STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335483	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Great Neck	15 St Pauls Place Great Neck, NY 11021

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 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not ensure that a comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team after each assessment. This was identified for one (Resident #71) of three residents reviewed for skin conditions. Specifically, Resident #71 was observed with tissues and rubber bands wrapped around two fingers on multiple occasions and Nursing staff did not revise the comprehensive care plan to address the resident's behavior. The finding is: The facility's policy, titled Behavioral Assessment, Intervention, and Monitoring, last reviewed in January 2024, documented behavior symptoms will be identified using a facility-approved behavior screening tool and a comprehensive assessment. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. The facility's policy titled Care Planning, last reviewed in January 2024, documented the facility's care planning/interdisciplinary team is responsible for the development of an individualized Comprehensive Care Plan for each resident. Resident #71 was admitted with diagnoses including Dementia, Chronic Kidney Disease, and Chronic Atrial Fibrillation. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #71 had a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. The Impaired Cognitive Function related to Dementia Comprehensive Care Plan initiated on 2/15/2022 and last revised on 4/28/2023 documented interventions for the Certified Nursing Assistant to report any changes in cognitive function to the Nurse and notify the Physician of inappropriate behavior. The Potential to Exhibit Behavior Symptoms Comprehensive Care plan initiated on 4/28/2022 and last revised on 5/10/2023 documented Resident #71 had the diagnoses of Psychosis and Dementia. The interventions included to administer psychotropic medications as ordered and notify the Physician of inappropriate behavior. (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: 335483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #71's Comprehensive Care Plans revealed there were no updates or revisions to address the resident's behavioral symptoms including the habit of wrapping tissues and rubber bands around two fingers. Resident #71 was observed in their room sitting in a chair on 7/11/2024 at 11:02 AM. Resident #71 had tissues and rubber bands wrapped around their left thumb and right middle finger. Resident #71 removed the rubber bands and tissues, in the presence of the Surveyor, and no cuts or bruises were observed on the resident's fingers. Resident #71 stated facility staff cut their fingernails and when doing so, cut their fingers. The resident stated they had a treatment in place to their fingers for three days. A review of the resident's Physician's Orders and Progress Notes revealed Resident #71 did not require skin treatments to their fingers. Resident #71 was observed in their room sitting in a chair on 7/11/2024 at 12:54 PM with tissues and rubber bands wrapped around the same two fingers, their left thumb and right middle finger. Resident #71 removed the rubber bands and tissues, in the presence of the Surveyor, to expose their fingers, and nothing unusual was observed. Resident #71 stated they put the tissues and rubber bands on their fingers because facility staff cut their fingernails too short. Resident #71 was observed in their room sitting in a chair on 7/12/2024 at 9:27 AM with their two fingers wrapped in tissues and rubber bands. Resident #71 stated they prefer to leave their fingers covered so they do not hurt and they must do this for three days. Resident #71 was observed in their room coming out of the bathroom and then sitting in a chair on 7/15/2024 at 10:09 AM with the Registered Nurse Manager (Registered Nurse #5) present. The resident had tissues and medical tape wrapped around their two fingers (the left thumb and the right middle finger). Resident #71 stated that Certified Nursing Assistant #1 put the tissues and tape on their (Resident #71's) fingers for them. Registered Nurse #5 stated they would remove the tissues and tape from Resident #71's fingers. Registered Nurse #5 stated the Certified Nursing Assistant should not have wrapped the resident's fingers and should have reported the behavior of Resident #71 to the Nurse for them to assess the resident's fingers. Registered Nurse #5 stated Resident #71's behavior of wrapping their fingers should have been documented in a progress note and the Comprehensive Care Plan for Behavior should have been updated. Certified Nursing Assistant #1 was interviewed on 7/15/2024 at 10:11 AM and stated they regularly provide care for Resident #71. Certified Nursing Assistant #1 stated Resident #71 was distressed because their (Resident #71) fingers were not wrapped and asked if Certified Nursing Assistant #1 could help the resident wrap their fingers. Certified Nursing Assistant #1 stated they calmed Resident #71 down and did not put the tissues and tape on Resident #71's fingers and the resident must have done it themself. Certified Nursing Assistant #1 stated they should have told the Nurse about the resident wrapping their fingers. Certified Nursing Assistant #1 stated everyone has seen Resident #71 with wrapped fingers and the resident always wraps their fingers with tissues and tape or rubber bands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nursing at Great Neck		STREET ADDRESS, CITY, STATE, ZIP CODE 15 St Pauls Place Great Neck, NY 11021	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 7/17/2024 at 12:02 PM and stated they were unaware of Resident #71's behavior of wrapping their fingers which should have been monitored and documented accordingly. The Director of Nursing Services stated Resident #71 should have had their behavior of wrapping their fingers added to their Behavior Comprehensive Care Plan. The Director of Nursing Services further stated Certified Nursing Assistant #1 should have brought this behavior to the attention of the Nurse on duty or the Nurse Supervisor. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49245

Based on observation, record review, and interviews during the Recertification Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (Resident #260) of three residents reviewed for Choices. Specifically, Resident #260 was admitted on [DATE] after a Micra Leadless Pacemaker Implantation (electronic device that is implanted in the body to monitor heart rate and rhythm) and required pacemaker remote monitoring. The facility did not initiate the pacemaker remote monitoring until 7/11/2024 and there was no documented Physician Order for the monitoring until 7/15/2024, seven days after Resident #260 was admitted to the facility.

The finding is:

The facility's Admission Notes policy dated 1/2022 documented preliminary resident information shall be documented upon a resident's admission to the facility including a brief description of any disabilities, prosthesis required, nursing history, and a preliminary assessment, the presence of a catheter, dressings, etc., Physician's orders that were received and verified and the general condition of the resident upon admission.

There was no documented evidence that the facility had a policy and procedure that addressed Pacemaker monitoring.

Resident #260 was admitted with diagnoses of the Presence of Cardiac Monitor, Atrial Fibrillation, and Fracture of the Left Acetabulum (hipbone). The Minimum Data Set assessment was not available as the resident was newly admitted .

A Comprehensive Care Plan dated 7/8/2024 documented Resident #260 had an Alteration in Cardiovascular Function and the Presence of a Cardiac Pacemaker. An intervention dated 7/9/2024 documented to check the Medtronic pacemaker monitoring device (a device that sends information on the pacemaker battery status, heart rhythm and heart rate to the Physician) was connected to the resident and was plugged in every shift. The care plan instructed to report if the device is not connected and if there are any changes to the resident's condition. Additionally, the care plan instructed to monitor blood the resident's blood pressure and vital signs.

The hospital discharge instructions dated 7/8/2024 at 10:08 AM documented to schedule a follow-up to evaluate Resident #260's pacemaker and to check the pacemaker battery.

A Baseline Care Plan dated 7/9/2024 documented that Resident #260 was alert and oriented to time, place, and person, cognitively intact, and could communicate with staff.

A review of the medical and nursing progress notes revealed routine checks of Resident #260's pacemaker monitoring device were not performed from 7/8/2024 to 7/11/2024.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #260 was observed lying in bed on 7/11/2024 at 10:35 AM. A pacemaker monitoring device was observed on Resident #260's nightstand and plugged into the wall. Resident #260 was subsequently interviewed and stated they (Resident #260) had a procedure for pacemaker implantation at the hospital and was admitted to the facility on [DATE]. Resident #260 stated they were concerned because the Registered Nurse Unit Manager (Registered Nurse #1) just came into their room [on 7/11/24] and set up the pacemaker monitoring device. Resident #260 stated that since their admission, the pacemaker monitoring device was not set up and was not transmitting any data to their Physician at the Cardiac Clinic. Registered Nurse #1 was interviewed on 7/12/2024 at 3:12 PM and stated they (Registered Nurse #1) completed the admission intake for Resident #260 on 7/8/2024 when the resident was admitted from the hospital. Registered Nurse #1 stated the pacemaker monitoring device came with Resident #260 upon admission. Registered Nurse #1 stated they plugged the monitor into the wall on 7/8/2024 and did not know they had to set up the machine for the Physician to receive a transmission. Registered Nurse #1 stated they did not call the Physician to verify if a transmission was received. Registered Nurse #1 stated they went to Resident #260's room to check the pacemaker monitoring device on 7/11/2024 at around 10:00 AM and they noticed the panel of the device was not set up. Registered Nurse #1 stated they (Registered Nurse #1) read the setup instructions for first-time transmission on 7/11/2024. Registered Nurse #1 stated they should have read the instructions when they completed the admission intake for Resident #260 on 7/8/2024. Physician #1 was interviewed on 7/15/2024 at 12:09 PM and stated they expected nursing staff to monitor Resident #260's vital signs. Physician #1 stated the Nurses should report if Resident #260 had abnormal vital signs or Atrial Fibrillation symptoms, including a pulse rate of more than 90 rate per minute or less than 60 rate per minute. Physician #1 stated that on 7/15/2024 they (Physician #1) ordered to monitor the pacemaker monitoring device's connection to the resident and ensure that the device was plugged in every shift. Physician #1 stated it was an error that the order was not placed upon admission on 7/8/2024. Physician #1 stated they entered the order on 7/15/2024 after it was brought to their attention [by the surveyor] that the physician's order was not in place. Registered Nurse #2 (Nurse at the Cardiac Clinic) was interviewed on 7/16/2024 at 9:10 AM and stated the Cardiac Clinic received the first transmission from Resident #260's pacemaker monitoring device on 7/11/2024 at 10:00 AM. Registered Nurse #2 stated the facility is expected to set up the pacemaker monitoring device immediately after admission to ensure that the Cardiac Clinic Physician receives transmissions after the pacemaker implantation procedure. The Director of Nursing Services was interviewed on 7/16/2024 at 10:22 AM and stated that when the facility received pacemaker monitoring devices, the Nurses would just plug it on the wall because they assumed the device was already set up. The Director of Nursing Services stated it was unfortunate that Resident #260's pacemaker monitoring device was not set up. The Director of Nursing Services stated the facility did not know the device was not functioning until Registered Nurse #1 had called the Cardiac Clinic on 7/11/2024 to confirm the data transmission. The Director of Nursing Services stated that Registered Nurse #1, who admitted Resident #260, should have called the Cardiac Clinic to confirm the transmission was received and should not have assumed that the pacemaker monitoring device did not need any setup. The Director of Nursing Services stated the facility does not usually enter a Physician's Order for a pacemaker monitoring device; however, an order was entered for Resident #260 to ensure that the nurses check the device's functioning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observation, record review, and staff interviews during the Recertification Survey, initiated on 7/11/2024 and completed on 7/18/2024, the facility did not ensure that each resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility. This was identified for one (Resident #135) of two residents reviewed for Rehabilitation Services. Specifically, the Rehabilitation Department recommended a floor ambulation program for Resident #135, however, the floor ambulation program was not completed. The finding is: The facility's Restorative Nursing Rehab Program Floor Ambulation policy, last reviewed on 1/2023, documented each resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care including but not limited to restorative services. The ambulation program refers to the activity of walking that provides weight-bearing that promotes bone health and joint mobility. Recommendations for nursing rehabilitation such as floor ambulation will be transcribed to the tasks in the resident's chart. The task should include frequency, distance, and assistive devices recommended for ambulation. After a successful ambulation session, the aide should document the resident's ambulation, and any concerns that occurred during the event should be reported to the nurse. Resident #135 was admitted with diagnoses including Non-Alzheimer's Dementia, Difficulty in Walking, and Congestive Heart Failure. The 6/16/2024 quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 9, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented the resident needed partial/moderate assistance of one person to walk 10 feet and could not walk 50 feet due to a medical condition. A progress note from the Rehabilitation Department dated 7/3/2024 recommended a Nursing Floor Ambulation Program twice a day for Resident #135 to walk 30 feet with a rolling walker with partial/moderate assistance of one person. The facility Task List Report (Certified Nursing Assistant Instructions) as of 7/18/2024 documented a Floor Ambulation Program for Resident #135 to walk 30 feet with a rolling walker with partial/moderate assistance of one person twice a day. The seven-day lookback of the resident's Certified Nursing Assistant Accountability Record documented a Floor Ambulation Program was performed on eight of ten opportunities from 7/12/2024 to 7/17/2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #135 was observed lying in bed in their room on 7/11/2024 at 10:23 AM with their Private Aide (Private Aide #1) seated at the bedside. Resident #135 stated that they had been receiving therapy from the facility's Rehabilitation Department, but their therapy had ended. Resident #135 stated that they (Resident #135) wanted to walk more, but could not, since their Rehabilitation Therapy had been discontinued. Private Aide #1 stated that they have cared for Resident #135 for the past [AGE] years and the resident used to be very active. The Director of Rehabilitation was interviewed on 7/18/2024 at 9:04 AM and stated Resident #135 started Physical Therapy on 3/18/2024 and was discharged from Physical Therapy on 7/3/2024 due to reaching their (Resident #135) therapy goals. The Director of Rehabilitation stated the resident was discharged from therapy with a recommendation for a Nursing Floor Ambulation Program to walk a distance of 30 feet twice a day. The Director of Rehabilitation stated rehabilitation staff educate the Certified Nursing Assistants and the Nurses when a resident is discharged from therapy and placed on a Floor Ambulation Program. The Director of Rehabilitation stated rehabilitation staff are expected to add the floor ambulation program task to the Certified Nursing Assistant Accountability Record and the Certified Nursing Assistant Care Instructions to ensure the task is done on a daily basis. The Director of Rehabilitation stated the facility does not use Physician's orders to implement a Nursing Floor Ambulation program. Private Aide #1 was interviewed on 7/18/2024 at 9:30 AM and stated they are with Resident #135 from 7 AM to 5 PM every day and have not seen anyone perform floor ambulation with the resident. Certified Nursing Assistant #2, regularly assigned to Resident #135 on the 7 AM to 3 PM shift, was interviewed on 7/18/2024 at 10:25 AM and stated that they had not completed floor ambulation with the resident and the documentation on the Certified Nursing Assistant Accountability Record of them doing so was a mistake. Certified Nursing Assistant #2 stated they have never walked with the resident on the unit when caring for them during the 7 AM to 3 PM shift. Certified Nursing Assistant #3 was interviewed on 7/18/2024 at 10:40 AM and stated they have never provided floor ambulation for Resident #135. Certified Nursing Assistant #3 stated they were not regularly assigned to Resident #135 and covered various units. Certified Nursing Assistant #3 stated they documented that they had completed that task on 7/15/2024 and 7/16/2024 because they thought the resident walked with a Rehabilitation Therapist. Registered Nurse Unit Manager #1 was interviewed on 7/18/2024 at 10:48 AM and stated they were not aware of Resident #135's Floor Ambulation Program. Registered Nurse Unit Manager #1 stated that if the Floor Ambulation Program was part of the Certified Nursing Assistant's instructions, the Certified Nursing Assistants were expected to perform the task and report if it was not completed. Registered Nurse Unit Manager #1 stated the Rehabilitation Department educates and informs the Nursing Staff which residents are on a Floor Ambulation Program. Licensed Practical Nurse #2 (Resident #135's Medication Nurse) was interviewed on 7/18/2024 at 11:03 AM and stated the resident was not on a Floor Ambulation Program and the resident goes to Rehabilitation Therapy every day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Rehabilitation was re-interviewed on 7/18/2024 at 11:41 AM and stated the Rehabilitation Staff provides education to the Nursing Staff using a paper lesson plan that outlines the material being taught and the nursing staff then signs off on it. The Director of Rehabilitation stated they could not find the lesson plan for Resident #135's Floor Ambulation Program. The Director of Nursing Services was interviewed on 7/18/2024 at 12:02 PM and stated Certified Nursing Assistants should not document that they provided Floor Ambulation to a resident if they did not do it. The Director of Nursing Services stated there was a clear disconnect between Nursing and Rehabilitation Staff in regards to Resident #135's Floor Ambulation Program. The Director of Nursing Services stated Resident #135 should have received Floor Ambulation as per the program recommended by the Rehabilitation Department. 10 NYCRR 415.12(e)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review, and interviews during the Recertification Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not ensure that residents who are incontinent of bowel and bladder received the appropriate treatment and services to prevent Urinary Tract Infection. This was evident for one (Resident #117) of three residents reviewed for Activities for Daily Living. Specifically, Resident #117 required total assistance from one caregiver for toileting and was frequently incontinent of bowel and bladder. Resident #117 was observed wearing a urine-soaked brief and had wet linens underneath them on 7/11/2024 at 11:11 AM. The resident was last changed on the 11:00 PM to 7:00 AM shift before the observation. The findings is: The facility Resident Care with Activities of Daily Living policy and procedure, last updated on 1/2024, documented the resident will be offered toileting assistance or incontinent care twice per shift and as needed. The policy documented that staff must report any changes in the resident prior to, during or after toileting or incontinence care such as refusal to the Charge Nurse/Supervisor. Resident #117 was admitted with diagnoses that included Dementia with Agitation, Insomnia, and Major Depressive Disorder. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10, indicating the resident had moderately impaired cognition. The resident had no mood symptoms and did not reject care. The resident was not on a toileting program, was frequently incontinent of bowel and bladder, and required total assistance from one caregiver for toileting. A Comprehensive Care Plan for Activities of Daily Living dated 11/8/2023 and last updated on 5/6/2024 documented Resident #117 required assistance with self-care and mobility due to impaired mobility. The interventions included to encourage the resident to participate to the fullest extent possible with each interaction. The care plan documented the resident was dependent on the care of one staff member for toileting and personal hygiene. A Comprehensive Care Plan for Resident Choice dated 11/9/2023 and last revised on 4/12/2024 documented Resident #117 refused activities of daily living care. The interventions included to assess the underlying reason for the resident's choices. There were no instructions for staff to report refusal of care to the Charge Nurse and/or Supervisor. The Certified Nursing Assistant Task Report (Certified Nursing Assistant Instructions) last revised on 3/23/2024 documented the resident required incontinence care, used a large-sized brief, and depended on one caregiver for toileting hygiene. There were no instructions for Certified Nursing Assistants to report refusals of care to the Charge Nurse and/or Supervisor. Review of Resident #117's progress notes on 7/11/2024 revealed there were no documented care refusals before 11:00 AM. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #117 was observed in their room lying in bed while awake and wearing sleepwear on 7/11/2024 at 11:11 AM. There was a strong urine odor in the resident's room. Resident #117 stated that their Certified Nursing Assistant had not come in to perform morning care all morning. Resident #117 stated they were wet, needed to be changed and assisted out of bed. At 11:12 AM, the resident was observed ringing the call bell and Certified Nursing Assistant #5 responded within one minute. Certified Nursing Assistant #5 stated that they (Certified Nursing Assistant #5) were assisting another resident and would help Resident #117 after they were finished. The resident stated they were last changed on the 11 PM to 7 AM shift. Certified Nursing Assistant #5 was observed assisting the resident with morning care on 7/11/2024 at 12:26 PM. There was a strong odor of urine in the hallway, and upon entering the resident's room, the pungent urine odor permeated the resident's room. The resident's soiled brief was observed to be saturated with urine and the inner lining of the diaper was balled up. The resident's bed linen was also observed to be wet and smelled of urine. Certified Nursing Assistant #5 was interviewed on 7/11/2024 at 12:53 PM and stated they had not cared for Resident #117 all morning and that the resident was last changed on the 11 PM to 7 AM shift. Certified Nursing Assistant #5 stated that they regularly worked with the resident, and they (the resident) were difficult to work with. Certified Nursing Assistant #5 stated the resident refused morning care on 7/11/2024. Certified Nursing Assistant #5 was re-interviewed on 7/16/2024 at 2:32 PM and stated Resident #117 usually gets out of bed around 11:00 AM daily. Certified Nursing Assistant #5 stated that the resident was incontinent of bowel and urine and had frequent urination. Certified Nursing Assistant #5 stated that on 7/11/2024, they (Certified Nursing Assistant #5) served the resident their breakfast tray after 8 AM and the resident did not complain about being wet. Certified Nursing Assistant #5 stated that they went into the resident's room after breakfast, at around 9:30 AM, and after 11:00 AM, and the resident stated that they were not ready to get out of bed. Certified Nursing Assistant #5 stated that they did not report to the Nurse that the resident was refusing care. Certified Nursing Assistant #5 stated that at 11:25 AM, they went to the resident and informed them (Resident #117) that they were with another resident and would come in after they had completed the other resident's care. Certified Nursing Assistant #5 stated when they returned to care for Resident #117 at around 11:45 AM, the resident's brief was soaked with urine and the bed linen was also wet. Certified Nursing Assistant #5 further stated they should have report to the Charge Nurse when a resident refuses care and encourage the resident to accept care. Certified Nursing Assistant #7, who cared for the resident on the 11:00 PM to 7:00 AM shift on 7/10/2024 into 7/11/2024, was unavailable for an interview. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nursing at Great Neck		STREET ADDRESS, CITY, STATE, ZIP CODE 15 St Pauls Place Great Neck, NY 11021	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #7, the Nurse Manager for the second floor Nursing Unit, was interviewed on 7/16/2024 at 3:03 PM and stated they were not made aware that Resident #117 was refusing care. Registered Nurse #7 stated Certified Nursing Assistant #5 should have checked the resident at the beginning of the shift to ensure they were dry. Registered Nurse #7 stated that the Certified Nursing Assistants are instructed to check the residents every two hours to ensure timely and appropriate incontinence care is rendered. Registered Nurse #7 stated if a resident refuses care, the Certified Nursing Assistant should re-approach the resident. Registered Nurse #7 stated if the resident continues to refuse care, the Certified Nursing Assistant should go to the Charge Nurse. The Charge Nurse and the Certified Nursing Assistant should report to the Nurse Manager if they were unable to encourage the resident to accept care and document the refusal in the progress notes. The Director of Nursing Services was interviewed on 7/17/2024 at 12:08 PM and stated Certified Nursing Assistant #5 should have reported to the Charge Nurse that Resident #117 refused care after they (Certified Nursing Assistant #5) approached the resident twice. The Director of Nursing Services stated the Charge Nurse should report to the Registered Nurse Manager that the resident continued to refuse care and document the incident in a progress note. The Director of Nursing Services stated they expect Certified Nursing Assistants to check and change a resident's brief every two to three hours. 10 NYCRR 415.12 (d)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews conducted during the Recertification Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice. This was identified for one (Resident #57) of four residents reviewed for Respiratory Care. Specifically, Resident #57 had a Physician's Order to receive 4 liters of oxygen therapy per minute via mist collar to a tracheostomy continuously. However, on multiple occasions, Resident #57 was observed receiving 6 liters of oxygen per minute via mist collar to their tracheostomy. The finding is: The facility's Assessing Oxygen Saturation Policy, last revised in January 2024, documented to assess the resident for the following signs and symptoms of impaired oxygen saturation: altered respirations, difficulty breathing, and abnormal breath sounds. The policy further documented to notify the Physician if the oxygen saturation level is less than an acceptable level for the resident's condition. Resident #57 was admitted with diagnoses including Acute Respiratory Failure with Hypoxia, Quadriplegia, and Cerebral Infarction. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, which indicated the resident had severe cognitive impairment. The Minimum Data Set further documented the resident received oxygen therapy. The Alteration in Respiratory System Care Plan, last revised on 3/21/2024, documented interventions which included to provide oxygen therapy via humidified air at 4 liters per minute via tracheostomy collar at all times, as per Physician's Orders. A Physician's Order dated 7/11/2024 documented oxygen therapy to be administered at 4 liters per minute via a tracheostomy collar continuously. Resident #57 was observed sleeping in a Geri chair (a large padded chair with wheeled bases designed to assist individuals with limited mobility) in their room with a mist collar delivering 6 liters of oxygen per minute to their tracheostomy on 7/11/2024 at 1:08 PM. Resident #57 was observed lying in bed in their room with a mist collar delivering 6 liters of oxygen per minute to their tracheostomy on 7/12/2024 at 8:53 AM. Resident #57 was observed sleeping in a Geri chair in their room with a mist collar delivering 6 liters of oxygen per minute to their tracheostomy on 7/12/2024 at 11:56 AM. Resident #57 was observed in their room in a Geri chair with Nurse Manager #5 on 7/16/2024 at 10:42 AM. The display window on the oxygen concentrator indicated the resident was receiving 6 liters of oxygen per minute via a mist collar to their tracheostomy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #3 was interviewed on 7/16/2024 at 10:46 AM and stated they just checked the oxygen level and thought it was set to 4 liters per minute. Registered Nurse #3 stated that the oxygen therapy setting was checked on each shift by a Nurse. Registered Nurse #3 stated they would speak to the Physician about the Oxygen order. Registered Nurse #3 stated they would set the oxygen therapy to 4 liters per minute and check Resident #57's oxygen saturation level (measurement of the amount of oxygen in your blood). Registered Nurse #3 stated they would continue to monitor the resident's oxygen saturation level during the 7 AM - 3 PM shift and if Resident #57's oxygen dropped, they would increase the oxygen and call the Physician. The Registered Nurse Manager (Registered Nurse #5) was interviewed on 7/16/2024 at 10:49 AM and stated the Nurse caring for Resident #57 should monitor the resident's oxygen saturation levels and notify the Physician that the resident required more oxygen. Registered Nurse #5 stated the Nurse caring for Resident #57 was responsible for monitoring and documenting the resident's oxygen level every shift. Registered Nurse #5 checked Resident #57's Physician's Orders and verified the resident should have received 4 liters per minute and not 6 liters per minute as observed. Physician #2 was interviewed on 7/17/2024 at 11:22 AM and stated they expect the Nursing staff to follow their Physician Orders as they were written for Resident #57. Physician #2 stated when a resident is not receiving enough oxygen, they can become hypoxic (a condition in which the body does not have enough oxygen at the tissue level), have difficulty breathing, and have a rapid heart rate. Physician #2 stated too much oxygen therapy can cause problems with vision and dizziness. Physician #2 stated they expect the Nursing staff to monitor the respiratory levels of the residents and to notify them (the Physician) if a resident continues to be hypoxic. Physician #2 stated they would then put in an order for an increase in oxygen therapy if needed. Physician #2 further stated that they expected the nursing staff to continue monitoring the resident's oxygen saturation level after the increase in oxygen therapy was made. The Director of Nursing Services was interviewed on 7/17/2024 at 12:00 PM and stated they expect the Nursing staff to frequently monitor the oxygen levels and the settings of oxygen therapy as per the Physicians' Orders. The Director of Nursing Services stated if a Nurse observes changes in the oxygen level of a resident, they are expected to notify the resident's Physician. 10 NYCRR 415.12(k)(6)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not ensure it obtained laboratory services to meet the needs of each resident. This was identified for one (Resident #41) of three residents reviewed for Transmission-Based Precautions. Specifically, Resident #41 was receiving the antibiotic Vancomycin for Methicillin-Resistant Staphylococcus aureus (a bacteria that causes serious infection) in the urine and mastoid bone (the bone behind the ear) and the Physician ordered a Vancomycin trough level (a laboratory test used to determine therapeutic dosage) to be drawn on 7/9/2024. There was no documented evidence in the resident's medical record that the laboratory order was completed. The finding is: The facility's Laboratory and Diagnostic Test Results Clinical Protocol, last reviewed 1/2024, documented the Physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory will report test results to the facility. Nursing staff are expected to review all results and relay results to the medical professional. A nurse will identify the urgency of communicating with the Attending Physician based on the Physician's request, the seriousness of any abnormality, and the individual's current condition. Nursing staff will consider the following factors to help identify situations requiring prompt Physician notification concerning lab or diagnostic test results: High or toxic drug levels. A Physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. If the Attending or Covering Physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. Resident #41 was admitted with diagnoses including Cancer, Acute Mastoiditis, and Infection with Multi-Drug Resistant Organism. The 6/19/2024 significant change Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented that the resident was taking an antibiotic. A Physician's Order dated 6/12/2024 documented Resident #41 required Strict Contact Precautions for an Active Methicillin-Resistant Staphylococcus Aureus Infection in Urine. The physician's order directed all services to be completed in the resident's room. A Comprehensive Care Plan effective 6/15/2024 documented Resident #41 was on Contact Precautions due to a Methicillin-Resistant Staphylococcus Aureus Infection to Mastoid Bone and Urinary Tract. The interventions included administering medications or treatments as per the Physician's Order. A Physician's Order dated 6/15/2024 documented to administer Vancomycin Hydrochloride in Sodium Chloride Intravenous Solution 750-0.9 milligram per 150 milliliter, use 750 milligram intravenously every 12 hours for Methicillin-Resistant Staphylococcus Aureus until 7/19/2024. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bloodwork for Resident #41's Vancomycin trough level was collected on 7/5/2024 and the result was reported to the facility on [DATE]. The result was 35.7 micrograms per milliliter and was flagged by the laboratory as critically high (meaning above peak levels as the normal reference range is between 10.0 and 20.0). A Progress Note written by Physician #1 dated 7/6/2024 documented a high Vancomycin level of 35.7 on the Vancomycin trough test. Physician #1 recommended decreasing the Vancomycin to once a day and repeating the Vancomycin laboratory test in three days. A Physician's Order dated 7/6/2024 documented to give Vancomycin Hydrochloride in Sodium Chloride Intravenous Solution 750-0.9 milligram per 150 milliliter, use 750 milligrams intravenously in the evening for Methicillin-Resistant Staphylococcus Aureus for 13 days. A Physician's Order dated 7/6/2024 documented to obtain a Vancomycin trough level on 7/9/2024. A review of Resident #41's medical record revealed no documented evidence of bloodwork collection for a Vancomycin trough level test on 7/9/2024. Resident #41 was observed in their room in their wheelchair on 7/12/2024 at 10 AM. There was a contact precaution sign at the doorway and a full personal protective equipment cart outside the resident's room door. The Registered Nurse Unit Manager (Registered Nurse #1) was interviewed on 7/15/2024 at 9:24 AM and stated they were not sure if the 7/9/2024 Vancomycin trough level had been ordered. A review of the resident's medical record revealed that another order for a Vancomycin trough level was entered on 7/15/2024 at 9:34 AM. The Registered Nurse Unit Manager (Registered Nurse #1) and Licensed Practical Nurse #2 were interviewed concurrently on 7/15/2024 at 10:38 AM. Licensed Practical Nurse #2 stated the order for the 7/9/2024 Vancomycin trough was entered in the laboratory-ordering system and for some reason, the laboratory did not collect it. Registered Nurse #1 stated an immediate (STAT) order for a Vancomycin trough level was just placed today (7/15/2024) to be collected as it was never done on 7/9/2024 and should have been. Registered Nurse #1 stated the Vancomycin trough level for Resident #41 was last collected on 7/5/2024. Physician #1 was interviewed on 7/15/2024 at 11:25 AM and stated the Methicillin-Resistant Staphylococcus Aureus infection was in Resident #41's urinary tract and mastoid bone. Physician #1 stated they did not follow up on the Vancomycin trough level they ordered on 7/9/2024 because they were addressing another health issue Resident #41 had. Physician #1 stated that monitoring the Vancomycin trough level was important to ensure the resident received a therapeutic dose. The Registered Nurse Unit Manager (Registered Nurse #1) was re-interviewed on 7/15/2024 at 12:41 PM and stated the Laboratory Technician may have missed the resident when coming in to draw the blood. Registered Nurse #1 stated the Nurse who entered the laboratory work order or the Physician should have followed up on the status of the order. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Laboratory Technician (Laboratory Representative #1) was interviewed on 7/15/2024 at 1:36 PM and stated they did not see Resident #41's order for the 7/9/2024 Vancomycin trough level. Laboratory Representative #1 stated they only saw an order for the Vancomycin trough from today, 7/15/2024, and another from 7/5/2024. Licensed Practical Nurse #2 was interviewed on 7/16/2024 at 9:47 AM and stated they entered the Vancomycin trough level order on 7/9/2024 via the laboratory's website. Licensed Practical Nurse #2 stated they could not explain why the bloodwork was not collected and they did not follow up with the laboratory. The Director of Nursing Services was interviewed on 7/16/2024 at 10:49 AM and stated that they (the Director of Nursing Services) were unable to determine why Resident #41's Vancomycin trough level was not collected on 7/9/2024. The Director of Nursing Services stated that the facility ordered Resident #41's laboratory work, so there may have been an issue on the laboratory's side in not completing it. The Director of Nursing Services stated the Nurse on the unit and the resident's Physician were supposed to follow up the next day to ensure that laboratory work was completed. 10 NYCRR 415.20

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 28173 Based on observation, record review, and staff interviews during the Recertification and Abbreviated (NY00323936) Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not maintain medical records on each resident that were complete and accurate for one (Resident #91) of one resident reviewed for Abuse. Specifically, Resident #91's family member reported bruising to Resident #91's left eye on 9/13/2023. However, the resident's skin assessment and medical evaluation to rule out trauma were not documented in the medical record. The finding is: The facility's Charting and Documentation policy, last reviewed in 1/2024, documented objective observations, treatments or services performed, events, incidents or accidents involving the resident are to be documented in the medical record. Resident #91 was admitted with diagnoses including Unspecified Dementia, Type 2 Diabetes Mellitus, and Venous Insufficiency. The 7/21/2023 annual Minimum Data Set assessment documented a Brief Interview for Mental Status score of 99, indicating the resident was unable to complete the interview. The staff assessment for mental status documented the resident had impaired short-term memory and long-term memory as well as moderately impaired cognitive skills for daily decision-making. Resident #91's family member was interviewed on 7/15/2023 at 11:58 AM and stated during a virtual videoconferencing meeting on 9/13/2023, they observed Resident #91 with a discoloration under their left eye. The family member reported the discoloration to the Director of Nursing Services and the Administrator on 9/13/2023. The family member stated they were informed that the Director of Nursing Services assessed the resident and concluded the skin condition was an old discoloration. The family member alleged the Director of Nursing Services compared the resident's discoloration to an admission photograph from 2016. A review of Resident #91's medical records for September 2023 revealed no documented evidence of any evaluation of the left or right eye areas for discoloration. Resident #91 was observed with the Director of Nursing Services present in the second-floor main dining room on 7/16/2024 at 1:15 PM. The resident's complexion showed varying pigmentation across different areas of the face, with no signs of bruising. The Director of Nursing Services was interviewed on 7/16/2024 at 1:20 PM and stated they spoke to Resident #91's family member on 9/13/2023 and immediately assessed Resident #91's eye area. The Director of Nursing Services stated they concluded that the discoloration was related to a birthmark or pigmentation. The Director of Nursing Services stated they did not document the skin assessment or the communication with the family member in the resident's medical record. The Director of Nursing Services stated they should have documented the family member's allegation and Resident #91's skin assessment. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The Physician Assistant was interviewed on 7/18/2024 at 12:24 PM and stated the Director of Nursing Services reported the family member's allegation to them immediately on 9/13/2023. The Physician Assistant stated they assessed Resident #91 the next day (9/14/2023) and concluded that the discoloration around the resident's eye was not the result of trauma, but rather a birthmark or pigmentation. The Physician Assistant stated they did not feel it was necessary to document their evaluation in Resident #91's medical record because it was a verbal concern expressed by the Director of Nursing Services. The Physician Assistant did not report the family member's allegation to the attending Physician because they did not observe a change in Resident #91's condition. The Administrator was interviewed on 7/18/2024 at 12:51 PM and stated they were made aware of the family member's allegation but could not recall the exact date. The Administrator stated licensed providers are expected to document all medical assessments in the resident medical records. 10 NYCRR 415.22(a)(1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 7/11/2024 and completed on 7/18/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #112) of six residents reviewed in the Medication Administration Task. Specifically, Resident #112 had a physician's order for Strict Contact Precautions for Pseudomonas Aeruginosa (a type of bacteria) in the urine which required the use of Personal Protective Equipment including a gown and gloves. The Licensed Practical Nurse (Medication Nurse) #1 was observed on 7/12/2024 entering the room without wearing a gown and gloves and administered medications to Resident #112. The finding is: The facility's Initiation of Transmission-Based Precautions policy, last revised on 1/2024, documented it is the policy of the facility to prevent the spread of infection within the facility through the use of isolation precautions. Contact Precautions in addition to standard precautions are used for residents known or suspected to be infected with microorganisms that can easily be transmitted by direct or indirect contact such as handling environmental surfaces or resident care items. Special instructions are to be explained to all staff involved. Education will be provided to the resident if applicable, and visitors/family members regarding the use of isolation precautions. Resident #112 was admitted with the diagnoses of Urinary Tract Infection, Epilepsy, and Schizoaffective Disorder. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13 which indicated Resident #112 had intact cognition. The Annual Minimum Data Set assessment documented that Resident #112 was incontinent of both bowel and bladder. Resident #112 was dependent on staff for all activities of daily living including toileting, personal hygiene, and bathing. A Urinary Culture Report dated 7/7/2024 documented Resident #112 had Pseudomonas Aeruginosa (a bacteria) of 10,000 to 49,000 colony-forming units per milliliter and needed Ciprofloxacin (an antibiotic). The Comprehensive Care Plan for Urinary Tract Infection dated 7/8/2024 documented interventions which included implementing Transmission-Based Precautions as per Physician Order, specifically contact precautions; performing hand hygiene before and after contact with residents; using Personal Protective Equipment; and encouraging fluid intake and diet compliance. A Physician's Order dated 7/11/2024 documented to implement Strict Contact Precautions for an active infection and to complete all services in the resident's room. A Physician's Order dated 7/11/2024 documented to administer Ciprofloxacin Hydrochloride (an antibiotic) 500 milligrams one tablet by mouth once a day for one day and one tablet by mouth every 12 hours for 7 days to treat a Urinary Tract Infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A sign posted outside Resident #112's room on Unit 2 that read Contact Precautions was observed on 7/12/2024 at 8:49 AM in Unit 2 during the Medication Administration task. The sign instructed everyone must clean their hands before and after entering and when leaving the room. The sign also instructed to use Personal Protective Equipment including wearing a gown and gloves. Licensed Practical Nurse #1 was subsequently observed entering Resident #112's room to administer medications to the resident without a gown and gloves. Licensed Practical Nurse #1 proceeded to administer medication to Resident #112, who was lying in bed. Licensed Practical Nurse #1 was interviewed on 7/12/2024 at 9:00 AM and stated they (Licensed Practical Nurse #1) did not wear gloves and a gown when entering Resident #112's room because Resident #112 had an infection in the urine. Licensed Practical Nurse #1 stated they were not providing care at the time and were just giving medications to Resident #112. Licensed Practical Nurse #1 stated they read the signage outside Resident #112 room, but thought it only pertained to high-contact care such as toileting. Licensed Practical Nurse #1 stated they were not aware that a gown and gloves were needed for medication administration. The Registered Nurse Infection Preventionist was interviewed on 7/12/2024 at 3:38 PM and stated Licensed Practical Nurse #1 should have worn a gown and gloves before entering Resident #112's room. The Registered Nurse Infection Preventionist stated that Resident #112 was on Contact Isolation and the signage was very specific that everyone who entered the room must wear a gown and gloves. The Director of Nursing Services was interviewed on 7/16/2024 at 10:35 AM and stated Licensed Practical Nurse #1 should have worn gloves and a gown as indicated on the Contact Precautions signage outside Resident #112's room. The Director of Nursing Services stated that all the staff and visitors should follow the Contact Precautions signage outside Resident#112's room and wear a gown and gloves when entering the resident's room. 10 NYCRR 415.19 (a) (1-3)