

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Methodist Home for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  4499 Manhattan College Parkway Bronx, NY 10471	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842</b></p> <p>Based on observation, record review, and interviews conducted during a Recertification Survey from 5/9/2024 to 5/16/2024, the facility did not ensure that services provided meet professional standards of quality. This was evident for 1 (Resident #34) of 22 total sampled residents. Specifically, Resident #34, who was cognitively impaired, was observed in their room holding a medication cup containing 4 tablets without a licensed nurse present. Resident #34 stated the Licensed Practical Nurse gave them the pills and they do not know what the small pill was for.</p> <p>The findings are:</p> <p>The facility policy titled Administration of Medications-General Guide which was revised in November 2020 documented all medications are prescribed by a physician and administered by a licensed nurse. The policy documented that it is the responsibility of the nurse to observe resident to ensure medication consumption.</p> <p>Resident #34 was admitted with diagnoses of Dysphagia, Cerebral infarction, and Type 2 Diabetes.</p> <p>The Minimum Data Set assessment dated [DATE] documented Resident #34 was moderately impaired in cognition.</p> <p>A review of the physician's order dated 4/16/2024 documented active orders for acetaminophen 325 mg tablet, give 2 tablets (650 mg) by oral route every 6 hours as needed; ascorbic acid (vitamin C) 500 milligram tablet, give 1 tablet by oral route once daily at 10:00 AM; amlodipine 10 milligram tablet, give 1 tablet by oral route once daily at 10:00 AM; and Eliquis 2.5 milligram tablet, give 1 tablet by oral route 2 times per day at 10:00 AM and 6:00 PM.</p> <p>On 5/9/2024 at 12:07 PM, Resident #34 was observed in their room holding a medication cup containing 4 tablets without a licensed nurse present. Resident #34 stated Licensed Practical Nurse #2 gave them the pills and they do not know what the small pill was for.</p> <p>On 5/9/2024 at 12:09 PM, Licensed Practical Nurse #2 was interviewed and stated they thought Resident #34 already took the pills when they left the room. They stated the medications in Resident #34's medication cup were Eliquis, Vitamin C, Amlodipine, and Tylenol. After the Surveyor interviewed Licensed Practical Nurse #2, the Licensed Practical Nurse went back to Resident #34's room to watch Resident #34 swallow the tablets and told the Resident that the small pill was Eliquis.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Methodist Home for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  4499 Manhattan College Parkway Bronx, NY 10471	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/9/2024 at 12:45 PM, Registered Nurse #4 who was also the Nurse Manager was interviewed and stated licensed nurses must observe the resident swallow their medications during medication administration before leaving. Registered Nurse #4 further stated Resident #34 was forgetful and had periods of confusion and must be supervised when taking their medication.</p> <p>On 5/15/2024 at 3:36 PM, the Director of Nursing was interviewed and stated as per facility's policy on medication administration, the licensed nurse must ensure that the resident swallow their medications before leaving.</p> <p>10 NYCRR 415.11(c)(3)(i)</p>		