

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Morningside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Pelham Parkway South Bronx, NY 10461	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136</p> <p>Based on observations, record review, and interviews conducted during the Recertification Survey from 04/07/2024 to 04/12/2024, the facility did not ensure that the residents were treated with respect and dignity and cared for in a manner and environment that promotes enhancement of their quality of life. This was evident for one (Resident #158) of five residents reviewed for Dignity out of a sample of 38 residents. Specifically, Resident #158 was observed multiple times in their room with a strong urine odor.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Dignity, last revised in November 2016, documented that the facility's policy is to ensure services are provided in a manner that enhances/maintains a dignified existence.</p> <p>The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #158's cognition as moderately impaired with a Brief Interview for Mental Status score of 8, required supervision for toileting and hygiene, set-up only for personal hygiene, and was continent of urine and bowel.</p> <p>The Comprehensive Care Plan initiated on 06/19/2018 revised 2/9/24 documented that Resident #158 is continent of the bladder, at risk for bladder incontinence related to activity Intolerance and cognitive impairment. Interventions included incontinence: check and change resident every 2-4 hours, cleanse, rinse, dry, and apply a moisture barrier, and instruct resident to call for assistance and report the need to use the bathroom.</p> <p>A care plan note dated 02/09/2024 documented that Resident #158 remained incontinent of bladder and was free of signs and symptoms of urinary tract infection and skin breakdown.</p> <p>Review of the medical record revealed no documented evidence that Resident #158 had a behavior of urinating in their room.</p> <p>On 04/07/2024 at 10:33 AM, Resident #158 was observed in their room resting on the bed during the initial tour. The room was noted to have a strong odor of urine. Underwear was observed hanging in the bathroom.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/08/2024 at 10:32 AM, Resident #158's room was observed to have a strong odor of urine, and the bottom sheet on the bed was noted with a large urine stain. Resident #158 was out of bed, sitting on a chair in the room, well-groomed, and eating breakfast. Underwear was observed hanging in the bathroom.</p> <p>On 04/09/2024 at 9:47 AM, a strong urine odor persisted in the resident's room. Resident #158 was observed out of bed sitting in a chair asleep. The floor had been mopped, however there a strong urine odor persisted in the room.</p> <p>On 04/09/2024 at 11:59 AM, Resident # 158 was observed out of bed, sitting on a chair in their room, well-groomed, and their underwear was hanging in the bathroom. The odor of urine is still in the room.</p> <p>On 04/11/2024 at 12:15 PM, Housekeeper #1 stated that the mattress in Resident #158's room had been removed and the room smelled better.</p> <p>On 04/11/2024 at 12:17 PM, observation of Resident #158's room revealed that there was no mattress on the resident's bed, and the room no longer had an odor of urine. Resident #158's underwear was observed hanging in the bathroom.</p> <p>On 04/11/2024 at 11:12 AM, Certified Nursing Assistant #5 was interviewed and stated that Resident #158 is continent but incontinent of urine at times. Certified Nursing Assistant #5 also stated that the urine smell in the room comes from the underwear that the resident hangs in their room as Resident #158 refuses to send their underwear to the laundry. Certified Nursing Assistant #5 further stated that Resident #158 showers every day and washes their underwear in the sink but does not wash it well.</p> <p>On 04/11/2024 at 11:21 AM, Licensed Practical Nurse #1 was interviewed and stated that Resident #158 showers every day and washes their underwear and hangs it in the room. Licensed Practical Nurse #1 also stated that they have changed the mattress and the sheets before, and they did not know where the urine smell was coming from.</p> <p>On 04/11/2024 at 11:49 AM, Housekeeper #1 was interviewed and stated that the smell in Resident #158's the room could be coming from the mattress. Housekeeper #1 also stated that they have changed the mattress a few times, and they think the resident urinates on the mattress, and on the floor at times.</p> <p>On 04/12/2024 at 11:17 AM, Resident # 158 was observed out of bed making their bed. There was no urine odor detected in the resident's room, and Resident #158's underwear was observed hanging in the bathroom.</p> <p>During an interview on 04/12/2024 at 11:17 AM, Licensed Practical Nurse #1 stated that there is no longer a urine odor in Resident #158's room after the housekeeper removed the old mattress and replaced it with a new one.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/12/2024 at 10:38 AM, the Director of Nursing was interviewed and stated that that they did not remember if there was a smell in Resident #158's room. The Director of Nursing also stated that they were not aware of the strong smell of urine in the resident room, no-one had informed them about the smell and they were not aware of the issue.</p> <p>10 NYCRR 415.5(a)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>43350</p> <p>Based on interviews, observations and record reviews conducted during a recertification review (TD8B11), the facility did not ensure that a resident who is unable to carry out activities of daily living received appropriate services to maintain good grooming. This was evident for 1 (Resident #89) of 10 residents reviewed for Activities of Daily Living out of 38 sampled residents. Specifically, Resident #89 was observed with long, untrimmed fingernails that were imbedded with black matter.</p> <p>The findings are:</p> <p>The facility's policy and procedure titled Activities of Daily Living, last reviewed 11/2018, documented that the facility will provide the necessary care and services based on the comprehensive assessment of a resident, including hygiene, such as bathing, dressing, grooming and oral care.</p> <p>Resident #89 was admitted to the facility with diagnoses that included Cerebrovascular Accident, Hemiplegia, and Arthritis.</p> <p>The Activities of Daily Living Care Plan initiated 01/12/2024 documented that the resident required maximum assist of 2 persons for personal hygiene.</p> <p>On 04/08/2024 at 11:57 AM, Resident #89 was observed in bed with long, untrimmed fingernails with black matter underneath each nail. Resident #89 stated that they did not recall the last time anyone trimmed their fingernails and that they were aware their hands and nails were dirty.</p> <p>On 04/12/2024 at 9:15 AM, Resident #89 was again observed in bed with fingernails that were untrimmed and there was black matter under each fingernail.</p> <p>On 04/12/2024 at 9:21 AM, Certified Nursing Assistant #7 was interviewed and stated that they are assigned to Resident #89 most of the time but had not worked with Resident #89 in about two weeks. Certified Nursing Assistant #7 also stated that when they are assigned to Resident #89 they wash the resident every morning and trim their nails when the nails become long or dirty.</p> <p>On 04/12/2024 at 9:30 AM, Registered Nurse Supervisor #1 who was the Charge Nurse on the unit stated that the protocol is to clean each resident's hands before every meal and to clip their fingernails every Sunday. Registered Nurse Supervisor #1 examined Resident #89's hands and stated that it did not appear that the resident's hands had been washed or that their nails had been trimmed as per protocol. Registered Nurse Supervisor #1 further stated that Resident #89 eats with their fingers so this is especially distressing.</p> <p>On 04/12/2024 at 10:46 AM, Certified Nursing Assistant #8 was interviewed and stated that they are a floater currently assigned to Resident #89's on this shift. Certified Nursing Assistant #8 also stated that they served Resident #89 breakfast this morning and used hand sanitizer to clean the resident's hands prior to serving the tray. Resident #89 eats with their fingers and had pancakes with syrup today, so their hands would be sticky after breakfast. Certified Nursing Assistant #8 further stated that the resident's nails are dirty because they scratch themselves a lot, and they had not yet given the resident morning care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/12/2024 at 12:36 PM, the Director of Nursing was interviewed and stated that they always foster safe independence in Activities of Daily Living. We hire trained staff and in-service and monitor them regularly to make sure they provide the best care.</p> <p>10 NYCRR 415.12(a)(3)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49015</p> <p>Based on observation, record review, and interviews conducted during the Recertification survey from 4/7/24 to 4/12/24, the facility did not ensure that food was prepared, distributed, and served food in accordance with professional standards for food service safety. This was evident during observations during the Kitchen facility task. Specifically, 1) the dish washing machine did not maintain appropriate temperatures for washing and rinsing dishes, 2) hair was not covering appropriately by dietary staff preparing and serving meals, 3) the temperatures of food on the steam table was not checked or recorded prior to meals being served and, 4) food in unit pantry was not labeled and dated appropriately.</p> <p>The findings are:</p> <p>1. The facility policy and procedure titled Dish Machine Procedure with an effective date of May 2022 documented dish washer/dietary aide will report the machine for immediate repair if temperatures are not adequate. The policy also documented that the rinse temperature is 150 min, wash temp 160 min and final rinse 180 min and did not document the temperatures as Centigrade or Fahrenheit. The policy further documented that the Manager/Supervisor will monitor wash and rinse temperatures periodically through shift to ensure proper temperature.</p> <p>On 04/09/24 at 10:27 AM, an observation was conducted of the dish machine which registered temperatures as follows: wash 142 degrees F, rinse 142 degrees F, and final rinse 188 degrees F.</p> <p>The Director of Dietary Department was interviewed immediately and stated that they were not aware that the wash and rinse temperatures were not being reached on the dish machine, and they would contact maintenance.</p> <p>On 04/10/24 at 12:59 PM, a follow-up observation was conducted of the dish machine. Temperature were wash-141 degrees F, rinse-141 degrees F, and final rinse 193 degrees F.</p> <p>The Dishwasher Temperature Log for April 2024 Day 1 to Day 9 documented wash temperatures were between 154-165 degrees F at Breakfast, 160-165 degrees F at Lunch, and 160-170 degrees F at Dinner. Rinse temperatures were between 159-175 degrees F at Breakfast, 168-179 at Lunch, and 175-186 at Dinner. Final Rinse temperatures were within the 175-180 range at Breakfast, 175-179 range at Lunch, and 180-190 range at Dinner.</p> <p>On 04/10/24 at 01:24 PM, an interview was conducted with the Director of Dietary Department who stated that the dish machine was not meeting wash and rinse temperatures and they contacted the vendor on 4/9/24 who stated that they would order a part for the machine which would be sent to the facility overnight. The Director of Dietary Department also stated that the part would not arrive now until 4/11/24. The Director of Dietary Department further stated that they contacted corporate and were told they could continue using the dish machine even though the wash and rinse temperatures were not high enough as long as the final rinse temperature was high 180 degrees F or higher.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. On 04/10/24 at 12:01 PM, the Dietary Supervisor was observed on unit B5 dressed in street clothes behind the steam table, removing the coverings from the food items. The Dietary Supervisor had upper part of hair uncovered and hair net was observed loosely covering the ends of braids in their mid-back area.</p> <p>On 04/10/24 at 01:44 PM, the Dietary Supervisor was interviewed and stated that at the beginning of each shift they observe dietary staff to ensure that they have put on hair nets, have washed their hands, and are dressed in uniform scrubs or burgundy shirts and scrub pants. The Dietary Supervisor also stated that all hair has to be up in hair net, and if needed facial hair beard guard is worn. The Dietary Supervisor further stated that their hair is heavy so they have to wear two hair nets and they were not aware that their hair was not covered. The Dietary Supervisor stated that their clothing should have been covered with a lab coat or apron and they usually wear their lab coat on the unit but was rushing so left the lab coat behind in the kitchen.</p> <p>3. The facility policy and procedure titled Warming Unit Table Service with an effective date of February 2017 documented that the Dietary Aide will bring ice water in cup and calibrate thermometer, will take temperature of food, one pan at a time, wiping probe after each use to ensure that food is at a proper serving temperature and have designee record on log. The policy also documented that food will immediately be served after confirmation of proper food temperature.</p> <p>On 04/09/24 at 11:50 AM, Dietary Aide #1 arrived on unit B2, sanitized hands with alcohol based hand rub and put on a pair of gloves. Dietary Aide #1 was observed to have hair partially covered with pony tail at base of neck not covered by the hair net. In addition, Dietary Aide #1 was observed to be wearing a mask that did not cover their nose. Dietary Aide #1 uncovered all food items, sanitized hands with alcohol based hand rub, then placed utensils into each food item.</p> <p>On 04/09/24 at 12:07 PM, Dietary Aide #1 was observed taking the temperature of chicken parmesan only and placed the thermometer in the ice bath without first cleaning the probe. Dietary Aide #1 then served chicken parmesan, pasta, vegetables, and mechanical chicken, pasta without checking the temperature of all food items.</p> <p>Dietary Aide #1 then checked the temperature of the pasta at 12:10 PM, the vegetables at 12:12 PM, and the baked chicken at 12:15 PM. Dietary Aide #1 did not wipe the probe between checking food items.</p> <p>On 04/09/24 at 12:17 PM , Dietary Aide #1 checked the temperature of the stuffed cabbage, served mashed potato at 04/09/24 at 12:21 PM without checking the temperature, and checked the temperature of the mechanical chicken at 12:22 PM.</p> <p>On 04/09/24 at 12:26 PM, pureed chicken and vegetables were served without the temperature being checked.</p> <p>On 04/09/24 at 12:29 PM, the temperature of the pureed chicken was checked.</p> <p>On 04/09/24 at 12:32 PM, Dietary Aide #1 changed gloves, did not perform hand hygiene, and checked the temperature of the mashed potatoes.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Temperatures for the pureed vegetables, mechanical vegetables, and hamburger were not checked before the foods were served.</p> <p>Food temperatures were not recorded and the thermometer was not cleaned between each food item.</p> <p>On 04/09/24 at 12:39 PM, Dietary Aide #1 removed their gloves, unplugged steam table, removed utensils, and did not perform hand hygiene.</p> <p>On 04/10/24 at 01:05 PM, Dietary Aide #1 was interviewed and stated that they are supposed to check food temperatures before food is served to ensure it is at the right temperature but did not do this on 4/9/24 because they came to the unit late so checked the temperatures of the food one by one. Dietary Aide #1 stated that the thermometer is supposed to be cleaned after checking each food item, but they forgot to bring alcohol wipes with them. Dietary Aide #1 also stated that temperature of food is supposed to be documented in the log book on the truck inside the fridge and that sometimes they log the temperatures of food after meal service Dietary Aide #1 further stated that they are supposed to have hair fully covered and are taught to wash hands and sanitize. Masks are supposed to cover the nose, but sometimes it is a little hard to keep it in place. Dietary Aide #1 stated they do receive in-service in these things and last inservice was about 2 weeks ago.</p> <p>On 04/10/24 at 01:24 PM, the Director of Dietary Department was interviewed and stated that dietary staff are supposed to take the temperatures of food at start of service and are supposed to record the temperatures right then and there in the log book. Supervisors are supposed to make sure that staff are taking the temperatures each meal service. The Director of Dietary Department also stated that staff wash their hands in the kitchen downstairs, then they sanitize their hands when they get to the unit before they put on their gloves. Masks are supposed to be worn covering their nose and mouth in resident care areas and all hair is supposed to be covered. The Director of Dietary Department further stated that the supervisor is supposed to monitor the dietary staff and it is supposed to be a team effort.</p> <p>48876</p> <p>4. The facility policy titled Food Storage and Pantry Refrigerator Temperature effective date 2/2024 documented food stored in the pantry refrigerator, will be labeled with name, room number and the date the food was stored to ensure it is discarded after 48 hours. Commercially packed items will be discarded based on the manufacturer's expiration date. The nursing staff will remove and discard all unlabeled food each morning. The Director of Nursing and Director of Maintenance shall ensure compliance with this policy.</p> <p>On 4/9/2024 at 3:43 PM, the Director of Housekeeping was present during observation of the 3rd Floor pantry refrigerator. The refrigerator was observed to contain one unlabeled and undated ham sandwich, and 2 plastic containers of water which held numerous individual packets of coffee creamers and vegetable spreads that did not have expiration dates.</p> <p>On 4/9/2024 at 3:44 PM, Registered Nurse #5 was interviewed and stated that resident food in the pantry refrigerator should be labeled with preparation date, and name of the resident and that all foods and liquids should be discarded 48 hours after the preparation date.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/9/2024 at 3:45 PM, the Director of Nursing arrived on the 3rd Floor and observed the contents of the pantry refrigerator and stated all food in the pantry refrigerator from the facility kitchen should be dated and discarded after 48 hours.</p> <p>10NYCRR 415.14</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>49015</p> <p>Based on observations and interviews conducted during the Recertification survey from 4/7/24 to 4/12/24, the facility did not ensure that garbage and refuse were disposed of properly. Specifically, the garbage was not properly contained outside of the facility and various types of garbage were observed overflowing from the top of the dumpster.</p> <p>The finding is:</p> <p>The facility policy and procedure titled Proper Disposal of Garbage and Refuse effective date 11/2016 documented that the Food Service Director/Manager will monitor the garbage containers to ensure they are in good condition (no leaks) and with lids and evaluate loading docks, hallways, elevators that are used for both garbage and food transport are kept clean and free of foul odors.</p> <p>On 4/9/24 at 10:37 AM, an observation was made of the garbage disposal area. A large dumpster was observed containing cardboard, plastics, a white metal frame, papers, wood, and trash bags were observed hanging over edge of the dumpster. There was no covering over the dumpster. Dietary Aide #2 was observed throwing two bags of garbage into the open dumpster and placing cardboard into the compactor.</p> <p>Dietary Aide #2 was interviewed immediately and stated that the regular dumpster had been picked up and they were using this replacement dumpster which did not have a cover. Dietary Aide #2 also stated that the dumpster that was there had a door that closed, but this dumpster was temporary and did not have a cover.</p> <p>On 04/09/24 at 10:49 AM, Housekeeper #2 was observed approaching the garbage disposal area accompanied by the Director of Housekeeping. Housekeeper #2 placed four additional large garbage bags on top of the overflowing dumpster.</p> <p>The Director of Housekeeping was interviewed immediately and stated that the facility dumpster was leaking so was picked up on 4/7/24 by the vendor to be repaired. The Director of Housekeeping also stated that the vendor did not provide a cover for the dumpster, and they only expected the repair of the compactor to take one day. The Director of Housekeeping further stated that the dumpster should have been covered and they would try to cover it now.</p> <p>On 04/10/24 at 01:24 PM, the Director of Dietary Department was interviewed and stated that they were not aware of when the compactor had been changed to a dumpster as the facility usually uses a compactor. The Director of Dietary Department also stated that they do not usually go out to the garbage disposal area, but they ensure that any garbage leaving the kitchen is in covered bins.</p> <p>On 04/10/24 04:42 PM, an interview was conducted with the Administrator who stated garbage should be in covered receptacles. The Administrator also stated that when the vendor leaves an open dumpster they do not provide a covering, but will cover it when they remove the dumpster. The Administrator further stated that the vendor told them that when garbage bags are closed, no covering is needed.</p> <p>10 NYCRR 415.14(h)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37787</p> <p>Based on observation, record review, and interviews conducted during the Recertification survey from 04/07/2024 to 04/12/2024, the facility did not ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, 1) Enhanced Barrier Precautions were not maintained during wound care, and 2) the Registered Nurse failed to sanitize the blood pressure cuff between Resident #27 and #163 during Medication Administration.</p> <p>The findings are but not limited to:</p> <p>1. The Centers for Medicare and Medicaid Services (CMS) memo titled Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. Ref: QSO-24-08-NH dated 03/20/2024 documented Enhanced Barrier Precautions recommendation now includes using enhanced barrier precautions for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status-effective 04/01/2024.</p> <p>The facility policy and procedure titled Enhanced Barrier Precaution, last revised 04/01/2024, documented that all personnel, including visitors, who have direct contact with a resident with infection or colonization with a multidrug-resistant organism or with wounds and indwelling medical devices, even if the resident is not known to be infected or colonized with a multidrug will be observed enhanced barrier precautions. Enhanced barrier precautions involved gown and glove use during high-contact resident care activities, which provides opportunities to transfer multidrug-resistant organisms to staff hands and clothing.</p> <p>On 04/11/2024 at 11:32 AM, Registered Nurse #6 was obtained wound care treatment supplies and entered Resident #122's room. Registered Nurse #6 completed the dressing change appropriately and discarded soiled material in the soiled utility room. Registered Nurse #6 was not observed wearing a gown during the wound care treatment. There was no signage at the resident's room that Enhanced Barrier Precautions were in place or that personal protective equipment was required.</p> <p>On 4/11/2024 at 11:32 AM, Registered Nurse #6 was interviewed and stated that during a pressure ulcer dressing change, the nurse usually wears gloves and mask for infection control but no gown is needed.</p> <p>On 4/12/2024 at 9:45 AM, Registered Nurse #7 was interviewed and stated that staff need to have gloves, gown, and mask for the pressure ulcer dressing change. Registered Nurse #7 also stated that if the resident is on contact precautions, they will put the contact precautions signage at the entrance of the resident's room. Registered Nurse #7 further stated that if the resident has a wound and is not on contact precautions, staff go to the storage room where the personal protective equipment is kept, to get a gown, mask, and gloves for the dressing change.</p> <p>39136</p> <p>The facility records titled Residents on Enhanced Barrier Precautions last revised on 04/11/2024 documented the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Morningside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Pelham Parkway South Bronx, NY 10461	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9 residents with the multidrug-resistant organism</p> <p>9 residents with Foley catheter</p> <p>5 residents with Gastrostomy tube</p> <p>18 residents with Permacath (CVP) for Dialysis</p> <p>32 residents with wounds</p> <p>On 04/12/2024 at 8:46 AM, the Infection Preventionist was interviewed and stated that Enhanced Barrier Precautions are used for residents with Foley catheters, gastrostomy tubes, and Perma Cath. The staff is required to wear gloves and gowns during care, such as showering, changing their bedding, and performing catheter and wound care. Residents with multidrug-resistant organisms and indwelling medical devices, such as gastrostomy tubes, Foley catheters, Perma Cath, and PICC lines, are all supposed to be placed on enhanced barrier precautions. The Infection Preventionist also stated that they have residents whor receive dialysis with Permacaths, residents with gastrostomy tube, foley catheter, and chronic wounds, but these residents are not on Enhanced Barrier Precautions, because they just started to in-service their staff. The Infection Preventionist further stated they did not know that the Enhanced Barrier Precautions were supposed to be implemented already and that they planned to begin implementation on 4/15/2024. The Infection Preventionist stated that they are trying to educate all of the staff before implementing the Enhanced Barrier Precautions.</p> <p>On 04/12/2024 at 10:08 AM, the Director of Nursing was interviewed and stated that residents with indwelling medical devices and wounds are at risk of getting multidrug resistant organism. As of 04/01/2024, those residents should be placed on Enhanced Barrier Precautions. The Director of Nursing also stated that they have identified residents with indwelling medical devices and wounds who need to be placed on the Enhanced Barrier Precautions. They started in-service on the Enhanced Barrier Precautions and plan to implement it after they finished in-servicing the staff. The Director of Nursing further stated that they received the memo the last week of March and were supposed to implement the precautions effective 04/01/2024.</p> <p>On 04/12/2024 at 2:23 PM, the Administrator was interviewed and stated they did not receive the memo. They were notified by their Corporate office and initiated the policy on 04/01/2024. The Administrator stated that they cannot implement the Enhanced Barrier Precautions until all the staff are educated, and inservice of staff has started.</p> <p>44864</p> <p>2. The facility's policy titled Protocol for Disinfection of Residents Rooms and Equipment with effective date of 12/2023, documented that commonly used items such as the blood pressure machine, thermometer, blood pressure cuff, etc., should be disinfected in between use if contact with the equipment occurs.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Morningside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Pelham Parkway South Bronx, NY 10461	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/12/24 at 08:54 AM, during Medication Administration, Registered Nurse #2 was observed entering Resident's #163 room with the blood pressure machine. Registered Nurse #2 was not observed cleaning the blood pressure cuff prior to use. The blood pressure cuff was applied to Resident's #163 arm and blood pressure taken. Registered Nurse #2 then removed the blood pressure cuff and returned it to the machine, administered medication, and left the resident's room. Registered Nurse #2 then entered Resident's #27 room with the same blood pressure machine. Registered Nurse #2 placed the blood pressure cuff on Resident's #27 arm and obtained their blood pressure reading. Registered Nurse #2 did not sanitize the BP cuff in between use with Resident #163 and Resident #27.</p> <p>On 04/12/24 at 09:15 AM, Registered Nurse #2 was immediately interviewed and stated that they were supposed to clean the cuff with the germicidal wipes, and that they forgot to clean it. Registered Nurse #2 said that they were taught to clean it after every use.</p> <p>On 04/12/24 at 09:30 AM, Registered Nurse #1 was interviewed and stated that as the Supervisor on the unit, they are responsible to monitor the nurses as they administer the medications on the unit. The nurses were in-service and taught that they are supposed to clean the blood pressure cuff with the sanitizer, Clorox wipes, between resident's use. Registered Nurse #1 also stated that the nurses are initially in-serviced, and competencies are done by the educator, but the nurses are monitored periodically to ensure that they are doing the correct procedures.</p> <p>On 04/12/24 at 12:31 AM, the Registered Nurse Educator was interviewed and stated that they are responsible for educating the nurses on the mandatory tasks and policies. The nurses specifically are shown the tasks and then they do return demonstration. The Registered Nurse Educator also stated that the nurses must be able to sanitize the blood pressure cuff before and after use with each resident. The nurses are monitored through their competencies and then they would perform the task to ensure that they are doing it correctly. They are checked periodically to ensure that they are performing the skills correctly, and if any concerns are observed, a competency will be done to ensure accuracy.</p> <p>10 NYCRR 415.19(b)(4)</p>		