

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/29/2024
NAME OF PROVIDER OR SUPPLIER  Cold Spring Hills Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  378 Syosset Woodbury Road Woodbury, NY 11797	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20757</b></p> <p>Based on observation, record review and interviews conducted during an abbreviated survey (NY00322869) initiated on [DATE] the facility failed to ensure that each resident receive treatment and care in accordance with professional standards of practice for 1 out of 5 residents (Resident #1). Specifically, on [DATE] at 6:05 PM Resident #1 experienced respiratory distress. At 7:55 PM Nurse Practitioner #1 assessed the resident and ordered the resident to be transferred to the hospital. Registered Nurse #1 did not follow the order to call for emergency medical transportation, instead Registered Nurse #1 called a non-emergency ambulance service. The company reported that it would take 2 hours for the ambulance to arrive. The resident's family intervened at approximately 9:00 PM and demanded that emergency services (911) be called. The Registered Nurse #1 did not call for emergency transportation via emergency services until 9:20 PM, causing a 1 hour and 33-minute delay in emergency transport treatment. Subsequently, Resident #1 expired while waiting for emergency transportation. This resulted in actual harm to Resident #1 with potential for serious harm for 426 other residents in the facility that is Immediate Jeopardy and Substandard Quality of Care.</p> <p>The facility's policy titled Resident Change in condition dated [DATE] documented when a significant change in a resident's condition is identified, the licensed nurse will immediately inform the charge nurse or nursing supervisor. The charge nurse or nursing supervisor will promptly assess the resident and initiate appropriate interventions. The medical provider and the resident's authorized representative will be notified about the change. The policy does not address if or when Emergency Medical Services should be notified.</p> <p>A Comprehensive Care Plan dated [DATE] titled Ventilator Dependent documented resident is on a mechanical ventilator secondary to inability to maintain adequate oxygen saturation. Interventions include evaluate for gurgling respirations, increase secretions and sputum, and inform medical doctor as indicated.</p> <p>The facility Administrator stated that when an emergency requires an ambulance there is no policy that indicates how staff are to determine which ambulance provider to contact.</p> <p>Resident#1 was admitted to the facility [DATE] with diagnoses including Anoxic Encephalopathy (lack of oxygen to the brain causing brain damage), Chronic Embolisms (blood clot), Respiratory Failure/Ventilator Dependent. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) indicating severe impairment.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 335555	If continuation sheet Page 1 of 3

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Transfer Form (form to be sent when a resident is going to the hospital dated [DATE] at 8:03 PM documented that Resident #1 was being transferred to the hospital for Respiratory Distress.</p> <p>A review of the Nurse Practitioner Progress note dated [DATE] at 8:49 PM documented at 7:55 PM Resident #1 was seen for tachycardia (rapid heartbeat), profuse diaphoresis (excessive sweating), and tachypnea (fast breathing). Resident #1 was evaluated with the respiratory team present. Oxygen saturation desaturated to 89% with the ventilator setting set to 60% oxygen, (normal oxygen saturation is 95% or greater), the ventilator oxygen setting was increased to 100% by the respiratory team to maintain residents' oxygen at ,d+[DATE]%, heart rate ,d+[DATE] (normal heart rate ,d+[DATE] beats per minute). Resident was currently on intravenous fluids. Status Post Vancomycin and Zosyn (antibiotics). Resident #1 remains unchanged. Plan of care discussed with Medical Doctor. Transfer Resident #1 to the hospital for further evaluation. Discussed with nursing staff.</p> <p>The Nurse Practitioner #1 note dated [DATE] documented at around 9:00 PM Resident's family showed up and inquired as to why Resident #1 was still in the facility and not at the hospital. Resident's #1 family requested for emergency services to be called. Emergency services were called immediately. Resident #1 was unresponsive when Emergency Medical Services arrived, and they pronounced Resident #1 deceased .</p> <p>A review of Resident #1's Death Certificate dated [DATE] at 9:40 PM, documented the immediate cause of death as cardiorespiratory arrest due to respiratory failure.</p> <p>A review of the Prehospital Care Report filled out by the emergency medical transport technician documented that Emergency Medical Services were notified on [DATE] at 9:20 PM that Resident #1 had breathing problems. Emergency services ambulance staff were at Resident #1's bedside at 9:33 PM. Resident #1 was found in semi-Fowlers position (the head of the bed is elevated ,d+[DATE] degrees) in a hospital bed at the facility and was pulseless. Resident #1 is ventilator dependent, whom according to staff became tachycardic while being evaluated by nurse practitioner at 7:45 PM. Staff increased their ventilator settings, after no improvement called a private ambulance for transport to the hospital. After 1 hour waiting for a private ambulance, the staff decided to call 911. Resident #1 was pronounced deceased after an electrocardiogram (a test that records the hearts electrical activity) was attached to Resident #1 and was found to be in asystole (when the hearts electrical system fails entirely, which causes your heart to stop pumping).</p> <p>During a telephone interview on [DATE] at 4:35 PM, unit Registered Nurse # 1, who worked on the evening shift on [DATE], stated at 8:00 PM, Nurse Practitioner #1 stated to transfer Resident #1 to the hospital. Registered Nurse #1 stated they called the Richmond County Ambulance at 7:50 PM-8:00 PM. Registered Nurse #1 stated they told Nurse Practitioner #1 that there was a 2-hour timeframe for the ambulance. They stated the Nurse Practitioner did not say anything. They stated that at around 9:00 PM the next of kin came and told them to call Emergency Medical Services. Emergency Medical Services came to the facility within 10 minutes. The Emergency Medical Services stated there was no reason to take Resident #1 because the resident had already died .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Nurse Practitioner #1 on [DATE] at 4:44 PM they stated they assessed Resident #1 and called the Medical Doctor. The Medical Doctor stated to transfer Resident #1 to the hospital. They stated the order was to be carried out right away. Resident #1 was diaphoretic and tachycardic and they wanted Resident #1 to go to the hospital for further evaluation. During a re-interview with Nurse Practitioner #1 on [DATE] at 10:46 AM they stated they expected their order to transfer Resident #1 to the hospital to be carried out immediately. They stated they were not informed that the ambulance would take 2 hours. They stated had they been aware they would have called Emergency Medical Services immediately.</p> <p>During an interview on [DATE] at 12:57 PM with Medical Director, who is also the attending physician for Resident #1, they stated Resident #1 was ventilator dependent and was experiencing respiratory distress and was tachycardic. The Medical Director stated they gave the order for Nurse Practitioner #1 to transfer Resident #1 to the hospital at approximately 7:55 PM. The Medical Director stated that Resident #1's transfer to the hospital was delayed.</p> <p>During an interview with the Director of Nursing on [DATE] at 7:15 PM, they stated on [DATE] in the evening, Resident #1 had a change in condition, but the staff felt Resident #1 was stable. The Director of Nursing stated they reviewed the record on [DATE], after Resident #1 expired and identified no issues. They stated Resident #1 was a chronic tracheostomy resident. When the Nurse Practitioner and Registered Nurse assessed Resident #1 there was no need to call Emergency Medical Services. They stated they would not have called an ambulance because Resident #1 was stable, they would have called the regular Richmond County ambulance ambulette.</p> <p>During an interview with the Administrator on [DATE] at 7:30 PM they stated on [DATE] in the evening, Resident #1 had a change in condition, but the staff felt Resident #1 was stable. The facility will develop a policy related to calling an ambulance for an immediate need for transfer. The facility will train all medical providers and licensed nursing staff related to an emergency transfer policy.</p> <p>10 NYCRR 483.25</p>		