| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335441 | A. Building<br>B. Wing | 10/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Cortlandt Healthcare | 110 Oregon Road<br>Cortlandt Manor, NY 10567 |

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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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48822<br><br>Based on observation, interview and record review during the recertification survey conducted from 10/12/23 to 10/20/23, the facility did not ensure that each resident had the right to make choices about aspects of their life in the facility that were significant to the resident for 1 of 3 residents (Resident #21) reviewed for choice. Specifically, Resident #21 was not provided a choice regarding whether to receive a bed bath or shower and the resident was not provided the opportunity to participate in activities they enjoyed including going to the public library.<br><br>Findings include:<br><br>Resident #21 had diagnoses including diabetes (uncontrolled blood sugar), generalized muscle weakness, and cervicalgia (neck pain). The Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was cognitively intact. Resident #21 required extensive assistance with 1 person for personal hygiene and was totally dependent with 1 person for bathing and required a 2 person assist for transfers. The MDS documented it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The MDS also documented that it was very important to resident to do their favorite activities.<br><br>Review of the Recreation Evaluation dated 9/28/23, revealed it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath; and it was very important to the resident to do their favorite activities.<br><br>Review of computerized Point of Care (POC) documentation, completed by certified nurse aide (CNA) staff from 9/1/23-10/12/23 revealed the ADL (activities of daily living) section for Bathing did not specify the resident's preference. The documentation showed the resident was bathed daily except for 9/18/23, 9/28/23, 10/1/23, and 10/5/23. During the same time period it was noted that resident did not receive a shower on their assigned shower days. There was no documentation stating showers were offered or refused.<br><br>During an observation and interview on 10/12/23 at 10:40 AM, Resident #21 stated they were waiting for staff to assist with cares. The resident was in bed, wearing a gown, and the breakfast tray was on the bedside table. The resident stated that they had not had a shower and would prefer a shower instead of a bed bath. The resident stated they would like to be more involved in physical activities, missed going to the library, and felt they were declining by living at the facility.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/13/23 at 10:10 AM, with the Ombudsman present, the resident stated that they enjoyed attending the library and had been doing so for many years. The resident stated that they enjoyed doing research and did not want to just get books. The Ombudsman stated that they had been working since August to find a way for the resident to continue with this activity and attempted to speak with facility to facilitate library visits. The resident stated that at a care plan meeting the facility discussed getting an iPad for the resident but nothing has happened yet. Resident #21 again stated their preference for a shower instead of a bed bath, and that they were not gotten out of bed every day. During an observation later that day, 10/13/23 at 1:37 PM, Resident #21 was still in bed wearing a gown.<br><br>During an interview on 10/18/23 at 12:10 PM, the Activities Director stated when residents were admitted to the facility, an assessment was completed with their hobbies, activities, religion, etc. The information was documented and an individualized care plan was created and updated quarterly. They stated there had not been any outside trips since COVID and were attempting to arrange transportation to resume trips. They stated Resident #21 was offered an iPad and refused. When requested, they were unable to provide documentation regarding the refusal.<br><br>During an interview 10/18/23 at 01:08 PM, CNA #1 stated that residents were assessed for bathing preference before they entered the facility, and they accommodated preferences throughout the day. CNA #1 stated if a resident refused or care was not done, they made a note at the end of the shift, and communicated to the nurse in charge and to the staff on next shift.<br><br>During interview on 10/19/23 at 11:15 AM, Nurse Manager #2 reviewed the bathing/ shower documentation provided for September and October 2023. Nurse Manager #2 stated, that based on the documentation, it appeared the resident did not receive or was not offered a shower from 9/1/23 to 10/12/23.<br><br>415.5(b)(1,3) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>37658<br><br>Based on interview and record review conducted during the recent recertification survey, the facility did not ensure for 1 of 2 residents (#61) reviewed for hospitalization that the resident or resident's representative were notified in writing of transfer/discharge to the hospital, including the effective date of transfer, location of transfer, and reason for transfer.<br><br>The findings include:<br><br>Resident #61 had diagnoses including anemia, hypertension, and schizophrenia. The annual Minimum Data Set (MDS: an assessment tool) dated 8/22/2023 documented the residents' cognition was moderately impaired for decision making.<br><br>The nursing progress notes dated 10/11/2023 - 10/13/2023 documented that Resident #61 had a very abnormal Hemoglobin of 5, the resident's medical doctor was called and ordered for the resident to go to the hospital in the morning on the day shift for a transfusion. On 10/12/2023 at 8:36am Resident #61's Hemoglobin was 5.7, their medical doctor had ordered the resident to be sent to the hospital for blood transfusion; the hospital emergency room received status report, Health Care Proxy was aware of transfer, Emergency Medical Services arrived, and Resident #61 was transferred to the emergency room via ambulance. On 10/13/2023 at 2:54PMthe facility staff nurse called the hospital emergency staff, and resident had been admitted with diagnosis anemia.<br><br>There was no documented evidence in the resident's clinical record that the resident or the resident's representative, had been provided with a written notice of the transfer/discharge.<br><br>In an interview on 10/18/23 at 10:36 AM Resident #61 stated they did not believe they had received a written notice of the transfer/discharge. Resident #61 stated that their nephew was their designated representative.<br><br>In an interview on 10/19/23 at 9:02 AM the Social Work Director (SWD) was asked if written notification of Resident #61's transfer/discharge had been provided to the resident or the residents' representative. At that time, the SWD produced a discharge/transfer notice dated 10/12/2023 which indicated that a staff social worker had notified the resident's nephew of the transfer via phone, and the staff social worker had signed the notice. There was no evidence provided to suggest that the bed hold policy had been mailed to the resident or their representative, i.e., no return receipt was found with the transfer/discharge notice. When asked what the correct process was for notification of transfer and discharge, the SWD stated that they should have spoken with the resident, if the resident was not available, they should have spoken with the next available contact, the conversation should have been documented in the chart, and a letter should have been sent out to the resident or responsible party immediately after the phone notification.<br><br>In an interview on 10/20/23 at 9:05 AM the Administrator stated that they were aware that the social worker was reaching out to families regarding discharge, transfer, and bed hold, but they were not aware that the social worker had not been providing /sending written notification to residents or their responsible party.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10 NYCRR 415.3(i)(1) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>37658<br><br>Based on interview and record review conducted during the recertification survey from 10/12/23 to 10/20/23, the facility did not ensure that to the extent practicable, each resident was offered the opportunity to participate in their plan of care, or that an explanation was included in a resident's medical record if the participation of the resident and their resident representative was determined not practicable for the development of the resident's care plan for 2 (Residents #46 and #39) of 3 residents reviewed for care planning. Specifically, Residents #46 and #39 expressed interest in attending care planning meetings and reported they had not been invited.<br><br>The findings are:<br><br>1) Resident #46 was admitted with diagnoses including hemiplegia and hemiparesis, psychosis, and Diabetes Mellitus.<br><br>The Annual Minimum Data Set (MDS: a screening tool) dated 8/17/2023 documented that the resident had moderate cognitive impairment for decision making, usually understands verbal content, and was usually understood.<br><br>The resident was interviewed on 10/13/23 at 10:29 AM and stated they did not go to the care planning meetings, but it sounded interesting. The resident stated they did not recall being invited to care planning meetings.<br><br>The Social Work progress note dated 9/7/2023 documented the Interdisciplinary Care Plan (IDCP) meeting had been held that day and the resident's daughter was in attendance at the meeting via phone. There was no documented evidence that Resident #46 had been invited to the care planning meeting, and no explanation was documented in the resident's medical record indicating if the participation of the resident was determined not practicable for the development of the resident's care plan.<br><br>During an interview on 10/19/2023 at about 9:40 AM the Social Work Director (SWD) reviewed the record with surveyor and stated that the resident's daughter attended care planning on 9/7/2023. There was no documentation found that the resident was invited to attend CCP, or that their attendance at the meeting was not practicable. The SWD stated that the process was that the Social Worker or SWD would speak with the resident and ask if they would like to attend CCP, and if the resident said yes to the invitation, they would inform the resident of the date and time of the meeting. The SWD offered no explanation as to why the Resident #46 had not been invited to care planning meetings.<br><br>2) Resident #39 was admitted with diagnoses traumatic subdural hemorrhage, aphasia following other cerebrovascular disease, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The annual Minimum Data Set (MDS: an assessment tool) dated 7/7/2023 documented cognitive skills for decision making were severely impaired, hearing was adequate, they had an absence of spoken words, rarely or never made themselves understood, rarely understands verbal content, and sees adequately without corrective lenses. Section F, preferences for customary routine and activities were checked yes to indicate that an interview of the resident should be conducted, and daily preferences and activity preferences were documented.<br><br>Resident #39's care plan dated 7/13/2023 documented that the resident had aphasia, was non-verbal, could answer direct yes/no questions by nodding their head, they sometimes understood, and were sometimes understood.<br><br>The resident was interviewed on 10/13/23 at 11:43 AM and when asked if they had been invited to attend care planning meetings, they nodded their head no. When asked if they would like to attend care planning meetings, the resident nodded their head yes.<br><br>A social work progress note dated 10/18/2023 documented that IDCP had been held on that day, and the resident's fiance was in attendance. There was no documented evidence found that the resident had been invited to the care planning meeting, and no explanation was documented in the residents' medical record indicating if the participation of the resident was determined not practicable for the development of the resident's care plan.<br><br>During an interview on 10/19/23 at 9:50 AM the Social Work Director (SWD) reviewed the record with surveyor and stated that the resident's fiance had attended the care planning meeting on 10/18/2023 via telephone. The SWD offered no explanation as to why Resident #39 had not been invited to care planning meetings.<br><br>10NYCRR 415.11(c)(2) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>37658<br><br>Based on observation, record review and interview conducted during the recertification survey from 10/12/23 to 10/20/23, the facility did not ensure all residents were provided the necessary care and services for 1 of 3 residents (Resident #39) reviewed for activities of daily living (ADL). Specifically, Resident #39, who had a diagnosis of aphasia (a loss of ability to understand or express speech, caused by brain damage), was not assessed and treatment was not provided to enable the resident to communicate with others more normally including speech and/or other functional communication systems.<br><br>The findings are:<br><br>Resident #39 was admitted with diagnoses including traumatic subdural hemorrhage (brain bleed), aphasia following other cerebrovascular disease, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.<br><br>The annual Minimum Data Set (MDS: an assessment tool) dated 7/7/2023 documented cognitive skills for decision making were severely impaired, hearing was adequate, they had an absence of spoken words, rarely or never made themselves understood, rarely understands verbal content, and sees adequately without corrective lenses. Section F, preferences for customary routine and activities were checked yes to indicate that an interview of the resident should be conducted, and daily preferences and activity preferences were documented. Active diagnoses included aphasia, hemiparesis, or hemiplegia. Speech therapy (ST) was last provided 3/30/2023 - 4/19/2023. Occupational therapy (OT) was last provided 3/31/2023 - 4/25/2023, and physical therapy (PT) was last provided 3/29/2023 - 4/21/2023.<br><br>Resident #39's care plan dated 6/23/2023 documented the resident had a communication problem related to a cardiovascular accident as evidenced by aphasia. The goal was the resident would improve communication function. Interventions included OT/PT/Nurse to evaluate resident ability/dexterity to use communication board, writing, use computer, or use of sign language as alternate communication to speech, and to refer to speech therapy for evaluation and treatment as ordered.<br><br>A policy and procedure dated 10/2022 and titled Speech Therapy Level III documented the purpose of the procedure was to identify, assess, and treat speech and language problems. General guidelines documented the speech therapist works with other rehabilitation and medical professionals and families to provide a comprehensive evaluation and treatment program for residents with aphasia, anomia (word finding), dysarthria (muscles of the lips, tongue and other body parts used for speech are weaker than normal), and apraxia (a disorder of the nervous system that affects the ability to sequence and say sounds, syllables, and words. Speech therapy treatments included working on drills and exercises to improve specific language skills affected by damage to the brain, using a communication board, exercise of speech muscles, and teaching the resident to make use of gestures and writing to express ideas.<br><br>Resident #39's care Kardex (instructions for direct care staff) dated 10/19/2023, documented to use alternative communication techniques as needed, such as communication book/board, writing pad, gestures, signs, and pictures.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview conducted on 10/12/23 at 10:34 AM, Resident #39 communicated by shaking their head to indicate yes and no to questions about eating and verbalizing, and their response was accurate when responding yes that they did not eat by mouth, and inaccurate when responding they could verbalize. No functional communication systems were observed.<br><br>During an observation on 10/13/23 at 11:51 AM, 2 small dry erase white boards were observed on a bedside table. No dry erase markers or eraser were observed. Resident #39 was asked if they communicated with the dry erase boards and indicated no with a head shake.<br><br>During an observation on 10/19/23 at 12:26 PM, 2 small dry erase boards stored in a plastic bag without a dry erase marker or eraser were observed on an overbed table located behind the resident. At that time, the resident was out of bed in their wheelchair with their back was to the overbed table and dry erase boards. A small picture board with the words I want and pictures was also observed on the overbed table located behind the resident.<br><br>In an interview on 10/19/23 at 11:52 AM the Speech Language Pathologist (SLP) Therapist responsible for evaluation of speech for Resident #39 stated the last time they evaluated and treated the resident was 3/30 - 4/19/23 for swallowing related to dysphagia, and that they did not document anything about resident #39's communication at that time. The SLP stated that they have not specifically evaluated Resident #39 for communication. The SLP stated they were aware of the resident's communication deficits. The SLP stated that they could have done a more thorough communication exam or evaluation to determine if a picture board would be utilized more to communicate the residents' wants.<br><br>In an interview on 10/19/23 at 12:31 PM, the certified nurse aide (CNA) #6 stated that Resident #39 communicated with them by nodding their head and communicating with their eyes. CNA #6 stated that they had seen a dry erase board, but no dry erase pen or eraser in the resident's room. CNA #6 stated that they had not seen an I want communication board in the resident's room when they provided care to the resident that morning. CNA #6 stated they were not told how the resident communicated or about the dry erase board or an I want board.<br><br>In an interview on 10/19/23 at 12:51 PM CNA #7 stated they communicated with Resident #39 by verbalizing to them, the resident was able to understand, and the resident responded with shaking their head. CNA #7 stated the resident did not communicate with them in any other way. CNA #7 stated that they had not received any information from nursing about how to communicate with the resident.<br><br>10NYCRR 415.12(a)(2) |

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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** 41666<br><br>Based on observations, record review and interviews, during a recertification survey from 10/12/23-10/20/23, the facility did not ensure the resident environment remained free of accident hazards to prevent accidents for 1 (Resident #28) of 6 residents reviewed for accidents. Specifically, Resident #28, who was assessed as needing a bed rail to promote independence, had the rail removed and when they awoke from a nap and reached for the rail, they fell and sustained a fractured (broken) shoulder and blunt head trauma.<br><br>The findings are:<br><br>Resident #28 had diagnoses which include atrial fibrillation, spinal stenosis, hypertension. The annual Minimum Data Set (MDS), an assessment tool, dated 7/16/23, documented the resident had a Brief Interview for Mental Status (BIMS) of 15/15 indicating they were cognitively intact. The resident required extensive assistance of two persons for bed mobility and transfers and extensive assistance for dressing.<br><br>The resident's care plan for falls dated 4/20/2016, and updated 7/11/23 after a fall, documented the resident was at risk for falls and had interventions which included anticipating the resident's needs, and to re-educate to use the call bell for assistance.<br><br>The physician orders dated 7/20/22 document 1/2 side rails up to both sides of bed for bed mobility and transfer participation.<br><br>A side rail/grab bar review dated 7/25/23, documented the resident had demonstrated poor bed mobility and difficulty moving to a sitting position on the side of bed. The recommendation was bilateral half side rails were indicated and served as an enabler to promote independence.<br><br>The Accident/Incident report dated 9/21/23 documented at 4:45 PM the resident was found on the floor next to their bed bleeding from the right side of their head. The resident stated they were trying to sit up on side of the bed and fell off bed. The box on the A/I for side rails up was not checked.<br><br>The September 2023 Treatment Administration Record (TAR) documented 1/2 side rails up to both sides of the bed, check placement every shift, for bed mobility and transfer participation. The TAR was last signed for the 1/2 rails on 9/21/23 for the 7 AM to 3 PM shift. The TAR documented the resident was hospitalized [DATE] for the 3-11 PM shift.<br><br>Further review of the resident's medical record revealed no documented evidence that an assessment was performed to see if the resident could safely position themselves on the side of the bed without the enabler side rail, prior to the removal. There was no documentation the resident and/or their representative received education about side rail removal.<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 | During an interview with Resident #28 and the resident's family member on 10/12/23 at 10:28 AM and 3:29 PM, both stated the side rails had been on the resident's bed for a very long time but were removed abruptly three weeks ago. The Resident stated they awoke from a nap and went reach for the rail to pull themselves up, the rail was not there, and they fell out of bed. The resident's family member stated they visited the facility every day and no one told them the rails were going to be removed.<br><br>During an interview on 10/18/23 at 11:34AM, the Registered Nurse Unit Manager (RNUM) stated the facility received a letter from the State regarding side rail usage and side rails were removed. They stated all of the residents were assessed before putting rails in place but there were no plans for assessment before they were removed. RNUM#2 stated they did not provide education for staff, residents, or residents family members prior to removing the side rails. RNUM #2 stated there was a lot of confusion when the letter came out, so the facility just removed the rails without first having plans in place.<br><br>During an interview on 10/20/23 at 9:23 AM, Certified Nurse Aide (CNA) #1 stated they took care of Resident #28 many times and knew the resident well. The resident was able to help staff by grabbing the rail when they were being positioned or having the bed changed. The rail gave the resident support, and they used it while they were in bed. CNA #1 stated the rails were removed on a lot of the residents' beds, there was no education or reminders to be extra cautious with the residents.<br><br>During an interview on 10/19/23 at 12:24PM, the Director of Nursing (DON) stated they were at the scene on the day Resident #28 fell and the resident did not have rails on the bed. The DON stated they were not aware the resident was assessed to need the rails as an enabler, and they did not know there was a physician order for the rails.<br><br>During an interview on 10/19/23 at 1:18 PM, the Administrator stated they were not aware that Resident #28 was assessed to have a need for side rails and had a physician order, but the rails were removed anyway. The Administrator stated they were unaware that assessments were not done prior to removing side rails.<br><br>10NYCRR 415.12(h)(1) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335441 | A. Building<br>B. Wing | 10/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cortlandt Healthcare | 110 Oregon Road<br>Cortlandt Manor, NY 10567 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37658<br><br>Based on observations, interviews and record review conducted during the recent recertification survey, the facility did not ensure that emergency equipment was readily available for 1 of 2 residents (Resident #35) screened for respiratory care. Specifically, a resident with a tracheostomy did not have an Ambu bag (a hand-held device that provides positive pressure to residents who are not breathing) at the bedside.<br><br>The findings are:<br><br>Resident #35 was admitted with a diagnosis of traumatic brain injury and tracheostomy status. The resident's orders included Oxygen at 8L/min, humidification 50% via trach mask continuously every shift for respiratory care.<br><br>The annual MDS dated [DATE] documented the resident was comatose, had diagnoses including respiratory failure and a tracheostomy, and received oxygen and tracheostomy care.<br><br>The resident's care plan dated 11/11/2016, and revised 7/3/2023, documented the resident had tube out procedures which included keeping an extra trach tube and obturator at bedside. If tube cannot be reinserted, monitor /document for signs of respiratory distress. If able to breathe spontaneously, elevate head of bed 45 degrees and stay with resident. Obtain medical help immediately.<br><br>A policy and procedure dated 12/2/2022 and titled Tracheostomy Medical Emergencies documented: Tube Occlusion: .use an Ambu bag to ventilate, Decannulation: maintain tracheal airway and ventilation with bag tracheostomy mask as best as is possible, and If the patient is not ventilating adequately, close stoma and ventilate with bag and face mask with 100% O2 until CODE team arrives.<br><br>During an observation on 10/13/23 at 9:25 AM no Ambu bag was observed at bedside. An observation and interview were conducted in the residents' room on 10/13/23 at 9:35 AM with the Licensed Practical Nurse (LPN) #4 in attendance. LPN #4 was asked to show surveyor where the Ambu bag was kept. LPN #4 proceeded to check the room storage areas and stated there was no Ambu bag. When asked what the process for ensuring the Ambu bag was accessible in the room, LPN #4 stated they would find out.<br><br>During an observation on 10/16/23 at 5:55 PM no Ambu bag was observed at bedside. During an interview on 10/16/2023 at 5:58 PM, LPN #5 was asked what equipment was needed in case of a respiratory emergency for Resident #35, and they responded that they would need the suction machine, the inner cannula, and a suction catheter kit. When asked if they would need an Ambu bag for the resident in the case of a respiratory emergency, LPN #5 stated there was an Ambu bag in the dining room.<br><br>In an interview on 10/19/23 at 8:50 AM the Respiratory Therapist (RT #1) stated emergency equipment that should always be in the resident's room included an oxygen tank, an Ambu bag, and a spare, smaller size trach than the one the resident has.<br><br>10NYCRR 415.12(k)(6)<br><br>41666 |