. Certified Nursing Assistant #5 also stated that the bag is missing and was nowhere to be found. Certified Nursing Assistant further stated that the privacy bags are in the clean utility room, and they were on their way to get a new bag, got distracted and then forgot about it.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/26/2024 at 11:23 AM, the Director of Nursing was interviewed and stated that the privacy bag needs to be put on for the resident's privacy. The Director of Nursing further stated that in-service regarding catheter and catheter privacy bag are given on the unit by nurses in charge and nurse supervisors.</p> <p>10 NYCRR 415.5(a)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50820</p> <p>Based on record review and staff interviews conducted during the Recertification Survey from 08/21/2024 to 08/28/2024, the facility did not ensure that the resident and their representative were provided with a summary of the baseline care plan. This was evident for 1 (Resident #78) of 2 residents reviewed for Care Planning out of 25 total sampled residents. Specifically, Resident #78 was not provided a written summary of their baseline care plan.</p> <p>The findings are:</p> <p>The facility's policy titled Baseline Care Plan with a revised date of 01/07/2024 states that the resident or their representative will be provided a summary of the baseline care plan.</p> <p>Resident #78 was admitted to the facility with diagnoses that included Coronary Artery Disease, Arthritis, and Malnutrition.</p> <p>The Admission Minimum Data Set assessment dated [DATE] documented that Resident #78 was severely cognitively impaired and both resident and family participated in assessment and goal setting.</p> <p>On 08/26/24 at 04:25 PM, Resident #78's spouse was interviewed by telephone and stated that they did not receive a copy of Resident #78 baseline care plan. Resident #78's spouse stated they attended two care plan meetings but did not receive a copy of the baseline care plan.</p> <p>The Baseline Care Plan created and completed on 05/25/2024 documented signatures of five interdisciplinary team members. The lines for resident and representative signatures were blank and had not been signed.</p> <p>The Social Work Progress note dated 06/05/2024 documented an initial care plan meeting was held to review resident's plan of care and present status. Resident's spouse and child participated in the meeting to address concerns regarding care. The progress note also documented that Social Work provided family with a copy of their care plan summary for review.</p> <p>On 08/26/2024 at 11:42 AM, the Director of Social Work was interviewed and stated that the protocol is to get the baseline care plan signed when a resident is newly admitted . The Director of Social Work also stated that there is no signed copy of the baseline care plan to verify that Resident #78's family received it and they are unsure what happened.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/27/2024 at 10:39 AM, the Registered Nurse Supervisor #1 was interviewed and stated that if a resident is alert and oriented to person, place and time, the protocol is to explain the baseline care plan to the resident and have the resident sign it. If not, family is contacted, and a copy of the baseline care plan given which is then signed and scanned back into the system to ensure it was received. Registered Nurse Supervisor #1 also stated various staff are involved in the baseline care plan including the Registered Nurse Supervisor and Director of Nursing Services who are all responsible to ensure the resident receives a copy of the baseline care plan and that it is signed. Registered Nurse Supervisor#1 further stated they are not sure what happened with the signing of the baseline care plan for Resident #78. Registered Nurse Supervisor #1 stated they looked in Resident #78 chart and in the Electronic Medical Record but there is no signed care plan to confirm that Resident #78 received a copy.</p> <p>On 08/26/2024 at 12:53 PM, the Director of Nursing Services was interviewed and stated that the protocol is to get the baseline care plan signed by the resident or their representative to ensure they received a copy of the summary. The nurse on the unit will review the baseline care plan with the resident or family who will then get a separate sheet of paper that has to be signed. Nurses on the floor are responsible for getting the baseline care plan signed initially and if they are unable to get it signed, then another staff is responsible for following up and ensuring it is signed. The Director of Nursing Services also stated that they could not locate the signed copy of Resident #78's base line care plan in the chart. In this case the care plan was not signed, and they are unsure why that happened. The Director of Nursing Services further it is always important to get the care plan signed by the resident or family to ensure that they received a summary of the baseline care plan and that they are aware of the resident's plan of care.</p> <p>10 NYCRR 415.11(c)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864</p> <p>Based on observations, record review and interviews conducted during the Recertification survey from 08/21/2024 to 08/28/2024, the facility did not ensure that a person-centered Comprehensive Care Plan was developed and implemented to meet the resident's goal, and address the resident's medical, physical, mental, and psychosocial needs. This is evident for 1 (Resident #75) of 2 residents reviewed for Urinary Catheter out of 25 sampled residents. Specifically, Resident #75 was receiving Oxygen therapy, and a comprehensive care plan was not created.</p> <p>The findings include:</p> <p>The facility's policy titled Comprehensive Care Plan/Baseline Care Plan, review date 1/2024, documented that the facility must develop and implement a comprehensive person-centered care plan for each resident, to include resident's problems, strengths, and needs. An individual Comprehensive Care Plan will be developed for each problem, will be initiated immediately upon admission and appropriate care plans will be in place within 48 hours of admission.</p> <p>Resident #75 was admitted to the facility with diagnoses that include Coronary Artery Disease and Benign Prostate Hypertrophy.</p> <p>The Admission Minimum Data Set, dated dated dated [DATE] documented that Resident #75 had intact cognition, was dependent on staff for bed mobility, toilet use and transfers, and was on Oxygen therapy.</p> <p>The Physician's Order dated 07/17/2024, last renewed 08/14/2024, documented Oxygen device: via nasal cannula, rate 2L/min, continuous.</p> <p>On 08/28/2024 at 10:06 AM, Resident #75 was observed sitting in a wheelchair in their room, and was alert and oriented to name, person, and place. Oxygen was being administered via nasal cannula at 2 liters per min.</p> <p>The Treatment Administration Record dated 08/01/2024- 08/28/2024, documented Oxygen device via nasal cannula on the 7:00am-3:00pm, 3:00pm-11:00pm, 11:00pm-7:00am shift was given.</p> <p>A Physician's Progress note dated 8/2/24 documented that Resident #75's hospitalization procedure cancelled due to acute respiratory failure. The Physician's note also documented to continue current medications and care management.</p> <p>There was no documented evidence in the Electronic Medical Record that a comprehensive care plan had been created to address Resident #75's oxygen use.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/28/2024 at 10:03 AM, Registered Nurse #6 was interviewed and stated that they are the 7AM to 3PM Registered Nurse who does interim care plans. Registered Nurse #6 also stated that the Registered Nurse on the night shift is responsible for initiating the care plans on admission. Registered Nurse #6 further stated that Resident #75 was readmitted with Oxygen and has an order for continuous Oxygen. Registered Nurse #6 stated that they did not see a care plan for the Oxygen at this time, and the night shift nurse should have put in the Oxygen care plan for Resident #75.</p> <p>On 08/28/2024 at 10:15 AM, Registered Nurse Supervisor #1 was interviewed and stated that they are the Registered Nurse Supervisor and covers all the units. Registered Nurse #2 stated that there should be a care plan for the Oxygen if it was ordered and that the care plans are implemented by the Registered Nurse Supervisor at night. Registered Nurse #2 also stated that as the Registered Nurse Supervisors, they should all review the residents plan of care, to ensure that a care plan is completed.</p> <p>On 08/28/2024 at 12:08 PM, the Director of Nursing was interviewed and stated that on a resident's admission to the facility, the night shift Registered Nurse Supervisor will initiate all the care plans, and then the care plans are updated and followed up by the Registered Nurse Supervisor or the Charge Nurse on the unit is responsible for following up. The Director of Nursing also stated that if Resident #75 had an order for Oxygen use, there should have been a care plan initiated. The Director of Nursing further stated that there is a care plan meeting as well so the interdisciplinary team should be reviewing and updating the care plans discussed.</p> <p>10 NYCRR 415.11(c)(1)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37787</p> <p>Based on observation, record review, and interview conducted during the Recertification survey from 08/21/2024 to 08/28/2024, the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. This was evident for 1 (Resident # 3) of 4 residents reviewed for Urinary Catheter from a sample of 25 residents. Specifically, Resident #3, a resident with left hand weakness and left wrist drop was observed on more than one occasion without a left-hand splint in place as ordered.</p> <p>The findings are:</p> <p>Resident #3 was admitted to the facility with diagnoses which include Multiple Sclerosis, and Contracture of Muscle.</p> <p>The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #3 had moderate cognitive impairment, was dependent on staff for all activities of daily living activities. required extensive assistance of 2 staff for bed mobility, transfer, dressing, toilet use and personal hygiene. The Minimum Data Set also documented that Resident #3 had functional limitation in Range of Motion on left upper extremity and both lower extremities.</p> <p>The Physician's Order renewed on 07/26/2024 documented that resident is to wear the left resting hand splint during daytime. Splint is to be removed for skin check, as needed and at nighttime.</p> <p>The Nursing progress notes dated 01/26/2024 stated that the Resident #3 is currently on passive range of motion due to stiffness to bilateral lower and upper extremities. Will refer for physiatry consultation.</p> <p>On 08/21/2024 at 10:12 AM and 08/22/2024 at 3:12 PM, Resident #3 was observed in bed watching TV, with no left-hand splint in place.</p> <p>On 08/23/2024 at 2:36 PM and 08/26/2024 at 3:16 PM Resident #3 was observed in bed. There was no left-hand splint in place.</p> <p>On 08/26/2024 at 3:28 PM, Registered Nurse #3 was interviewed and stated that on observation, Resident #3 has no splint on. Registered Nurse #3 further stated that if there is an order for Resident #3 to have a splint on the left hand, it should be executed.</p> <p>On 08/26/2024 at 3:53 PM, Certified Nursing Assistant #6, who was assigned to Resident #3 in the absence of Resident #3's regular aide, stated that Resident #3 did not have a left-hand splint.</p> <p>On 08/26/2024 at 4:05 PM, the Director of Physical Therapy was interviewed and stated that quarterly and significant change assessment screening for mobility, activities of daily living and compliance for devices are done all the time. Occupational Therapy do weekly round for splint and braces. The Director of Physical Therapy further stated that as per the Occupational Therapist, all splints were checked and accounted for, but currently Resident #3's hand splint could not be located.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/26/2024 at 4:43 PM, Registered Nurse Supervisor #1 was interviewed and stated that when there is a device, there is an in-service given to all staff members about how to put the device on. The Certified Nursing Assistant who is assigned to the resident will put the device on for the resident. Registered Nurse Supervisor #1 also stated that the charge nurse and the nurse supervisors are to make sure that the device is on. Registered Nurse Supervisor #1 further stated that no one knows what happened to the hand splint, but Resident #3 is in need of it.</p> <p>10 NYCRR 415.12(e)(2)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>40565</p> <p>Based on observation, record review and interviews conducted during the Recertification survey between 08/21/2024 and 08/28/2024, the facility did not ensure that Nurse Staffing Information was posted in a prominent place readily accessible to residents and visitors. Specifically, the posting of staffing did not indicate the actual hours worked by staff or the resident census and was posted by the employee time clock, located in a corner at the entrance to the kitchen, that was not readily accessible to all residents and visitors.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Daily Staffing dated 01/2024 documented that the Nursing Staffing Coordinator will prepare and provide a monthly schedule of regular staff members. Such schedule shall be posted by the facility time clock. A copy shall be maintained in the Nursing Office, either electronically or on paper.</p> <p>During multiple observations made between 08/21/2024 and 08/27/2024, there was no Nurse Staffing Information observed posted on daily basis in a prominent place.</p> <p>On 08/27/2024 at 09:44 AM, the Staff Development Coordinator was interviewed and stated that the staffing information is posted by the time clock in a corner, for the staff to see when they are punching in or out. Staff Development Coordinator stated that it has always been posted in that location since June 11, 2024, when they were hired.</p> <p>On 08/27/2024 at 09:50 AM, the Staff Development Coordinator showed the State Surveyor that the Nurse Staffing Information was posted by the employee time clock, located in a corner at the entrance to the kitchen. The information documented on the Nurse Staffing Information was the names of the staff, and their assigned units. The Nurse Staffing Information did not include the actual hours worked by staff, or the resident census.</p> <p>On 08/27/2024 at 01:30 PM, the Director of Nursing was interviewed and stated that the Staffing Development Coordinator works under their supervision. The Director of Nursing also stated that they are aware that the staffing information is posted by the clock for the staff to see it when they report for work. The Director of Nursing further stated that they did not know what information needed to be included in the posting.</p> <p>On 08/28/2024 at 10:46 AM, the Administrator was interviewed and stated that the Staffing Coordinator is responsible for posting of daily staffing, supervised by the Director of Nursing and the Administrator. The Administrator also stated that the daily staffing is posted by the clock for the staff to see, and they thought that was the appropriate location for the posting. The Administrator further stated that they were not aware that the actual hours worked needed to be indicated in the posting.</p> <p>10 NYCRR 415.13</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565</p> <p>Based on observations, record review, and staff interviews conducted during the Recertification survey between 08/21/2024 and 08/28/2024, 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, resident's oxygen tubing was not changed and dated as per protocol. This was evident for 2 (Residents #9 and #29) of 2 residents reviewed for Respiratory Therapy out of 25 sampled residents.</p> <p>The findings are:</p> <p>The facility's policy and procedure titled Oxygen Therapy Administration dated 01/2024, documented in section Infection Control that cannulas, facemask, and tubing are to be changed weekly and as needed), and Humidifier bottles are changed when the level of distilled water reaches the low-level indicator.</p> <p>1. Resident #9 was admitted to the facility with diagnoses that included Congestive Heart Failure, Asthma, Chronic Obstructive Pulmonary Disease.</p> <p>The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #9 has moderate impairment in cognition, required partial/moderate assistance for most activities of daily living, and was on oxygen therapy.</p> <p>The Comprehensive Care Plan titled Oxygen Use dated 12/28/2016, last updated 07/02/2024 documented a goal of providing Oxygen therapy as per Physician's orders.</p> <p>The Physician's order dated 08/02/2024 documented change oxygen tubing weekly every week on Sunday at 11:00 pm-7:00 am</p> <p>On 08/21/2024 at 02:32 PM, Resident #9 was observed in their room receiving continuous oxygen therapy by nasal canula. The oxygen tubing was dated 8/12/24.</p> <p>On 08/23/2024 at 08:32 AM, Resident #9 was observed in room sitting in a wheelchair eating breakfast, receiving continuous oxygen by nasal canula from a concentrator. The canula tubing located on Resident #9's nose was brownish in color and was dated 8/12/24. The nebulizer tubing on Resident #9's nightstand was observed to be undated. Resident #9 was interviewed and stated that they did not know when the tubing was last changed.</p> <p>2. Resident #29 was admitted to the facility with diagnoses that included Congestive Heart Failure, Pneumonia, and Chronic Obstructive Pulmonary Disease/Respiratory Failure.</p> <p>The Significant Change in Status Minimum Data Set, dated dated dated [DATE] documented that Resident #29 had moderate impairment in cognition, required substantial/maximal assistance or partial/moderate assistance of staff for most activities of daily living and was on oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Comprehensive Care Plan titled Oxygen Use dated 07/27/2024 documented a goal to provide oxygen therapy as per orders.</p> <p>The Physician's order dated 07/26/2024 documented Oxygen Device: (mask/cannula/trach mask) at 2 Liter per minute, continuous. The order did not include instruction on changing oxygen tubing.</p> <p>On 08/21/2024 at 11:30 AM, Resident #29 was observed in the room with oxygen concentrator connected to Nasal canular tubing. There was no label or date noted on the oxygen tubing.</p> <p>On 08/23/2024 at 08:21 AM, Resident #29 was observed seated in a wheelchair in their room eating breakfast and was alert and oriented. Resident #29 was receiving oxygen from a concentrator via nasal canula. The tubing was not dated and was observed with brownish discoloration.</p> <p>On 08/23/2024 at 08:21 AM, Resident #29 was interviewed and stated that sometimes the tube falls off from their nose, but they are able to put it back, and the oxygen is helping them breathe properly. Resident #29 also stated that they cannot recollect when the tubing was last changed.</p> <p>On 08/23/2024 at 12:48 PM, an interview was conducted with Licensed Practical Nurse #1, who regularly works the 7AM to 3PM shift, who stated that residents' oxygen tubing is supposed to be changed by the 11PM -7AM shift staff every week as per Physician's order. Licensed Practical Nurse #1 also stated that they did not know that Resident #9's tubing had not been changed as per protocol, but they would go and change it immediately.</p> <p>On 08/23/2024 at 12:58 PM, Registered Nurse #3 was interviewed and stated that resident's oxygen tubing is changed every Saturday by the night nurse, and they are supposed to put a date on the tubing when it is changed. Registered Nurse #3 also stated that they cannot say when Resident #29's oxygen tubing was changed last as there was no date. Registered Nurse #3 further stated that they work day shift, and they did not check that the tubing so did not know it had not been changed by night shift nurse, but they are going to change it right now.</p> <p>On 08/26/2024 at 09:10 AM, an interview was conducted with Licensed Practical Nurse #2, who regularly works the 11PM-7AM shift, who stated that oxygen tubing is changed weekly on Sunday nights and is dated. Licensed Practical Nurse #2 also stated that Resident #9's oxygen tubing was changed and dated the weekend of 08/12/2024 when they last worked, and they did not know that the tubing had not been changed since that day.</p> <p>On 08/26/2024 at 09:58 AM, an interview was conducted with Registered Nurse Supervisor #1 who stated that the nasal canula is to be changed every Sunday on the 11PM-7AM shift, has to be dated, and the nurse in charge on the shift is responsible for the change. Registered Nurse Supervisor #1 also stated that when they make rounds to monitor what the staff are doing, they do not always pay close attention to the tubing, and they thought the nurses are changing the tubing as per protocol. Registered Nurse Supervisor #1 further stated that by not changing the tubing, it is an infection prevention protocol breach.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Little Neck Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 19 Nassau Blvd Little Neck, NY 11362	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/26/2024 at 10:15 AM, the Infection Preventionist was interviewed and stated that the tubing should be changed every week and when necessary and should be labeled with date of change. The Infection Preventionist also stated that if the date on Resident #9's tubing is 8/12/24, it means that the tubing has not been changed since that date. The Infection Preventionist further stated that they were surprised that the tubing for Resident #29 was not dated, and they cannot say when the tubing was last changed. The Infection Preventionist stated that the Unit Nurse and the Supervisor are supposed to be checking to ensure that the tubing is changed as per protocol, but from now on, they will also be checking to ensure it is being done properly.</p> <p>On 08/26/2024 at 12:13 PM, an interview was conducted with the Director of Nursing who stated that oxygen tubing is changed weekly and as needed, and the unit nurses and the supervisor are supposed to check to make sure that they are changed and dated as per protocol. The Director of Nursing further stated that by not changing and dating the tubing means that nobody is checking to ensure the right thing is done.</p> <p>10 NYCRR 415.19(a)(1)</p>		