STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335559	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024, the facility did not ensure that a comprehensive person-centered care plan was developed and implemented for each resident that includes measurable objectives and timeframes to meet each resident's medical and nursing needs. This was identified for one (Resident #246) of three residents reviewed for pain management. Specifically, Resident # 246 had a physician's order for a Lidocaine (a medication used to treat pain) patch to be applied to the resident's lumbar area (lower back). On 3/15/2024 during the medication pass observation, the medication nurse applied a Menthol patch to the resident's lower back instead of the Lidocaine patch. The finding is: The facility's policy titled Medication Administration, last revised 5/2023, documented that medication shall be administered as prescribed by the attending physician. Medication must be administered in accordance with the written orders of the attending physician. Prior to administering the resident's medication, the nurse should compare the drug and dosage scheduled on the resident's electronic medical record with the drug label. Resident #246 was admitted with diagnoses including Wedge Compression Fracture Fourth Lumbar Vertebra (a bone of the spinal column in the lower back), Low Back Pain, and Anxiety. The 1/18/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 8, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented no pain in the last five days and that the resident received scheduled and as-needed pain medications. A physician's order dated 1/11/2024 documented to apply a Lidocaine 4% topical patch, place one patch on the skin (lumbar area) in the morning, and remove and discard the patch within 12 hours, for a diagnosis of Pain. A comprehensive care plan titled Pain Management, effective 1/11/2024, documented under the Etiology section: Fracture (L4- the 4th lumbar vertebra), back injury, Osteoarthritis as evidenced by back pain, and the resident's verbalization of pain. Interventions included to administer medications as ordered by the physician. (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: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 255 Warner Avenue Roslyn Heights, NY 11577	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/15/2024 at 8:39 AM Licensed Practical Nurse #1 prepared medications to be administered to Resident #246. Licensed Practical Nurse #1 prepared Acetaminophen 325 milligrams, two tablets (an as-needed oral pain medication), and a Menthol Frosty Heat Patch, 5% Menthol. The surveyor asked Licensed Practical Nurse #1 if the Menthol Frosty Heat Patch was the same as the Lidocaine 4% topical patch, which was the physician-ordered patch. Licensed Practical Nurse #1 stated they usually use these Menthol patches and did not re-check the physician's order in the electronic medical record. The nurse applied the Menthol patch to Resident #246's lower back. A review of the March 2024 Medication Administration Record revealed that Licensed Practical Nurse #1 signed for applying the Lidocaine 4% topical patch on 3/15/2024. Registered Nurse #1, the unit supervisor, was interviewed on 3/15/2024 at 2:02 PM. Registered Nurse #1 stated Licensed Practical Nurse #1 should have applied the Lidocaine patch that was ordered because the Lidocaine patch and the Menthol patch are not the same and not interchangeable. A nursing progress note dated 3/15/2024 at 3:11 PM, written by Registered Nurse #5 documented that during the medication pass the resident was scheduled to receive a Lidocaine 4% topical patch. The nurse applied a Menthol 5% patch. The resident's Physician was made aware and ordered to apply a Menthol topical patch 5% as needed to the resident's lower back. The Lidocaine 4% patch order continues. The resident was also informed and agreed with the plan. The resident's skin was assessed, and no redness or irritation was observed. The Director of Nursing Services was interviewed on 3/18/2024 at 9:32 AM and stated the primary care physician was notified of the medication error right away and an order was obtained to apply the Menthol patch as needed and to continue the Lidocaine patch as a standing order. A medication error report was completed and Licensed Practical Nurse #1 was provided education counseling. The Director of Nursing Services stated the nurse should have applied the Lidocaine patch as per the physician's order. 10 NYCRR 415.11 (c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 255 Warner Avenue Roslyn Heights, NY 11577	

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on record review and interviews conducted during the Recertification and Abbreviated Survey (Complaint # NY 00320409) initiated on 3/14/2024 and completed on 3/21/2024, the facility did not ensure that they developed and implemented an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners, and effectively transition the resident to post-discharge care. This was identified for one (Resident #466) of one resident reviewed for Discharge. Specifically, Resident #466 was discharged from the facility on 7/17/2023 with no confirmation of acceptance from a Home Care Agency. On 7/18/2023 the referred Home Care Agency denied Home Healthcare Services for Resident #466. Consequently, Resident #466 did not receive acceptance for Home Healthcare Services until 7/25/2023, eight days after they were discharged from the facility. The finding is: The facility policy titled, Discharge Plan dated 11/2017 documented the post-discharge plan will include patient diagnosis, history, follow-up instructions, functioning status, and arrangements for home care and equipment that is needed. Resident #466 was admitted with diagnoses that included Symptomatic Epilepsy, Cerebral Palsy, and Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 00 which indicated the resident had severely impaired cognition. The Minimum Data Set assessment documented active discharge planning already occurring for the resident to return to the community. The Comprehensive Care Plan titled; Discharge Planning dated 6/26/2023 documented that the goal for the resident was to return home. The interventions included but were not limited to ordering equipment and a referral to a home care agency. The progress note, written by Social Worker #2, dated 7/12/2023 documented Resident #466 was to be discharged home on 7/17/2023 as per the family's request. The resident lives at home with family, and a referral for Homecare will be made. The progress note, written by Social Worker #2, dated 7/14/2023 at 3:27 PM documented that they spoke to Resident #466's Managed Care Plan. The representative from the Managed Care Plan stated that everything was in place and requested a copy of the resident's Discharge Summary. At 3:28 PM Social Worker #2 documented that a Home Care Referral will be made. The Discharge Plan and Instructions form dated 7/17/2023 documented that the resident required home care for Physical Therapy, Nursing care, and needed Aide care. A progress note, written by Licensed Practical Nurse #8, dated 7/17/2023 documented the resident was discharged from the unit in stable condition with family, and discharge instructions to follow up with the Primary Medical Doctor were provided to the family member. The resident's family member verbalized understanding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 255 Warner Avenue Roslyn Heights, NY 11577	

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Post Discharge Follow-Up Note, written by Social Worker #2, dated 7/18/2023 at 5:15 PM documented they spoke to the resident's family; the resident was referred to a Home Care agency but was denied due to lack of skilled services. The resident was referred to an agency for Physical and Occupational Therapy and was approved. A referral will be made to other agencies for getting skilled Nursing Services. The progress note, written by Social Worker #2, dated 7/20/2023 at 9:32 AM documented that they spoke to the Resident's Managed Care Plan regarding the resident's Home Care referral. The resident was denied due to the lack of skilled need and the need for a nurse. The resident was accepted for Physical Therapy and Occupational Therapy with another Home Care Agency, but the start of care date was mid to end of August 2023. Social Worker #2 requested a referral to other agencies for an earlier start of care date. The progress note, written by Social Worker #2, dated 7/20/2023 at 3:45 PM documented that Social Worker #2 reached out to a Home Care Agency for Physical and Occupational Therapy and discussed the resident's family's request for an earlier start date. The Home Care Agency representative explained that there was no earlier date available. The progress note, written by Social Worker #2, dated 7/25/2023 at 10:17 AM documented Social Worker #2 spoke with the resident's Managed Care Plan and inquired about authorization for the Home Care Agency to start services (earlier). The Case Manager/Discharge Coordinator was interviewed on 3/19/2024 at 11:59 AM and stated for discharge planning a meeting is held with the Nursing, Rehabilitation, and Social Worker along with the Resident and family members to discuss the resident's discharge, 72 hours before the resident's discharge. When a resident is being discharged with Home Care Services, the facility will submit a referral to an agency that the family agrees with, and the facility will make sure that the resident is accepted by the Home Care Agency. The Home Care Agency will then communicate with the facility if the resident was accepted for Home Care services along with the start date of the Home Care services. The communication held with the Home Care Agency is documented in the resident's medical record by the Social Worker or the Discharge Coordinator. The Case Manager/Discharge Coordinator stated they do not always document in the resident's medical record because they do not always have time to do so. The Case Manager/Discharge Coordinator was re-interviewed on 3/19/2024 at 12:37 PM and stated a Home Care referral was made for Resident # 466; however, they could not recall the date of the referral. The Case Manager/Discharge Coordinator stated after the referral a confirmation was not obtained to ensure Home Care services for Resident #466. The Case Manager/Discharge Coordinator stated that the Discharge Coordinator or the Social Worker was responsible for ensuring that confirmation for Home Care services was received and documented in the resident's medical record prior to the resident's discharge. The Case Manager/Discharge Coordinator stated after Resident #466 was discharged from the facility, Home Care Agency #1 called the facility on 7/18/2023 to notify them that they (Home Care Agency #1) would not take the case because Resident #466 had no skilled needs. The Case Manager/Discharge Coordinator stated that Resident #466 was approved for Home Care eight days after they were discharged from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Social Work was interviewed on 3/19/2024 at 3:05 PM and stated that Resident #466 had developmental disabilities and required a skilled level of care. The resident's Social Worker sent a referral to a Home Care Agency for continuing services. After Resident #466 was discharged from the facility on 7/17/2023, the liaison at the Home Care Agency called the facility on 7/18/2023 and informed the facility that they found no skilled needs for Resident #466 and the resident would not qualify for a Home Health Aide. The Director of Social Work stated that the facility should have confirmed the provision of Home Care services before the resident was discharged from the facility. 10 NYCRR 415.11(d)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observation, record review and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024 the facility did not ensure that residents receive proper treatment and assistive devices to maintain hearing abilities. This was identified for one (Resident #155) of four residents reviewed for communication. Specifically, Resident #155 required hearing aid devices for both ears. Resident #155 lost the left ear hearing aid. The resident had multiple physician orders on 1/18/2024, 1/23/2024, 2/03/2024, 2/20/2024, 3/11/2024, and 3/19/2024 for an Audiology Consult. The Audiology appointment was not confirmed until 3/19/2024, two months after the first physician's order was written. The finding is: Resident #155 was admitted with diagnoses that included Type 2 Diabetes, Hypertension, and Congestive Heart Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15 which indicated the resident had intact cognition. The Minimum Data Set assessment documented the resident had minimal difficulty hearing and was not utilizing the hearing aids. A review of the physician's orders from January 2024 through March 2024 revealed the resident had multiple physician orders on 1/18/2024, 1/23/2024, 2/03/2024, 2/20/2024, 3/11/2024, and 3/19/2024 to obtain an Audiology Consult. Resident #155 was observed in their room on 3/14/2024 at 9:30 AM. Resident #155 was observed wearing a hearing aid in their right ear. When the surveyor greeted the resident, they had to adjust the tonal quality for the resident to hear the greeting. Resident #155 was interviewed on 3/14/2024 at 9:31 AM and stated over a year ago they lost their left hearing aid when they were in the hospital. Now they only have the right ear hearing aid and it does not always work well. Resident #155 stated the facility staff is aware that they (Resident#155) need new hearing aids because they have told the nursing staff on several occasions that the left ear hearing aid is lost and the right ear hearing aid does not function properly. Registered Nurse Supervisor #3 was interviewed on 3/19/2024 at 8:52 AM and stated that Resident #155 lost their left hearing aid in the hospital over a year ago and the insurance would not pay for a new hearing aid at that time and the hospital also refused to pay for the lost hearing aid. The resident was also not willing to pay for the new hearing aid as it was not their fault that the hearing aid was lost at the hospital. Registered Nurse Supervisor #3 stated that the social worker was aware that the resident's hearing aid was lost and may qualify for a new hearing aid at this time. Registered Nurse Supervisor #3 was re-interviewed on 3/20/2024 at 8:54 AM and stated the resident had an appointment set for an Audiology Consult; however, did not know the date of the appointment. Registered Nurse Supervisor #3 stated that when a consult order is obtained, the nursing supervisor is responsible for filling out the consult form and the unit clerk is responsible for making an appointment with the Consultant's office, arrange the transportation, and notify the charge nurse of the appointment date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 3/20/2024 at 10:47 AM and stated there has been a change with the unit clerk that caused the delay in obtaining the Audiology consult for Resident #156. The Director of Nursing Services stated that it is not acceptable to have a resident wait this long for an Audiology appointment. 10 NYCRR 415.12(a)(3)(b)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34798

Based on observations, interviews, and record review during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024 the facility did not ensure that each resident received adequate supervision to prevent accidents. This was identified for two (Resident #240 and Resident #101) of seven residents reviewed for Accidents. Specifically, 1) on 3/15/2024 Resident #240 was observed unsupervised outside of the building on the front sidewalk in the facility's designated smoking area. The resident was smoking but was not one of the residents that had been assessed and determined to be a safe smoker. The facility was not aware the resident had exited the building; and 2) Resident #101 was observed with multiple medication tablets in a medication cup and an inhaler on their overbed table on 3/14/2024 and 3/20/2024. There were no staff members in the vicinity. Resident #101 was not assessed to safely self-administer medications.

The findings are:

1) The facility's policy titled Out on Pass, dated 7/2022, documented residents that request an independent out on pass order need to be reviewed by the interdisciplinary team to determine the reason for out on pass and if the facility could assist in meeting the resident's needs to avoid being alone when out on pass; the resident's cognitive and physical ability to safely function independently in the community for several hours; and the risk factors that a resident has that could result in a negative outcome if allowed out on pass independently. Based on interdisciplinary team review, if a resident is deemed safe to go out on pass independently, the primary physician will review and give final approval and a physician's order will be placed for independent out on pass.

The facility's policy titled, Non-Smoking Facility, last reviewed/revised 4/28/2023, documented that the facility is non-smoking, but there are certain residents admitted prior to 4/28/2023 who are active smokers and considered grandfathered and are permitted to smoke. For the grandfathered smokers, the facility will provide supervision as needed.

The facility's undated Receptionist Job Description documented duties and responsibilities which included operating paging/telephone system, directing all incoming calls, greeting visitors and directing to appropriate office/room, giving directions to visitors, ensuring guests/visitors abide by existing rules, observing television cameras for illegally parked cars, viewing cameras and monitoring/supervising any issues, assisting residents to their destination, and being alert and aware of residents in and around the first-floor lobby and outside the main front entrance.

Resident #240 was admitted with diagnoses including Diabetes Mellitus, Hypertension, and Major Depressive Disorder. The 2/22/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set documented that the resident did not use tobacco.

A physician's order dated 3/9/2024 documented that Resident # 240 may go out on pass with a responsible party.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 3/18/2024 documented Resident # 240 may ambulate on the nursing unit using a rolling walker with assistance; wheelchair use for off unit as needed. A comprehensive care plan titled Smoking, effective 2/19/2024, documented on 2/19/2024 that resident reports that they quit smoking about a month ago. The Social worker offered the resident a smoking cessation program, but the resident declined. Resident #240 was educated on the no smoking policy and the resident indicated they have no current desire to smoke. On 3/15/2024 at 2:24 PM, the surveyor was present at the facility's front reception/security guard desk area reviewing the smoking supplies that are left at the front desk with security. Receptionist/Security Guard #1 was present, who stated the smoking materials are left in a plastic box at the front desk for the residents to retrieve before they go out the front door to the designated smoking area. An approved smoker, Resident #172 was observed retrieving their smoking supplies and stated they had to sign a form before they went out and give the form to the Receptionist/Security Guard. The large video screen, that the Receptionist/Security Guard uses to monitor the smokers as well as various cameras located around the building, including the rear patio, was observed. The Receptionist/Security Guard was observed answering multiple phone calls at the desk. At this time, the lobby/reception area was very busy with guests coming into the building and leaving, and various staff members passing by. The surveyor went outside to talk to the residents who were smoking in the designated smoking area on 3/15/2024 at 2:33 PM. There were three residents smoking, two of the facility-approved residents (Resident # 172 and another resident who was not part of the survey sample) and a third resident (Resident #240). Resident #240 was sitting in their wheelchair and stated they keep their cigarettes in their pocket and did not know anything about a smoking contract. Resident # 240's name was not included on the list of names on the smoking paraphernalia box at the Receptionist/Security Guard desk. On 3/15/2024 at 3:05 PM Receptionist/Security Guard #1, a security company contract employee, was interviewed. Receptionist/Security Guard #1 stated sometimes it is very busy at the front desk and in the lobby. Receptionist/Security Guard #1 stated they are required to monitor the residents who are coming and going through the front entrance, including the smokers. Receptionist/Security Guard #1 stated they did not see Resident #240 exit the building to go outside. A progress note, written by the Social Work Director, dated 3/15/2024 at 4:42 PM documented Resident #240 was observed smoking on this date (3/15/2024). The Social Work Director met with the resident to re-review the smoking policy and procedure. Resident #240 stated they were admitted a few weeks ago and saw smokers when they went out on pass with their family and had a desire to smoke. During the out on pass with their family, Resident #240 took cigarettes from the home setting. Resident #240 stated that when they observed other residents smoking outdoors in the front of the building when out on pass, they assumed they could smoke. Resident #240 was interviewed on 3/18/2024 at 8:15 AM. Resident #240 stated they went outside on their own on Friday (3/15/2024) right after they finished their rehabilitation session which is located adjacent to the front lobby. Resident #240 stated no one wheeled them outside and they can self-propel their wheelchair. Resident #240 stated they saw other residents smoking when they went out on pass and thought it was okay to smoke. Resident #240 stated they did not tell anyone they were going outside, and they were not aware that they could not go outside by themselves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #1 (the Social Worker for Resident #240's unit) was interviewed on 3/18/2024 at 8:21 AM. Social Worker #1 stated whenever a resident leaves the unit, they should inform the staff and the staff should know each resident's whereabouts. The Assistant Director of Nursing Services was interviewed on 3/18/2024 at 8:25 AM. The Assistant Director of Nursing Services stated Resident #240 does not a physician's order order to go outside independently and does not have privileges to go outside in front of the building on their own. The Assistant Director of Nursing Services stated if Resident #240 wants to go outside, they can go outside on the rear patio. The Assistant Director of Nursing Services stated residents who go out independently require a physician's order. Registered Nurse #1, the unit supervisor, was interviewed on 3/18/2024 at 8:39 AM. Registered Nurse #1 stated for a resident to go outside in front of the building independently, the Rehabilitation Department must evaluate the resident for safety and the Physician must issue an independent out on pass order. Registered Nurse #1 stated residents can not go outside in front of the building if they do not have an order. Registered Nurse #1 stated if a resident attempts to leave through the front entrance and does not have an independent out on pass order, then security must intervene. The Rehabilitation Director was interviewed on 3/18/2024 at 9:09 AM. The Rehabilitation Director stated if a resident has an order to go out on pass with a responsible party, then that resident has not been assessed yet to go out independently. The Rehabilitation Director stated Resident #240 has been expressing that they want to go home, so they (Resident #240) have been getting training to be independent, but the resident has not reached that status yet. The Rehabilitation Director stated going on the back patio area is safer and is different than going out front. Out front of the facility requires an assessment because the area is very busy. There are deliveries, cars, and families coming and going. The Rehabilitation Director stated even if a resident can maneuver a wheelchair, they would have to be assessed by the Rehabilitation Department to be out front independently. The Rehabilitation Director stated Resident #240 has not been assessed to go out front independently and that the resident still needs assistance. The Director of Nursing Services was interviewed on 3/18/2024 at 1:53 PM. The Director of Nursing Services stated security is responsible to monitor who is outside in front of the building and also responsible to monitor the camera surveillance. The Director of Nursing Services stated alert and oriented residents can go from floor to floor on their own, but should not go outside in front of the building without the proper assessment. Receptionist/Security Guard #2, the facility's regularly assigned 8:00 AM-4:00 PM receptionist, was interviewed on 3/20/2024 at 8:34 AM. Receptionist/Security Guard #2 stated their job is both the receptionist and security guard. They monitor the smoking area through cameras and also monitor who comes and goes out of the building. They have to know who goes out and who comes into the facility. Residents are not allowed to freely leave the facility. The residents who are allowed to smoke must sign a form to go out. Residents can not just leave. Receptionist/Security Guard #2 stated they have to multitask and it is possible that a resident could go out without being seen by them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 255 Warner Avenue Roslyn Heights, NY 11577	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 3/20/2024 at 9:29 AM. The Administrator stated the regularly assigned 8:00 AM - 4:00 PM Receptionist/Security Guard #2 was off on Friday, 3/15/2024, and Receptionist/Security Guard #1, who is from a contracted agency, was working that shift. The Administrator stated the Receptionist/Security Guard's job is to monitor who comes and goes in and out of the building, answer phones, greet visitors, monitor security cameras located all over the building through a video screen at the front desk, and periodically monitor the smokers. If there are any immediate concerns identified on the video screen, the Receptionist/Security Guard must contact the nursing supervisor to intervene or call for an immediate response through the paging system. The Administrator stated that it is the Receptionist/Security Guard's responsibility to monitor the front entrance and that the Receptionist/Security Guard should have stopped Resident #240 from going out front. Receptionist/Security Guard #1 was re-interviewed on 3/21/2024 at 12:00 PM. Receptionist/Security Guard #1 stated they did not see Resident #240 go out in front of the building on 3/15/2024. Receptionist/Security Guard #1 stated one of their responsibilities is to monitor the front entrance. Receptionist/Security Guard #1 stated the phone calls at the desk are overwhelming. 49245 2) A facility's policy and procedure titled, Medication Administration last revised on 5/2023 documented that medication must be administered following the written order of the attending Physician. Medications may not be set up in advance and must be administered within one hour before and or one hour after their prescribed time. During routine medication passes, the nurse should position the medication cart inside the doorway of the resident's room. Drawers should be facing inward. The nurse administering the medications must initial the resident's Electronic Medical Record, on the appropriate line and date for that specific day. Resident #101 was admitted with diagnoses that included Chronic Kidney Disease, Restless Leg Syndrome, and Asthma. A Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #101's Brief Interview for Mental Status (BIMS) score was 15 which indicated that Resident #101 was cognitively intact. The Minimum Data Set assessment documented that Resident #101 was taking high-risk drug classes including Anti-Anxiety, Anti-Depressant, Hypnotic, Anticoagulant, Opioid, and Hypoglycemic medications. The physician's order dated 12/18/2023 and last renewed on 3/14/2024 documented to administer the following medications: -Sertraline 25 milligrams tablet, give 5 tablets (125 milligrams) daily for Depression. -Eliquis 5 milligrams tablet, give one tablet twice a day for Atrial Fibrillation. -Famotidine 20 milligrams, give one tablet daily for Gastroesophageal Reflux Disease. -Ventolin Hydrofluoroalkane (HFA) 90 microgram/actuation aerosol inhaler, give 2 puffs every 6 hours as needed for Asthma and shortness of breath. A Comprehensive Care Plan dated 7/16/2022 and last revised on 1/3/2024 for Multiple Medication Use, documented interventions that included but were not limited to monitor for side effects; review medication monthly; monitor vital signs as ordered; and monitor for Gastrointestinal (GI) discomfort. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan for Polypharmacy dated 12/13/2023 documented that the resident will not experience adverse side effects related to the use of nine or more medications. Interventions included to administer medications as ordered, and observe for any adverse reactions and notify the Physician. A review of the Electronic Medical Record revealed that Resident #101 was not assessed to self-administer their medications including the inhalers. During an observation on 3/14/2024 at 11:02 AM, Resident #101 was sitting in a wheelchair in their room. A medication cup containing seven tablets, and an inhaler that had no label, were observed on the resident's bedside table. There was no staff member present in the resident's room. Resident #101 was interviewed on 3/14/2024 at 11:02 AM and stated that they take a while to take the medications and they do not want to be rushed into taking the medications. Resident #101 stated that the medication cup contained medications for their Depression, stomach, and heart, and the inhaler was for their Asthma. Licensed Practical Nurse # 4 was observed knocking on the resident's room door on 3/14/2024 at 11:20 AM and asked Resident #101 if they had taken all the medications. Resident #101 stated that they would take their medications as soon as possible and that they were just getting ready for the day. Licensed Practical Nurse #4 was re-interviewed on 3/14/2024 at 11:30 AM and stated that Resident #101 does not abide by the medication schedule set up by the facility. Licensed Practical Nurse #4 stated that Resident #101 has scheduled medications at 9:00 AM and they usually administer medications to Resident #101 at around 10:00 AM. Resident #101 usually refuses some of their medications and will tell the nurses that they do not feel good, and will take their medications later. Licensed Practical Nurse #4 stated that this morning (3/14/2024) they went to the resident's room multiple times to see if Resident #101 had taken their medications. Registered Nurse #1, the Unit Supervisor, was interviewed on 3/14/2024 at 1:30 PM and stated that residents should not have any medications in their rooms unless there is a Physician's order for the resident to self-administer their medications. During a subsequent observation on 3/20/2024 at 10:38 AM Resident #101 was observed in their room sitting in a wheelchair. Two inhalers with no label, were observed on the bedside table. No staff member was present in the room. Resident #101 was interviewed on 3/20/2024 at 11:00 AM and stated they had the inhalers with them for a long time and did not know who gave the inhalers to them. Resident #101 stated they keep both inhalers in their pocket. Today, 3/20/2024, they took a shower in the morning, emptied their pocket, and placed the inhalers on the bedside table. Resident #101 stated that they knew how to use the inhaler and used the inhalers during transportation from the Dialysis treatment to the facility when they felt out of breath. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 255 Warner Avenue Roslyn Heights, NY 11577	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent interview with Licensed Practical Nurse #4 was completed on 3/20/2024 at 11:24 AM. Licensed Practical Nurse #4 stated that they did not know why Resident #101 had two inhalers in their possession. The inhaler prescribed by the Physician (Ventolin) was kept in the medication cart and was not administered to the resident on 3/20/2024. Resident #101 did not ask for the inhaler when Licensed Practical Nurse #4 gave the resident their medications that morning. A subsequent interview with Registered Nurse #1 was completed on 3/20/2024 at 11:30 AM. Registered Nurse #1 stated that Resident #101 had two inhalers in their room. Registered Nurse #1 stated they removed both inhalers from the resident's room on 3/20/24 after the surveyor found the inhalers on the bedside table. One of the inhalers (Albuterol) was not ordered by the Physician and was empty; the second inhaler was Ventolin. Resident #101 has a Physician's order for the use of Ventolin on an as-needed basis. Registered Nurse #1 stated that the Ventolin inhaler that was removed from the resident's room was not supplied by the facility. Registered Nurse #1 stated they did not know how and when the resident got the inhalers. The Director of Nursing Services was interviewed on 3/20/2024 at 11:45 AM and stated that all nurses should administer medications according to the scheduled times and according to the doctor's orders. The Director of Nursing Services stated they expected nurses to follow the facility's guidelines for dispensing the medications. The medications can be administered one hour before and an hour after the scheduled medication administration time. The Director of Nursing Services stated that unless a resident has a Physician's order to self-administer their medications, all medications should only be administered by the nurses. 10 NYCRR 415.12(h)(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observation, record review and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024 the facility did not ensure that a resident who is fed by enteral means receives the appropriate treatment, care, and services to prevent complications of enteral feeding. This was identified for one (Resident #161) of one resident reviewed for Tube Feeding. Specifically, on 3/15/2024 at 12:03 PM, Resident #161's tube feeding and hydration (water) bags were observed hanging without labels including the resident's name, and the time the tube feeding was initiated. The finding is: The facility's Gastrostomy Tube Feeding policy dated 5/2023 documented that the facility will provide gastrostomy tube feedings to residents according to Physician's orders. Step 11 of the procedure documented to fill out the label that is included with the pouch to affix to both the feeding bag and the water bag. Resident #161 was admitted with diagnoses of Cerebral Infarction, Aphasia, and Hemiplegia. The Significant Change Minimum Data Set assessment dated [DATE] documented that Resident #161 had a Brief Interview for Mental Status score of 3, indicating the resident had severely impaired cognition. Resident #161 utilized a feeding tube and received 51% or more of the total calories through tube feeding. Resident #161 also received 501 cubic centimeters or more fluid intake per day by tube feeding. The Physician's Orders dated 3/15/2024 documented to administer Tube Feeding Formula Diabetisource 1500 milliliters per 24 hours, 1 bag via Percutaneous Endoscopic Gastrostomy tube pump. Rate: 75 milliliters per hour, start at 5:00 PM and end at 1:00 PM or until completed. Flush 35 milliliters of water every hour with a total minimum fluid of 2200 milliliters per 24 hours. Total Calories Provided 1800 Kilocalories per 24 hours, total Protein Provided: 90 grams per 24 hours, and total water Provided 1924 milliliters per 24 hours. The Tube feeding care plan dated 12/21/2022 and revised on 2/8/2024 documented that Resident #161 was at nutritional/hydration risk related to Hemorrhage, Diabetes, Percutaneous Endoscopic Gastrostomy tube (12/7/2022), right-sided weakness status post Stroke, motor Aphasia, and Dysphagia. Resident #161 had a need for therapeutic tube feeding formula and tube feeding as the primary source of nourishment and hydration. Interventions included to check the feeding pump before each feeding and to check the feeding tube patency/position before each feeding. On 3/15/2024 at 12:03 PM, Resident #161 was observed with a tube feed and hydration bag hanging without a label (including the resident's name and start time of the feeding). The feeding formula was observed to be placed on hold on the enteral pump machine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #6 was interviewed on 3/15/2024 immediately after the observation at 12:05 PM and stated that the tube feed bag was hung by the evening shift nurse and should have been labeled. Resident #161 is scheduled for feedings from 5:00 PM to 1:00 PM the next day. Licensed Practical Nurse #6 stated that the tube feed and water bag should be labeled with Resident #161's name, the start time of the feed, and the amount of the feeding tube in cubic centimeters per hour. Licensed Practical Nurse #6 stated that they paused the tube feed moments ago so that the assigned Certified Nurse Aide could get Resident #161 dressed for the day. Licensed Practical Nurse #6 stated that they knew that the tube feeding and the water bags were not labeled by the nurse who hung the tube feeding the day before. Licensed Practical Nurse #6 stated they did not get around to labeling the bag themselves and would now. Licensed Practical Nurse #7, the 3:00 PM-11:00 PM nurse, was interviewed on 3/18/2024 at 9:25 AM. Licensed Practical Nurse #7 stated that they usually hang Resident #161's tube feeding bags on the 3:00 PM to 11:00 PM shift. Licensed Practical Nurse #7 usually writes on the tube feeding bag and water bag with a Sharpie marker and includes the Resident's name, feed volume, date, start time, and flow rate directly on the tube feeding bag. Licensed Practical Nurse #7 stated that on 3/15/2024 they must have forgotten to label the tube feeding and water bags. The Director of Nursing Services was interviewed on 3/18/2024 at 1:45 PM. The Director of Nursing Services stated that the evening shift nurse should have labeled the water and tube feed bags with the name, date, feed rate, and start time for Resident #161. 10 NYCRR 415.12(g)(1-7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 03/14/2024 and completed on 03/21/2024, the facility did not ensure that each resident received care and services for the provision of parenteral fluids consistent with professional standards of practice and in accordance with physician orders and the comprehensive person-centered care plan. This was identified for one (Resident #216) of one resident reviewed for Hydration. Specifically, on three separate occasions, 03/14/2024 at 10:02 AM, 03/15/2024 at 10:30 AM, and 03/18/2024 at 09:12 AM, Resident #216 was observed with a Peripheral Intravenous Catheter in their left hand; however, there was no Physician's order for the placement and the care of the Intravenous Catheter. The finding is: The facility policy's titled Guidelines for Preventing Parenteral/Intravenous Catheter-Related Infections documented that residents receiving Parenteral/Intravenous therapy will receive therapies safely, timely, and efficiently in according with the Physician's orders. Additionally, Parenteral/Intravenous lines will be maintained according to evidence-based practices to maximally reduce the risk of infection associated with Parenteral/Intravenous Catheters. Resident #216 was admitted with diagnoses that included Heart Failure, Type 2 Diabetes Mellitus, and Vascular Dementia. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15 which indicated the resident had intact cognition. The Comprehensive Care Plan titled, Intravenous Therapy: Hydration dated 03/15/2024 documented to monitor the Intravenous Catheter site every shift and as needed. The Physician's order dated 3/15/2024 documented to administer Sodium Chloride 0.9% Intravenous Solution, give 80 cubic centimeters per hour intravenously, 1000 milliliters only. A review of the resident's medical record revealed there was no Physician's order for the insertion, assessment, or care of the Peripheral Intravenous Catheter. A review of the Treatment Administration Record revealed no documentation related to the care and assessment of the Peripheral Intravenous Catheter. The Physician's order dated 3/19/2024 documented the removal of the Peripheral Intravenous Catheter. Resident #216 was observed to have a Peripheral Intravenous Catheter in their left hand on 3/14/2024 at 10:02 AM, with no fluids infusing. Resident #216 was interviewed on 3/14/2024 at 10:02 AM and stated they were not sure why and for how long they had the Peripheral Intravenous Catheter in their left hand. The resident further stated that they were told by nursing staff to keep the Intravenous catheter covered so it doesn't fall out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #216 was observed 3/15/2024 at 10:30 AM and on 3/18/2024 at 9:12 AM with the Peripheral Intravenous Catheter in their left hand. The resident's Peripheral Intravenous Catheter had a dressing in place with no date. No fluids were infusing through the catheter. On 3/18/2024 at 9:12 AM Registered Nurse Supervisor #3 was present during the observation. Registered Nurse Supervisor #3 was interviewed on 3/18/2024 at 9:13 AM and stated they were not sure why Resident #216 had a Peripheral Intravenous Catheter in their left hand. Registered Nurse Supervisor #3 stated they just reviewed the Physician's order dated 3/15/2024 which indicated to administer Sodium Chloride Intravenously; however, there was no order in place for the placement, care, or assessment of the Peripheral Intravenous Catheter. Registered Nurse Supervisor #3 stated they were unsure who placed the Peripheral Intravenous Catheter in the resident's left hand. Registered Nurse Supervisor #3 further stated that the Peripheral Intravenous Catheter should be assessed every shift and the assessment should be documented in the electronic medical record. The Director of Nursing Services was interviewed on 3/18/2024 at 1:46 PM and stated there should have been an order for the placement, assessment, and care of the Peripheral Intravenous Catheter. The Director of Nursing Services stated that the assessment should have been conducted and documented on the Treatment Administration Record every shift. Physician # 1 was interviewed on 3/18/2024 at 2:28 PM and stated intravenous fluids were ordered for Resident #216 to help with maintaining hydration because the resident forgets to eat and drink. Physician #1 stated the intravenous fluids were started last month. The Peripheral Intravenous Catheter should have been removed after fluids were finished infusing. Physician # 1 stated that not assessing the Peripheral Intravenous Catheter could result in complications such as phlebitis (inflammation of the walls of veins), infection, and skin breakdown. 10 NYCRR 415.12(k)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34798 Based on record review and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024, the facility did not ensure that for each resident, as-needed orders for psychotropic drugs were limited to 14 days, and there was a rationale and indication for the duration of the medication. This was identified for one (Resident #68) of one resident reviewed for Choices. Specifically, on 2/9/2024 Resident #68 was prescribed Ambien (a sedative medication to help people sleep) 10 milligrams to be taken as needed. The order was not limited to 14 days and there was no rationale and indication for the continued use of the medication documented in the physician's notes. The finding is: The facility's undated policy titled Use of Psychoactive Medications and Gradual Dose Reductions documented psychoactive medications will be used in accordance with F758 of the State Operations Manual and shall minimize use of as-needed psychoactive medications whenever possible and ensure use is in accordance with F758 of the State Operations Manual. Resident #68 was admitted with diagnoses including Leukemia, Anxiety Disorder, and Depression. The 1/12/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. There were no documented mood or behavior concerns in the Minimum Data Set assessment. A physician's order dated 2/9/2024 documented to administer Ambien 10 milligram tablet, give one tablet by oral route once daily at bedtime as needed for adjustment Insomnia. The physician's order was not limited to 14 days for Ambien on an as needed basis. A review of the February 2024 and March 2024 Medication Administration Records revealed that the resident received Ambien every night from 2/9/2024 to 3/18/2024. A pharmacist medication regimen review dated 2/28/2024 documented the resident currently has an active order for Zolpidem (Ambien) as needed without a specified stop date. Please note that Centers for Medicare and Medicaid Services guidelines do not allow open-ended orders for as-needed psychotropics. Please evaluate and consider discontinuing, if appropriate. Physician #1, who was the resident's primary care physician, progress note dated 3/14/2024 documented under the action/plan section of the note: Insomnia-Ambien as needed. Physician #1 responded to the pharmacist's recommendation on the medication regimen review form on 3/17/2024, disagreeing with the consult. The Physician documented: per resident's adamant wishes. Physician #1's progress note dated 3/17/2024 documented under the action/plan section: Insomnia-Ambien as needed; resident wants the ability to refuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician #1 was interviewed on 3/18/2024 at 12:30 PM. Physician #1 stated they did not know of the requirement of the 14-day limit for as-needed psychotropics and the need to provide a rationale for continued use and duration. Physician #1 stated they were new to the Nursing Home role and the resident requested the medication be ordered as needed because they (Resident #68) wanted the option to refuse. Physician #1 stated the resident could refuse the medication even if the medication is a standing order, but the resident wanted the medication ordered as needed. The Medical Director was interviewed on 3/19/2024 at 11:35 AM. The Medical Director stated they spoke to Physician #1 and provided education. The Medical Director also stated they spoke to Resident #68 and educated the resident about the regulation and that the resident can always refuse the Ambien if they do not want it. A comprehensive care plan titled Insomnia was initiated on 3/19/2024. The resident's Insomnia was due to Anxiety and Obsessive-Compulsive disorder. Interventions included to medicate as per the physician's order, make the environment conducive to sleep, and to avoid heavy meals and caffeine before bedtime. 10 NYCRR415.12(I)(2)(ii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024 the facility did not ensure that all drugs used were labeled in accordance with professional standards including expiration dates, and that the medications were stored at proper temperatures. This was identified for three of twelve medication carts reviewed during the Medication Storage task. Specifically, 1a) an open Lantus Solostar insulin pen for Resident #194 was observed on 3/19/2024 in the medication cart with an open date of 2/23/2024, more than 28 days. 1b) Resident # 518's unopened Admelog insulin pen was observed stored in the medication cart which was supposed to be stored in the refrigerator at a temperature range of 36-46 degrees Fahrenheit 1 c) Resident #3's unopened Humalog insulin pen was observed stored in the medication cart which was supposed to be stored in the refrigerator at a temperature range of 36-46 degrees Fahrenheit. The finding is: The facility's policy titled, Medication Storage revised on 12/2008 documented medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents. Expired, discontinued, and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. Medications will be stored at the appropriate temperature in accordance with the pharmacy and/or manufacturer's labeling. Appropriate temperatures will be determined as per the following: Controlled Room Temperature: 59-86 degrees Fahrenheit. Cold Place: 36-46 degrees Fahrenheit. Medications requiring refrigeration will be stored in a refrigerator that is maintained between 36-46 degrees Fahrenheit. 1a) A Physician's order for Resident # 194 dated 2/12/2024 documented to administer Lantus Solostar U-100 insulin 100 unit/milliliter subcutaneous pen. Inject 25 units by subcutaneous route at bedtime. During the medication storage task with Licensed Practical Nurse #2 on 3/19/2024 at 8:45 AM on Unit 2 South a used Lantus insulin pen was observed in the medication cart. The insulin pen was opened more than 28 days with an opening date of 2/23/2024. Licensed Practical Nurse #2 from Unit 2 South was interviewed on 3/19/2024 at 9:30 AM and stated that they did not know why Resident # 194's Lantus pen was still in the medication cart. Licensed Practical Nurse #2 stated that after the insulin pen is first opened it is only good for 28 days and should have been discarded. 1b) A Physician Order for Resident #518 dated 3/13/2024 documented to administer Admelog Solostar U-100 Insulin lispro 100 unit/milliliter subcutaneous pen. Accucheck (fingerstick blood sugar check) four times a day, before meals and at bedtime with insulin coverage for blood sugar readings as follows: 60-200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, below 60 or above 400 notify the doctor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1c) A Physician Order for Resident #3 dated 2/8/2024 documented to administer Humalog Kwikpen U-100 Insulin 100 unit/milliliter subcutaneous. Inject 10 units by subcutaneous route with breakfast, 10 units by subcutaneous route at lunch and 16 units subcutaneous route with dinner. During the medication storage task with Licensed Practical Nurse #3 on 3/19/2024 at 9:15 AM on Unit 1 South an Admelog Solostar Insulin pen and a Humalog Insulin pen were both unopened, not dated, and were in the medication cart. Licensed Practical Nurse # 3 from Unit 1 South was interviewed on 3/19/2024 at 9:40 AM and stated that they were not sure why the two unopened insulin pens for Resident # 518 and Resident #3 were in the medication cart and not in the refrigerator. Licensed Practical Nurse # 3 stated that unopened insulin pens should be stored in the refrigerator. Registered Nurse #1, the Manager for Unit 1 South and 2 South, was interviewed on 3/19/2024 at 11:30 AM and stated that the medication nurses are responsible for making sure that all medications in the medication carts are properly labeled, and that all expired medications are discarded. The Pharmacist was interviewed on 3/19/2024 at 11:33 AM and stated that all medications labeled refrigerate upon delivery should be stored in the refrigerator. The stated that Lantus insulin should be discarded after the 28th day once opened. Medications that have specific guidelines for storage, including insulin pens, must be followed. Medications that are not stored or discarded properly can lose their efficacy and the residents who use them will not receive the desired effect. A policy provided by the Pharmacist titled, Insulin Expiration Updates dated 10/2022 documented that all insulins should be stored in the refrigerator until opening and protected from light. Once opened or removed from the refrigerator for storage in the medication cart, the insulin should be dated as it will expire in a specified time as per the manufacturer. The policy documented: Expiration Upon Opening or Removing from Refrigerator: Lantus- 28 days. Admelog and Humalog- 28 days. The Director of Nursing Services was interviewed on 3/20/2024 at 8:23 AM and stated that all medications in the medication cart should be checked for proper labeling and the expired medications should be discarded as per the manufacturer's guidelines. The Director of Nursing Services further stated that all medications, including the insulin pens, should be stored at appropriate temperatures according to the manufacturer's guidelines and pharmacy recommendations. 10 NYCRR 415.18(e)(1-4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024, the facility did not ensure that residents were assisted in obtaining routine dental care. This was identified for one (Resident #2) of one resident reviewed for Dental. Specifically, Resident #2 had a Physician's Order for a dental consult dated 7/6/2023; however, the resident was not seen by the Dentist until 2/4/2024. Additionally, during a subsequent dental visit on 2/16/2024, the Dentist made a recommendation for the resident to have six tooth extractions so that a full upper and lower denture could be made. These recommendations were never addressed by the facility until it was brought to the facility's attention on 3/19/2024 by the Surveyor. The finding is: The facility's undated policy for Dental Department documented that residents will be assisted to obtain regular and emergency dental care. Resident #2 has diagnoses which include Type 2 Diabetes Mellitus and Peripheral Vascular Disease. The resident was readmitted from the hospital on 7/6/2023. The annual Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderately impaired cognitive skills for daily decision making. Resident #2 was interviewed on 3/14/2024 at 10:22 AM and stated that they were waiting for dentures. Resident #2 stated that they were seen by the Dentist a while ago and would like some follow-up because they still did not know when they would be getting their new teeth. The Nursing Progress Note dated 7/6/2023, written by the 3:00 PM-11:00 PM Registered Nurse Supervisor (Registered Nurse #2), documented that the resident was admitted from the hospital, their vision and hearing were adequate, and they had no teeth. The Physician's Order dated 7/6/2023, obtained by Registered Nurse #2, documented for the resident to have a Dental Consult. This Physician's Order was renewed by the Physician on 8/3/2023, 9/8/2023, 10/13/2023, 11/17/2023, 12/16/2023, and 1/27/2024 and was discontinued on 2/1/2024. The Physician's Order dated 2/1/2024 obtained by Registered Nurse #3 documented for the resident to have a Dental Consult. The Initial Dental Exam dated 2/4/2024 documented that some of the resident's natural teeth were lost and they did not have/did not use dentures or a partial plate. The resident had broken teeth and no work needed to be done. The Physician's Order dated 2/16/2024, obtained by the Registered Nurse Minimum Data Set Assessor #1, documented for the resident to have a Dental Consult for possible tooth extraction and new dentures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunharbor Manor	255 Warner Avenue Roslyn Heights, NY 11577

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dental Progress Note dated 2/16/2024 documented that the resident was seen regarding dentures and that they would need 6 tooth extractions in the lower jaw and then a full upper/full lower denture could be made. A review of the resident's medical record on 3/19/2024 at 11:25 AM revealed no documented evidence that the recommendations made by the Dentist on 2/16/2024 were ever addressed. Registered Nurse #2 was interviewed on 3/19/2024 at 2:27 PM and stated that they were the Registered Nurse Supervisor who admitted the resident on 7/6/2023 when they (Resident #2) returned from the hospital. Registered Nurse #2 stated that after they obtain any Physician's Order for a Dental Consult, a handwritten consult form is completed and placed in the Dentist's folder in the nursing office. When the Dentist comes to the facility, they (Dentist) collect the Consult form and complete the Consult. Registered Nurse #2 stated that they could not remember if they filled out the consult form for Resident #2, but they should have. Registered Nurse #3 was interviewed on 3/19/2024 at 3:20 PM and stated that while doing an audit on 2/1/2024 of the 3 South unit, they realized that despite the resident having a Physician's Order since 7/6/2023 to have a Dental Consult, the resident was never seen by the Dentist and should have been. Registered Nurse #3 stated that at that time, they discontinued the old Dental Consult Physician's Order dated 7/6/2023 and put in a new Physician's Order on 2/1/2024 for the resident to be seen by the Dentist and filled out a new Dental Consult form and put the completed form in the Dentist's folder in the nursing office. Registered Nurse #3 stated that they were not aware that the resident was seen again by the Dentist on 2/26/2024 who made recommendations for the resident to have 6 tooth extractions, but they should have been. Registered Nurse Minimum Data Set Assessor #1 was interviewed on 3/19/2024 at 3:50 PM and stated that when they had met with the resident to assess them for their annual Minimum Data Set assessment on 2/16/2024, the resident had mentioned that they would like to have a nice smile after showing Assessor #1 that all of their (Resident #2) teeth were broken. Assessor #1 stated that it was at this time they put a Physician's Order into the computer for the resident to be evaluated by the Dentist for possible dentures. The Dental Comprehensive Care Plan initiated on 4/5/2023 was updated on 2/20/2024 by the Registered Nurse Minimum Data Set Assessor #1. Annual Assessment: Resident remains edentulous with broken roots on mandibula (jaw). The resident was seen by Dentist on 2/16/2024 regarding dentures. As per the Dentist, the resident requires 6 tooth extractions in the lower jaw in order to have dentures. The Registered Nurse Minimum Data Set Assessor #1 was re-interviewed on 3/20/2024 at 10:05 AM and stated that they had updated the resident's Dental Comprehensive Care Plan on 2/20/2024 and documented what the Dentist wrote in their evaluation of the resident on 2/16/2024, but never checked the resident's medical record to confirm if the recommendations were carried out. The Registered Nurse Minimum Data Set Assessor #1 stated that when the Dentist completes a consult, they would tell a Registered Nurse Supervisor of any recommendations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER: Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 255 Warner Avenue Roslyn Heights, NY 11577	

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dentist was interviewed on 3/20/2024 at 11:40 AM and stated that when they (Dentist) make recommendations for a resident, they usually tell the Nurse sitting at the Nurse's station; however, the Dentist could not recall if they (Dentist) did that for this resident, but they should have. The Dentist stated that the nursing staff should have contacted the resident's Primary Physician to make them aware of their (Dentist) recommendations because the resident required medical approval for the tooth extractions. The Director of Nursing Services was interviewed on 3/21/2024 at 9:50 AM and stated that the Dental Consult should have been completed as per the Physician's Orders and if the Dentist makes any recommendations, they (Dentist) usually tell one of the Nursing Supervisors. The Nurse should have then followed up on the recommendations made by the Dentist for Resident #2. 10 NYCRR 415.17(a-d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 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 observations, record review, and interviews during the Recertification Survey initiated on 3/14/2024 and completed on 3/21/2024, 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 #252) of four residents reviewed for Infection Control. Specifically, Resident #252 had a physician's order for Contact Precautions for an infection of Clostridium Difficile(C-Diff). During an observation on 3/14/2024 of the resident's room, the Contact Precaution signage that included instructions for the use of specific Personal Protective Equipment was not posted in a conspicuous location outside of the resident's room. There was a Droplet Precaution sign stored in the pocket of a caddy that was hanging outside the resident's door and the Droplet Precaution signage was not visible to the staff and visitors. The finding is: The facility's policy titled Infection Control Precaution: Transmission-Based Precautions, revised on 5/2023 documented that Transmission-Based Precautions shall be used when caring for residents who are suspected to have communicable diseases or infections that can be transmitted to others. Based on the Centers for Disease Control definitions, three types of Transmission Based Precautions are airborne, droplet, and contact. In addition to standard precautions, the facility shall implement contact precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or residents' care items in the environment. The facility will implement a system to alert staff to the type of precaution the resident requires. A yellow caddy will be placed over the resident's door or a container with a drawer to hold the gowns, gloves, and mask. Contact Precaution sign to be placed inside the clear pocket of the over-the-door caddy or on the resident's door. Resident #252 was admitted with diagnoses including Osteomyelitis, Enterocolitis due to Clostridium- Difficile infection, and Malignant Neoplasm of the Breast. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. A physician's order dated 2/28/2024 documented to administer Ceftriaxone (antibiotic medication) 2 grams solution for injection once daily for three days. Provide a private room due to positive Clostridium-Difficile. Administer Vancomycin 50 milligrams/milliliter, give 2.5 milliliters by oral route every 6 hours for 40 days with the start date of 3/5/2024. A Comprehensive Care Plan (CCP) dated 3/5/2024 for Clostridium Difficile Toxin Infections documented interventions that included to always maintain Contact Precautions, maintaining infection control practices through proper handwashing, and to provide a private room due to Clostridium Difficile infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Sunharbor Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Warner Avenue Roslyn Heights, NY 11577	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/14/2024 at 9:20 AM, a caddy was observed hanging on the door with Personal Protective Equipment including gloves, gowns, and masks. There was no signage posted outside the resident's room indicating that the resident was on Transmission-Based Precautions. A laminated signage was observed sticking out of the caddy; however, the signage was not visible to staff and visitors to identify the type of Transmission-Based Precaution that Resident #252 required. Registered Nurse #1 and Licensed Practical Nurse #2 posted the signage that was inside the caddy outside the resident's room immediately after an observation made by the surveyor on 3/14/2024. The signage read, Droplet Precaution-Visitors please see Nurse before entering. Clean Hands before entering and leaving the room. If contact with secretions/body fluids likely, use gown and gloves. Eye cover if splash/sprays likely. Licensed Practical Nurse #2 was interviewed on 3/14/2024 at 9:25 AM and stated that they did not know why the Transmission-Based Precaution sign was not posted outside Resident #252's room and was kept inside the caddy instead. Licensed Practical Nurse #2 stated that the precaution sign was not visible to staff and visitors and should have been. Licensed Practical Nurse #2 stated they were aware that Resident #252 was on Contact Precautions for Clostridium Difficile infection. Licensed Practical Nurse #2 stated they must use gowns and gloves prior to entering the resident's room, and any equipment used by Resident #252 must be designated for Resident #252's room only. Registered Nurse #1, the unit Supervisor, was interviewed on 3/14/2024 at 9:39 AM and stated that the Unit Supervisor is responsible for placing the appropriate Transmission-Based Precaution signage for any resident who is on isolation precautions. Registered Nurse #1 stated not posting the Contact Precaution signage, and then putting the wrong sign (Droplet Precaution) was an oversight. The Assistant Director of Nursing Services, who is the facility's Infection Control Preventionist, was interviewed on 3/18/2024 at 8:44 AM. The Assistant Director of Nursing Services stated that residents on Transmission-Based Precautions should have appropriate signage outside their rooms. There are specific signs for Contact, Droplet, and Airborne Precautions. Resident #252 was on Contact Precautions due to Clostridium-Difficile infection. The unit supervisor should have placed the appropriate Contact Precaution sign outside the resident's room. The Assistant Director of Nursing Services stated they did not know why the signage was never posted outside Resident #252's room door and why the wrong isolation precaution sign was posted afterward. The Director of Nursing Services was interviewed on 3/20/2024 at 8:30 AM and stated that the correct signage should be posted outside the residents' door who are supposed to be on Transmission-Based Precautions for the staff and visitors to know what precautions to follow. 10 NYCRR 415.19(a)(1-3)