STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335470	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boro Park Center for Rehabilitation and Healthcare	4915 10th Ave Brooklyn, NY 11219

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49169 Based on observations, record review, and staff interviews conducted during the Recertification survey from 04/20/2024 to 05/06/2024, the facility did not ensure that the survey results were posted in a place readily accessible to residents, visitors, or legal representatives where individuals wishing to examine survey results do not have to ask to see them. In addition, notices of the availability of such reports were not posted in areas of the facility that are prominent and accessible to the public. Specifically, the survey results were located inside a binder placed behind the Security desk, and there were only two notices posted about the availability of the survey results, and the notices which were not in conspicuous locations. The finding is: The facility policy and procedure titled Survey Results revised on 10/2015 stated that copies of all survey reports along with approved plans of correction are on file in the administrative office, and that survey results must be readily accessible for viewing. The policy also documented that residents, visitors etc. should not be required to ask to see the results. During multiple observations from 04/29/2024 to 05/06/2024, survey results could not be located throughout the facility. On 05/01/24 at 10:58 AM, during the Resident Council meeting, five of six residents present stated that they did not know where to locate the survey results. Resident #34 stated that if someone asked at the security desk the results would be given to them. On 05/01/24 at 01:09 PM, a notice which stated that the Annual Department of Health survey results are located at the security desk was observed posted on a wall around the corner from the elevator bank. In addition, a copy of the notice was also observed posted in a bulletin board opposite the employee time clock. During multiple observations from 05/01/2024 at 1:10 PM to 05/06/2024 at 12:15 PM, the survey results were not visible at the security desk. (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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/06/24 at 12:16 PM, an interview was conducted with Security Guard #1 who stated that the survey results are located in a binder that is located at the Security desk, right behind where the officers sit. Security Guard #1 also stated that residents or family members would have to ask the security officers for the survey results and they would hand the binder to them. Security Guard #1 further stated that previously the results were displayed behind fiberglass at the front desk, and the fiberglass has been broken for a few months now. Security Guard #1 was asked for the survey results and they proceeded to take a black binder, with a label that stated Department of Health survey, from a metal bin behind the Security desk. In the bin were 4 other colored binders. The black binder did not have a label on the spine indicating that it contained the survey results. On 05/06/24 at 01:19 PM, an interview was conducted with the Administrator who stated survey results signage is located in the lobby after the elevators. The Administrator stated that signage was always placed there and they considered this a conspicuous place because residents going to therapy can see it and residents congregate in that area on occasion. The Administrator further stated that they did not know that signage should be posted in more than one location. The Administrator stated that survey results are considered accessible because they are available at the Security desk and could be received once requested by residents or family members. The Administrator also stated that they were not aware that results should be available without being asked for. 10 NYCRR 415.3(d)(1)(v)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44843 Based on observations, record review, and interviews conducted during the Recertification Survey from 4/29/2024 to 5/6/2024, the facility did not ensure residents remained free from physical restraints. This was evident for 1 (Resident #151) of 1 resident reviewed for Restraints out of 38 total sampled residents. Specifically, Resident #151's right hand was observed wrapping by a towel to prevent the free movement of the hand and there was no documented evidence of an evaluation or physician's order for use of a restraint. The findings are: The facility policy titled Restraint Use with creation date 10/2015 and last revised date 12-2022 documented restraints shall only be used to treat the resident's medical symptom and shall not be imposed for the purposes of discipline, staff convenience or that unnecessarily inhibits a resident's freedom of movement or activity. Resident #151 had diagnoses which included Cerebral infarction, Alzheimer's disease, and Dysphagia. The Quarterly Minimum Data Set 3.0 dated documented Resident #151 had severely impaired cognition, did not reject care, and had no behavioral symptoms. The Minimum Data Set also documented Resident #151 had no restraint and only the representative participated in the assessment. During multiple observations between 04/29/2024 at 11:02 AM and 05/03/2024 at 09:24 AM, Resident #151 was observed lying in bed with their right hand wrapped in a white towel. The Physician's Order dated 4/18/2022 stated apply Right Mitten to reduce risk of digging into skin/pulling gastrostomy tube, and the order was discontinued on 8/29/2022. Review of the medical record revealed that there was no current physician order, care plan, nor restraint assessment for applying right mitten or any other physical restraint to Resident #151. The Certified Nursing Assistant Visual/Bedside Kardex Report documented in the alerts in the Safety section Right hand Mitten to reduce risk of digging into skin/pulling gastrostomy-tube under Safety section. This was not included in the tasks on the Certified Nursing Assistants record. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/2024 at 09:25 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #151 was confused and required total care for Activities of Daily Living. Certified Nursing Assistant #1 also stated that they applied the right mitten or used the towel to wrap Resident #151's right hand when the mitten was not available to prevent Resident #151 from scratching their body and pulling out the gastrostomy tube. Certified Nursing Assistant #1 further stated that they removed the mitten or the towel to wash Resident #151's hands 1-2 times per shift. Certified Nursing Assistant #1 stated that Resident #151 has had the mitten or towel applied to their right hand for some time now and they did not recall when Resident #151 started using the mitten or the towel. Certified Nursing Assistant #151 also stated that they followed the task in the Kardex to apply the right mitten. On 05/03/2024 at 11:04 AM, Registered Nurse #1 (also the Unit Manager) was interviewed and stated they made rounds on the unit at least three times every day. During this time, they speak to residents and representatives about resident care and looked for safety and environment issues. Registered Nurse #1 also stated that they were not aware Resident #151 had their right hand wrapped with a towel. Registered Nurse #1 further stated that they entered and revised the tasks in the Certified Nursing Assistant accountability for the Certified Nursing Assistant to follow, and they were not sure why Resident #151 had the right-hand mitten listed in the Safety section in the Kardex. Registered Nurse #1 stated there was no active order to apply right mitten to Resident #151, and so the right-hand mitten or towel would be considered as a physical restraint for Resident #151. On 05/03/2024 at 11:37 AM, the Certified Occupational Therapy Assistant was interviewed and stated they provided occupational service 5 days in a week to Resident #151. The Certified Occupational Therapy Assistant also stated that they observed that Resident #151's right hand was wrapped with a towel sometimes and they removed it for right hand movement. The Certified Occupational Therapy Assistant further stated that Resident #151 was not able to remove the towel from the right hand by themselves. On 05/03/2024 at 11:47 AM, the Attending Physician was interviewed and stated they ordered to apply right mitten a while ago to prevent Resident #151 from skin lesions by scratching their body with right hand, and the order was discontinued after a while. The Attending Physician also stated they had not placed an order to apply a mitten or anything else to Resident #151's right hand recently. On 05/03/2024 at 11:55 AM, the Director of Nursing was interviewed and stated they made round to the floors at least once during the day shift and evening shifts where they looked at the residents, their rooms, meals, environment, and wander guard. The Director of Nursing also stated that the interdisciplinary team had to discuss the use of physical restraint, obtain family consent and physician order, conducted the restraint assessment, and removed the physical restraint for 20 minutes every 2 hours. The Director of Nursing further stated that they were not aware that Resident #151's hand had been wrapped with a towel. The Director of Nursing stated it was considered a physical restraint if Resident #151 was unable to remove the towel themselves as it limited Resident #151's right hand movement. 10 NYCRR 415.4(a)(2-7)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on observation, record review, and interviews conducted during the Recertification Survey from 04/29/2024 to 05/06/2024, the facility did not ensure residents unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene. This was evident for 1 (Resident #263) of 5 residents reviewed for Activities of Daily Living out of 38 total sampled residents. Specifically, Resident #263 did not receive bladder/bowel care in a timely manner. The findings are: The facility policy titled Activities of Daily Living (ADL) Care and Support with creation date 8/2016 and current revision date of 3/13/2024 documented that activities of daily living will be provided for residents who are unable to carry out activities of daily living independently, with consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care. Resident #263 had diagnoses which included Non-Hodgkin's Lymphoma, Dysphagia, and Other reduced mobility. The Quarterly Admission Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #263 had severely impaired cognition, did not reject care, and was dependent for toileting hygiene. The Quarterly Admission Minimum Data also documented Resident #263 and their representative participated in the assessment. On 04/29/2024 at 11:33 AM, the Resident Representative was interviewed and stated they often found the incontinent brief was very wet and sometime with feces when they visited Resident #263 at around 10 AM in the morning. The Resident Representative also stated this happened when the regular Certified Nursing Assistant was off. The Resident Representative further stated that the covering Certified Nursing Assistant did not change or check the incontinent brief for Resident #263. The Resident Representative also stated that they had been to the nursing station a few times today to report this but Resident #263 still had not received care. The Comprehensive Care Plan related to Activities of Daily Living initiated 2/1/2020 documented Resident #263 required substantial assistance for toileting hygiene. The Certified Nursing Assistant Accountability record dated April 2024 documented that bladder/bowel continence care was provided each shift for the day, evening, and night shifts. On 04/30/2024 at 10:40 AM, the Resident Representative was observed trying to change the Resident #263's incontinent brief which was soiled with feces. The Resident Representative stated that no staff had checked on or changed the incontinent brief for Resident #263 this morning. There was no documented evidence that bladder/bowel continence care was provided in a timely manner for Resident #263. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/2024 at 11:47 AM, Certified Nursing Assistant #2 was interviewed and stated they were a floater and they received they report from the medication nurse for the 6 AM to 2 PM shift and so they knew their assignments. Certified Nursing Assistant #2 also stated that they made rounds to the assigned residents first, provided care to residents at high risk of fall and moved them to the dining room. Certified Nursing Assistant #2 stated they were also busy delivering breakfast to residents in the dining room, assisted in feeding residents, and then took their own lunch break from 10:15 AM to 11:15 AM. Certified Nursing Assistant #2 further stated that they had not yet had the opportunity to check if Resident #263 needed continence care since beginning the shift at 6 AM. Certified Nursing Assistant #2 stated that they are supposed to check the bladder/bowel continence of each resident every 2 hours. Certified Nursing Assistant #2 also stated that they only documented continence care once per shift in the Certified Nursing Assistant Accountability record. Certified Nursing Assistant #2 further stated that they were new to the facility and had not reported to anyone that they were not able to provide care to all their residents in a timely manner. On 05/03/2024 at 11:16 AM, the Registered Nurse #1 (also the Unit Manager) was interviewed and stated that the Certified Nursing Assistants are required to check to see if the residents require continence care every 2 hours if the residents required assistance or were dependent on staff for toileting. Registered Nurse #1 also stated that they were not sure if the Certified Nursing Assistants were required to document bladder/bowel continence care every 2 hours or once only for each the shift. Registered Nurse #1 further stated that they made rounds on the unit at least three times per shift and spoke to residents and representatives about their care and environment. Registered Nurse #1 stated that they were not aware that Resident #263 had not received continence care in a timely manner. On 05/03/2024 at 12:02 PM, the Director of Nursing was interviewed and stated they made round to the floors at least once during the day shift and evening shifts where they looked at the residents, their rooms, meals, environment, and wander guard. The Director of Nursing also stated that the Certified Nursing Assistant had received orientation or in-service on their responsibility to check the continence needs of the residents every 2-4 hours and as needed. The Director of Nursing also stated that the settings for documentation of continence care in the Certified Nursing Assistant Accountability only permitted the Certified Nursing Assistant to document that the task was done once per shift and not every 2 hours. The Director of Nursing further stated that they had no documented evidence to show the blader/bowel continence care was provided to Resident #263 every 2-4 hours. 10 NYCRR 415.12(a)(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observations, record reviews, and interviews, conducted during the Recertification survey from 04/29/2024 to 05/06/2024, the facility did not ensure that a resident received care consistent with professional standards of practice to prevent pressure ulcers and to promote healing. This was evident for 2 (Resident #523 and Resident #380) of 7 residents reviewed for Pressure Ulcer out of 38 sampled residents. Specifically, 1) during multiple observations Resident #523 was observed without heel booties in place as ordered and, 2) Resident #380 was observed during wound assessment with loose stool and an uncovered Stage 3 sacral pressure ulcer. The findings are: The facility policy titled Skin and Pressure Ulcer Injury Prevention effective October 2014, last revised March 13, 2023, documented that the facility will assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice. Risks that increase a resident's susceptibility to develop or to not heal a pressure ulcer injury include impaired/decreased mobility, decreased functional ability and exposure of skin to urinary and fecal incontinence. Once the assessment is conducted and risk factors are identified and characterized, a resident care plan can be created to address the modifiable risk for pressure injuries and skin protection interventions. 1. Resident #523 was admitted to the facility with diagnoses of Diabetes, Malnutrition, Morbid Obesity, and Pressure Ulcer of the sacral region. The Admission Minimum Data Set, dated dated dated [DATE] documented that Resident #523 was moderately cognitively impaired and was dependent on staff for toileting, showers, lower body dressing, putting on footwear and required substantial assistance for personal hygiene. The Minimum Data Set also documented that Resident #523 was at risk of developing pressure ulcers and pressure relieving devices are applied to chair and bed. A Physician's order initiated 04/13/24 documented Heel boots, remove daily for skin monitoring, and notify provider/nurse/supervisor of any new skin alteration or decline. The Braden Scale for predicting pressure sore risk dated 04/15/24 documented that Resident #523 was at high risk for skin breakdown. On 04/29/24 at 11:05 AM, 04/30/24 at 10:45 AM, 05/01/24 at10:42 AM, 05/02/24 at 11:25 AM and at 02:36 PM, and on 05/03/24 at 12:18 PM, Resident #523 was observed in bed with no heel boots in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/24 at 12:19 PM, Certified Nursing Assistant #7 was interviewed and stated that Resident #523 needs two staff assistance for bed mobility and transfer. Certified Nursing Assistant #7 also stated that they receive report at the beginning of the shift and the charge nurse lets them know what the residents' needs are and they also check the Certified Nursing Assistant Accountability sheet to see what each resident needs. Certified Nursing Assistant #7 further stated that they are aware that Resident #523 is supposed to wear heel boots. Certified Nursing Assistant #7 stated that Resident #523's family members do not like the resident to wear the heel boots, and Resident #523 does not like to keep on the boots. Certified Nursing Assistant #7 also stated that the Charge Nurse was not told about Resident #523 refusing to keep the heel boots on. Certified Nursing Assistant #7 stated that all Certified Nursing Assistants assigned to care for Resident #523 were told at the beginning of their shift that the resident had an order for heel boots, and it was also reflected on the Nursing Assistant Accountability sheet. On 05/03/24 at 12:27 PM, Licensed Practical Nurse #3 was interviewed and stated that they give medications and treatments, make rounds, and make the assignments for the Certified Nursing Assistants. Licensed Practical Nurse #3 also stated that they respond to any emergencies that come up, and check to ensure all doctor's orders are carried out. Licensed Practical Nurse #3 further stated that Resident #523's heel boots should have been applied. Licensed Practical Nurse #3 stated they check to ensure all residents with high risk for developing pressure ulcers are being taken care of and ensure that all required interventions to prevent pressure ulcers are being implemented. On 05/06/24 at 11:08 AM, Registered Nurse #4 was interviewed and stated that they manage the unit and supervise all nursing staff and the care that they provide. Registered Nurse #4 also stated that they do rounds very frequently on the unit. In the morning, they go to the resident's rooms to ensure the residents are receiving adequate care, and throughout the day, they do quick rounds on the unit. Registered Nurse #4 further stated that Resident #523 does not like the heel boots, however the heel boots should have been applied. Registered Nurse #4 stated that they will reinforce with staff that Resident #523 is to wear the heel boots and they ensure that the boots are worn. On 05/06/24 at 11:55 AM, the Director of Nursing Services was interviewed and stated that every resident is assessed for pressure ulcers upon admission. If they are determined to be at high risk for developing pressure ulcers, we would initiate an at risk for pressure ulcer care plan and ensure preventive measures are in place. The Director of Nursing Services also stated that the heels boots should have been applied. The Certified Nursing Assistants must follow the Doctors orders and apply the heel boots. If the resident is refusing, the Certified Nursing Assistants must inform the nurse. The Director of Nursing Services further stated that the whole purpose of the heel boots to prevent further injury. The Director of Nursing Services stated that the Charge Nurse and the nurse manager are responsible for ensuring all doctors' orders are being followed and they should have documented Resident #523's refusal to wear the heel boots in the medical record. Heel boots are also supposed to be reflected on Certified Nursing Assistant Accountability sheet. The Director of Nursing Services also stated that the Certified Nursing Assistants must inform the nurses of any refusals so that the resident can be educated and the refusal can be documented in the progress notes. 48876 2. Resident #380 was admitted with diagnoses that included Dementia, Generalized Muscle Weakness, and Osteoarthritis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Minimum Data Set 3.0 assessment dated [DATE], documented that Resident #380 had severe cognitive impairment, was frequently incontinent of bowel and bladder, was dependent on staff to perform Activities of Daily Living. The Comprehensive Minimum Data Set 3.0 Assessment also documented that Resident #380 was at risk for developing pressure ulcers, and had one unhealed Stage 2 pressure ulcer. The Physician's Order dated 3/27/2024 and renewed 5/1/2024 documented Santyl External Ointment 250 Unit/Gram, apply to the sacrum topically as needed for soilage/displacement for 30 days. Clean with saline. Pat dry. Apply Santyl ointment to wound bed, cover with dry dressing and silicone border. On 5/1/2024 at 10:00 AM, the Wound Care Nurse Practitioner was observed performing the wound assessment and consultation for Resident #380, whose wound had developed into a Stage 3 sacral pressure ulcer. Certified Nursing Assistant #3 removed the incontinence brief and a large amount of loose stool was observed. There was no dressing covering the wound leaving the wound exposed to loose stool. The Nurse Practitioner Wound Progress Note dated 5/1/2024, documented that Resident #380 was noted to have one Stage 3 sacral pressure ulcer measuring 2.8 centimeters in length, 4.5 centimeters in width and 0.3 centimeters in depth. The tissue surrounding the pressure ulcer was documented as bright red. The Wound Progress note also documented that Resident #380 was at risk for further skin breakdown, incontinent of urine and feces, increasing the possibility of contamination. Prevent contamination, cover the wound with moisture proof silicone border gauze and manage incontinence. Plan discussed with nursing. The Certified Nurse Aide Documentation Report dated April 2024, documented urinary catheter care, skin observation, turning and positioning for Resident #380 completed by Certified Nursing Assistant #5 on 4/30/24 at 5:35 AM. The Treatment Administration Record dated 4/1/2024 thru 4/30/2024 documented sacral pressure ulcer treatment performed for Resident #380 by Licensed Practical Nurse #1 on 4/30/24 at 1:05 PM. On 5/1/2024 at 10:00 AM, during observation of the wound, the Wound Care Nurse Practitioner stated that there should be a dressing covering the wound, and wound treatment is ordered daily and as needed. On 5/2/2024 at 12:25 PM, Registered Nurse #3, (Nurse Manager for the floor) was interviewed and stated that when they inquired they found that morning care was performed by Certified Nursing Assistant #5 who did not notify Licensed Practical Nurse #1 that there was no dressing on the Stage 3 sacral pressure ulcer site. 10 NYCRR 415.12(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observation, record review, and interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure medications and biologicals were stored in accordance with currently accepted professional principles and expiration date, if applicable. This was evident for 2 of 16 medication storage areas (2 East medication room and 2 [NAME] Unit medical supply room). Specifically, 13 bags of expired intravenous fluids were observed in the medication room on unit 2 East, and 12 bags of expired intravenous fluids were observed in the medical supply closet on 2 West. This was evident for the Medication Storage task. The findings are: The facility policy titled Medication Storage revised [DATE] documented the facility will store medications in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance with state and federal regulations. Expired, discontinued and or contaminated medications will be removed from the medication storage areas and disposed of in accordance with the facility policy. On [DATE] between 04:38 PM & 04:58 PM, the medication room on unit 2 East was observed with Licensed Practical Nurse #8. The following was observed in the drawer below the counter level: 1 bag of 0.9% sodium chloride 250 milliliter bag with an expiration date of [DATE] bags of 5% dextrose 50 milliliters with an expiration date of [DATE] bag of 5% dextrose and 0.45% sodium chloride 500 milliliters with an expiration date of [DATE]. In addition, there were 7 bags of 5% Dextrose and 0.9% sodium chloride injection USP 1000ml with an expiration date of [DATE]. On [DATE] at 12:13 PM, the medication supply/intravenous fluid storage room on 2 [NAME] was observed with the Central Supply Clerk and 12 bags of 5% Dextrose injection 50 milliliter bags were observed with an expiration date of [DATE]. On [DATE] at 04:49 PM, Licensed Practical Nurse #8 located on unit 2 East was interviewed and stated that the bags of intravenous solution in the drawer are to be used to start antibiotics for residents. If there is an emergency, the 50 milliliter, 250 milliliter or 500 milliliter intravenous fluid bags may be used depending on the antibiotic to be administered. Licensed Practical Nurse #8 also stated that they check the medication room weekly as part of their normal duties and the intravenous fluids should be checked, and thrown out if expired. On [DATE] at 05:08 PM, Registered Nurse #5 (the Unit Manager for 2 East) was interviewed and stated that they check the medication room daily for neatness and the expiration dates of items in the room. Registered Nurse #5 also stated that central supply also checks and stocks the intravenous medications. Registered Nurse #5 further stated that the many intravenous bags were tucked in there and so the expiration dates might not have been noticed. Registered Nurse #5 stated that additional intravenous fluids can be used to dilute ordered intravenous antibiotics if needed, and they have been using the prefilled intravenous bags that they get them from the pharmacy which is labeled with the correct intravenous fluids for mixing the antibiotics for the past 6 months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335470	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boro Park Center for Rehabilitation and Healthcare	4915 10th Ave Brooklyn, NY 11219

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:23 AM, the Director of Nursing was interviewed and stated that the pharmacist is remote, and the medication rooms are supposed to be checked by the nurse and unit managers on the unit. 10 NYCRR 415.18(e)(,d+[DATE])

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observations, record review, and interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure food was stored in accordance with professional standards for food service safety to prevent foodborne illness. Specifically, 1) expired enteral feeding was observed in the nourishment/supplement room in the kitchen, and 2) there was unlabeled food, degraded, rotted food and expired yogurt in the 5th floor unit refrigerator, and expired ice cream in the freezer. This was evident for the Kitchen Task and Dining Task. The findings are: 1. The facility policy titled Food Safety Food Handling revised ,d+[DATE] documented food will be stored, prepared, handled, and served so that they reduce the risk of foodborne illness is minimized. This policy does not contain any information in relation to the rotation of food items or when food items may need to be discarded. The facility policy titled Enteral Nutrition revised ,d+[DATE] documented the facility provides Dietary-Nursing nutritional support to residents unable to obtain nourishment orally and are receiving enteral feeding ordered by a physician and not clinically contraindicated. Central supply or Designee will be responsible for ordering all tube feeding supplies. On [DATE] from 09:39 AM to 10:22 AM, the kitchen tour was conducted with the Assistant Food Service Director. In the supplement/nourishment room an open cardboard box which held 24 cartons was observed to contain 21 cartons of Osmolite 1.0 with a use by date of 01 [DATE]. On [DATE] at 02:25 PM, the Storeroom Dietary Aide #1 was interviewed and stated they manage the storeroom. Nourishments are delivered on Tuesday and they did not notice any expired items. The Storeroom Dietary Aide #1 also stated that when orders come in they rotate items, and a company collects expired goods every other month. On [DATE] at 02:30 PM, the Dietary Supervisor was interviewed and stated that the Dietary Aide is responsible for checking the storeroom for any missing items. The Dietary Supervisor also stated that expired nourishments are supposed to be stored on the side and tagged so they can be picked up and returned to the vendor. The Dietary Supervisor further stated that expired items should not be stored with current items as they can be picked up and given to residents in error. On [DATE] at 11:49 AM, the Assistant Food Service Director was interviewed and stated that they check the storeroom along with the Food Service Director and the storeroom staff. The Assistant Food Service Director also stated that the last time they checked the nourishment room was at the beginning of [DATE] when they conducted a mock survey. The Assistant Food Service Director further stated that they do random checks on Wednesdays to make sure there are no expired oral feeding or enteral feedings and they did not notice any expired items. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335470	A. Building B. Wing	05/06/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:51 AM, the Dietary Director was interviewed and stated that when the nourishment vendor switched companies they helped clean out the inventory and they gave the inventory form to purchasing for items to be sent back ,d+[DATE] months ago. 48876 2. The facility policy titled Food - From Outside, last date reviewed [DATE], documented food or beverage that is brought in from the outside will be monitored by nursing staff for spoilage, contamination, and safety. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. A label will identify resident name, room number, item, date received and discard date. The policy also documented that all refrigerated food will be discarded within 48 hours. Nursing staff will monitor resident's room, unit pantry, and refrigeration units for food and beverage disposal. The nursing staff will discard perishable foods on or before the discard date. The nursing and or food service staff will discard any foods prepared for the resident that shows obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). The facility policy titled Unit Food Storage, last date reviewed ,d+[DATE], documented food items stored for nourishment or brought in by residents shall be stored in designated areas only. The unit area designated for food storage will remain clean and safe for food handling. Food items will be identified with name of owner and date placed in designated refrigerator. All resident food items will be dated with use by date. Dietary and nursing staff will be responsible to ensure food items stored in pantry refrigerators and freezers are not expired or past perish dates. On [DATE] at 10:48 AM, the 5th Floor Pantry/Nourishment Refrigerator was observed with Registered Nurse #3 (the Nurse Manager). One thermal bag was observed with 2 Tupperware bowls. 1 bowl contained spoiled peaches that had become liquified and the other bowl contained 1 plastic bag of dry rotted fruit. In addition, the refrigerator contained one loaf of wheat bread with no expiration date, one 4-ounce cup of strawberry yogurt with an expiration date of [DATE], one 5-ounce cup of strawberry yogurt with an expiration date of [DATE], and multiple cups of ice cream in the freezer with an expiration date of [DATE]. On [DATE] at 10:52 AM, a sign posted on the refrigerator stated all food placed refrigerator must be labeled and discarded after 48 hours. On [DATE] at 10:53 AM, Registered Nurse #3 was interviewed and stated that they ask staff to clean the refrigerators as is posted but a lot of staff have access to the refrigerators including recreation and volunteer staff. On [DATE] at 10:57 AM, the Housekeeping Supervisor was interviewed and stated items were not discarded from the refrigerator because the bread had no expiration date, and the thermal bag is someone's lunch. The Housekeeping Supervisor further stated that staff lunch is supposed to be stored in the refrigerator in the nurses' lounge. 10 NYCRR 415.14(h)