

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  Alpine Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  755 E Monroe Street Little Falls, NY 13365	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>48052</p> <p>49831</p> <p>Based on record review and interview during the recertification and abbreviated survey conducted 4/29/2024-5/3/2024, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 2 of 3 residents (Residents #71 and #233) reviewed. Specifically, Resident #71 remained in the facility after discontinuation of Medicare Part A services and the facility did not provide the resident with a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) for Medicare Part A as required; and Resident #233 was discharged home and the facility did not provide the resident with a Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) for Medicare Part A as required.</p> <p>Findings include:</p> <p>The undated facility policy, Medicare Cut Letters documented Medicare cut letters would be issued by Minimum Data Set staff, working with the financial coordinator, in a timely fashion and the Financial Coordinator would upload the notice into the system. A Notice of Medicare Non-coverage was given when a resident was going to be terminated from skilled services and going home once cut. The notice must be issued a minimum of 2 days before cutting. When a resident on Part A services still had days remaining, but was being cut, and was staying in the facility under custodial care, they must be provided a Notice of Medicare Non-coverage and a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage.</p> <p>The Center for Medicare and Medicaid Services form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055, expiration date 1/31/26, documented a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (form 10055) must be issued by providers to beneficiaries in situations where Medicare payment is expected to be denied. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending.</p> <p>The Center for Medicare and Medicaid Services form-10123 instructions documented a Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage to enrollees receiving skilled nursing no later than two days before the termination of services.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1) Resident #71 was admitted to the facility with diagnoses including peripheral vascular disease, diabetes mellitus, and anxiety. The 11/3/2023 Minimum Data Set assessment documented it was a Skilled Nursing Facility Prospective Payment System Part A discharge (end of stay) assessment.</p> <p>An 11/1/2023 social service note documented a care conference was held on 11/1/2023 and it was determined the resident would remain at the facility for long term care.</p> <p>The Notice of Medicare Non-coverage documented the last covered day of Resident #71's Medicare Part A skilled services was 11/3/2023. The notice was delivered via phone to the resident's representative on 11/1/2023 at 2:08 PM. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The facility did not provide the resident a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Centers for Medicare and Medicaid Services-10055 for Medicare Part A as required.</p> <p>2) Resident #233 was admitted to the facility with diagnoses including a fracture and diabetes. The 1/18/2024 Minimum Data Set assessment documented it was a Skilled Nursing Facility Prospective Payment System Part A discharge (end of stay) assessment.</p> <p>The 1/18/2024 social service progress note documented the resident was discharged home with family and services were in place.</p> <p>The SNF Beneficiary Protection Notification Review documented the resident's Medicare Part A skilled services start date was 12/15/2023 and the last covered day of Part A service was 1/18/2024. A Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services-10123 was not provided with an explanation, no letter was generated prior to discharge.</p> <p>During an interview on 5/2/2024 at 4:15 PM, Financial Coordinator #32 stated the process for issuing Notice of Medicare Non-coverage documents was initiated by the therapy department. The process for issuing a Notice of Medicare Non-coverage was determined in the utilization review meeting. Following the Utilization Review process, the Financial Coordinator #32 was notified by therapy of service discontinuation for residents. The resident or resident representative was provided 48 hours advance notice of service discontinuation. Financial Coordinator #32 stated they were unaware Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverages needed to be issued until recently. They stated Resident #71 remained in the facility after their benefit end date of 11/3/2023 and was not issued an Advanced Beneficiary Notice of Medicare Non-coverage because they were not aware of this requirement. Financial Coordinator #32 stated Resident #233 was not issued a Notice of Medicare Non-coverage prior to their discharge because they were not aware that a notice had to be provided to residents who were discharged from the facility while still covered by their Medicare benefit. They stated if a resident was not provided a Notice of Medicare Non-Coverage or a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage, they would not know their appeal rights and may have a potential loss of benefits.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/2/2024 at 4:43 PM, the Administrator stated issuing the Notice of Medicare Non-Coverage, and the Advanced Beneficiary Notice of Non-Coverage was previously the responsibility of the Minimum Data Set person. When that person left, it became the responsibility of the finance department. They were unaware that the Financial Coordinator did not realize that Notices of Medicare Non-Coverage had to be issued to discharging residents or they had to issue Skilled Nursing facility Advanced Beneficiary Notice of Non-coverages. They stated the notices needed to be issued so the residents knew their services were ending.</p> <p>10 NYCRR 483.10 (g) (18)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27522</b></p> <p>48895</p> <p>Based on record review, observation, and interview during the recertification and abbreviated (NY00309906 and NY00338730) surveys conducted 4/29/2024-5/3/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 2 of 2 resident units (north and south units) reviewed. Specifically, the South Unit hallways and common areas smelled of urine and had sticky floors; there was a stained ceiling tile on the South Unit; resident room [ROOM NUMBER] had sticky floors and strips of missing paint; resident room [ROOM NUMBER] had strips of missing paint; the South unit shower room had tiles missing around the drain; the floor in resident room [ROOM NUMBER] was unclean and sticky; resident rooms [ROOM NUMBERS] were cluttered with refuse; and resident rooms [ROOM NUMBERS] smelled of urine.</p> <p>Findings include:</p> <p>The facility policy Quality of Life - Homelike Environment, dated 5/2018, documented the facility staff and management should maximize, the characteristics of the facility that reflected a personalized, homelike setting. These characteristics include a clean, sanitary, and orderly environment and pleasant, neutral scents.</p> <p>The facility policy Dust Mopping, dated 7/2016, documented all areas were maintained in a clean and pleasant manner. Removal of litter, dust, and light soil from floors was a daily maintenance procedure, or in preparation for wet mopping. For resident rooms, dust mopping started at the entrance of the room, and a broom and dustpan were used to pick up trash and dirt.</p> <p>The facility policy Facility Cleaning - General Policy and Procedure, dated 7/2016, documented floors were mopped daily. Floors should be dust mopped then wet mopped using an approved diluted cleaning agent in mop water.</p> <p>The following observations were made on the South Unit:</p> <ul style="list-style-type: none"> <li>- on 4/29/2024 at 10:47 AM, the lobby area between rooms [ROOM NUMBERS] had a strong urine odor.</li> <li>- on 4/29/2024 at 11:31 AM, the area between rooms [ROOM NUMBERS] had a strong, sharp, sour smell.</li> <li>- on 4/29/2024 at 11:19 AM, the floor outside room [ROOM NUMBER] was sticky. Inside of room [ROOM NUMBER] there were long strips of paint missing along the wall where the television was.</li> <li>- on 4/29/2024 at 11:22 AM, room [ROOM NUMBER] had strips of paint missing along the wall under the window.</li> <li>- on 4/29/2024 at 11:57 AM, the South Unit shower room had missing tiles around the drain.</li> <li>- on 4/29/2024 at 11:58 AM, the South Unit hallway floors were sticky.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 4/30/2024 at 9:12 AM, the ceiling above the puzzle table between rooms [ROOM NUMBERS] had dark colored stains.</p> <p>- on 4/30/2024 at 8:38 AM, the seating area near room [ROOM NUMBER] smelled of urine.</p> <p>- on 4/30/2024 at 12:42 PM, the seating area at the far end of the unit, between rooms 114, 116, 119, and 121 had sticky floors.</p> <p>The following observations were made on the North Unit:</p> <p>- on 4/29/2024 at 10:16 AM, room [ROOM NUMBER] had unclean, sticky floors.</p> <p>- on 4/29/2024 at 10:21 AM, room [ROOM NUMBER] had a tray table cluttered with books, food, soda, and water bottles; paper, cups, and tubing on the floor; a half-eaten donut and chip bag were on the chair; bags of empty bottles were in the corner; and there were personal items on the bed.</p> <p>- on 4/29/2024 at 11:45 AM, room [ROOM NUMBER] smelled of urine.</p> <p>- on 4/29/2024 at 1:05 PM, room [ROOM NUMBER] smelled of urine.</p> <p>- on 5/1/2024 at 7:54 AM, room [ROOM NUMBER] had crumbs on the floor between the bed and window, and dirty linen on the floor by the door.</p> <p>- on 4/29/2024 at 1:09 PM, room [ROOM NUMBER] had a chip bag, cups and tubing, a chip tube container, and piles of clothing on the floor; there was pizza crust on the over bed table; a large chip bag on the chair; and a bag of bottles in the corner of the room.</p> <p>- on 4/30/24 at 9:26 AM and 1:14 PM, Resident #59's room had a cup and crumbs on the floor. Resident #59 stated the debris had been on the floor for 3 days and they wished the facility would clean their room.</p> <p>During an interview on 5/1/2024 at 9:11 AM, certified nurse aide #10 stated there were bags of food on the ground in room [ROOM NUMBER], and it was not homelike to have crumbs on the floor of a resident room. They stated there were a lot of resident rooms that were not maintained in a homelike environment. Certified nurse aide #10 stated and this could lead to odors, bugs, and it was an infection control issue.</p> <p>During an interview on 5/2/2024 at 11:35 AM, the Director of Maintenance stated if a room was cluttered, they would advise staff to clean the room. They stated that resident rooms should not have trash on the floor. They expected each resident room to be swept each day, and other area of the rooms should also be cleaned. The housekeeping staff should wipe down resident rooms with bleach wipes and dust the surfaces every day. If food was left in resident rooms, it could lead to pests and infection control issues.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/02/24 at 4:20 PM, the Director of Environmental Services stated the floor tiles were missing on the floor in the South Unit shower room. Resident room walls could be damaged by chairs and wheelchairs. The damaged sections of walls, like resident room [ROOM NUMBER] and resident room [ROOM NUMBER], should be repaired as soon as they were observed. Resident rooms should also be checked for damaged walls and other environmental concerns when the rooms were deep cleaned. The damaged wall in the North Unit housekeeping room was repaired. The resident room call bell cord plates came out of the wall very easily and could have been pulled out by accident. If urine and other odors were detected in resident rooms or hallways it would be immediately cleaned. The resident hallways were cleaned daily. They stated it was important for the facility to be maintained for residents and for staff.</p> <p>10 NYCRR 415.29(j)(1)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>48052</p> <p>Based on record review and interview during the recertification and abbreviated (NY00333325) surveys conducted 4/29/2024-5/3/2024, the facility did not ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for 1 of 1 resident (Resident #37) reviewed. Specifically, Resident #37 eloped (exited the facility without being detected) out of an egress door, and the incident was not thoroughly investigated.</p> <p>Findings included:</p> <p>The facility policy Completing an Accident/Incident Investigation Guidelines effective 8/21/2020 documented it was the responsibility of the facility to immediately initiate and conduct a thorough investigation that included appropriately managing the investigation to ensure a factual and objective accounting of the events to determine if potential abuse, neglect, or mistreatment occurred. The investigation included protecting the resident, gathering evidence, interviewing witnesses to the event, analyzing the documents obtained, addressing any gaps of the incident, documenting the gaps, concluding based on the facts, and taking corrective action. Staff who conducted interviews with residents, staff, and visitors who were witnesses of an incident were to take clear notes or organize transcription of the interview. The summary of the investigation was to include a synopsis, the factual details, and a conclusion that included if a reasonable cause threshold has been established.</p> <p>Resident #37 had diagnoses including Pick's disease (a type of dementia) and pseudobulbar affect (uncontrollable laughing or crying). The 2/2/2024 Minimum Data Set documented the resident had severely impaired cognition, had physical behavioral symptoms directed towards others on 1-3 of 7 days, was independent with ambulation, did not wander, and had a wander/elopement alarm used daily.</p> <p>The comprehensive care plan did not include risk for elopement prior to 2/11/2024.</p> <p>A 2/11/2024 at 11:42 AM Resident Accident/Incident Report completed by licensed practical nurse #3 documented Resident #37 was found outside the window of Resident #23's room. The resident walked out the back egress door. The resident was observed walking out the door by a visiting family member (unidentified). They were alerted immediately by the family member of Resident #23 and Resident #37 was brought back inside. Vital signs were stable and there was no injury. The Director of Nursing was notified at 11:45 AM.</p> <p>Investigation Statements included:</p> <p>- on 2/11/2024 certified nurse aide #4 documented they were walking down the hallway after providing care to another resident when they were alerted by another resident's family member that Resident #37 was standing outside their parent's window. They and licensed practical nurse #3 went outside to get the resident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 2/11/2024 licensed practical nurse #3 documented they were alerted by a certified nurse aide that Resident #37 was outside another resident's window. They went to the end of the hall and there was a resident's family member (unidentified) sitting there. The family member stated the resident had just walked out the door. The resident was standing at the window, wearing pants, a long-sleeved shirt, and grip socks. The temperature outside was 40 degrees with no snow on the ground. The resident's vital signs were taken, no injuries were noted, and the resident denied being cold.</p> <p>- on 2/11/2024 the Director of Maintenance documented all egress doors were checked, functioning, and they could not find any issues with the doors.</p> <p>The monthly maintenance log for the magnetic door locks on the egress doors documented the doors were last checked on 2/2/2024.</p> <p>A 2/12/2024 investigation summary completed by the Director of Nursing documented facility staff was alerted by a visitor that Resident #37 was outside at their parent's window. The resident had last been seen by facility staff standing outside another resident's door inside the facility shortly before that. Licensed practical nurse #3 went outside to get the resident and brought the resident back in where an assessment was conducted. Licensed practical nurse #3 reported there was a family member (unidentified) of another resident sitting at the end of the hall who watched Resident #37 exit the facility through the egress door at the end of the South Hall. The facility conducted a head count to ensure residents were accounted for. The door locked appropriately when staff brought the resident back inside, but the door did not sound when the resident exited. The resident's wander alert device was immediately checked and found to be functioning. The egress door was not a wander alert device activated door. Inspection of the door revealed no device was used to prop the door or that the door was utilized by staff. The Maintenance Director was called to the facility and checked all doors for proper function. Elopement education and the importance of checking the security of the doors was conducted. The investigation revealed there was cause to believe alleged resident abuse, mistreatment, or neglect occurred.</p> <p>The investigation did not include if the facility determined how the resident was able to exit the facility. There were no documented witness statements from the family member of Resident #23 who reported the resident was outside the window, or the unidentified visitor who witnessed the resident going outside.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/2024 at 11:58 AM, the Director of Maintenance stated the egress doors open by a passcode put into the keypad next to the door. They stated the door would not open if a resident pushed on the door and did not enter the code. The doors stayed unlocked for five seconds and when the door was opened, an alarm sounded after five seconds. They stated the alarm continued to sound until the magnetic strips met and the code was entered into the keypad again. They stated the alarm was loud and if it sounded staff would hear it. If the door was not opened, the door relocked after five seconds. They stated they audited the egress doors every month to ensure functionality. They stated prior to Resident #37's elopement, the licensed practical nurses and the charge nurses could have the code to the doors. Staff were not supposed to use the egress doors. They did not have a system that logged when the doors were opened. After the elopement the door was set to five seconds to alarm if opened and relock if not opened. The door could not be propped without the alarm sounding. The door could not be tampered with unless the maintenance department or a vendor was working on it. During the interview, the Maintenance Director stated they had to verify information and returned at 12:17 PM. They stated at the time of the elopement, there was a malfunction on the timer of the door. They could not state what happened or what the timer was set at. They did not have a vendor look at the door as they were able to fix the issue themselves, so a vendor was not called.</p> <p>During a follow up interview on 5/2/2024 at 11:29 AM, the Maintenance Director stated they determined a door malfunction by looking at the door. They checked the wires and there was nothing frayed so they determined it was a malfunction. They could not explain how the door malfunctioned or what the malfunction was. They did not know if the staff who retrieved the resident had noted if the keypad was green which indicated the door was unlocked and unalarmed. There was not a way to leave the door unlocked and unalarmed. They stated they had reviewed the camera, but they were not able to see details of the door when they zoomed in because the picture became pixelated (blurred with a grid of squares).</p> <p>During an interview on 5/1/2024 at 1:11 PM, certified nurse aide #4 stated no staff should go out the egress doors. They had previously been informed of the door code but did not remember what it was. Resident #37 had been following them around that day, but they had been busy. They asked Resident #37 to wait outside another resident's room when they went in to provide care so Resident #37 would not follow them in. They were alerted by another resident's family that Resident #37 was outside their family member's window. They did not know how or why the door was unlocked as no one had used it on their shift. The door did not alarm when the resident exited. They and licensed practical nurse #3 went out the back egress door and retrieved the resident. The door was unlocked when they went out of it and did not alarm. They stated a resident's family member (unidentified) who was sitting next to the egress door told them they thought Resident #37 was a family member exiting the facility. They did not know when the door was unlocked or how long it had been unlocked.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 5/1/2024 at 1:35 PM, licensed practical nurse #3 stated they were alerted by a staff member and a resident's family member that Resident #37 was outside. They went and retrieved the resident from outside. They stated they went through the egress door on the South unit, the same door the resident went out of. They stated the door was unlocked and the keypad light was green. No alarm sounded when they went through the door. They stated they relocked the door by entering the code when they returned inside. The keypad light turned red when it was locked, and they double checked by pushing on the door which did not open. They were unsure if all staff had the code to the door, but the code was in the supervisor book in the front of the building. They were unaware how long the keypad stayed green and was unlocked and unalarmed. The family member who sat at the end of the hall and watched the resident walk out the door stated to them they had watched Resident #37 walk out the door and thought they were someone's family member.</p> <p>During an interview on 5/1/2024 at 2:03 PM, the Director of Nursing stated on 2/11/2024 licensed practical nurse #3 was the nurse Supervisor on shift and called to inform them Resident #37 had eloped outside. They were informed that licensed practical nurse #3 was leaving the dining room when they were told by another staff member that Resident #37 was outside. A resident's family member had seen the resident exit through the door at the end of the South wing, but the visitor had not thought anything of the resident exiting out of that door. The staff checked the resident's temperature, noted what the resident had on, did a complete head count of the facility, and checked the other doors. They stated they did not see anything propping open the door, so they called the Maintenance Director. The Maintenance Director went in and checked the doors. The Maintenance Director did not report to them what the outcome of the inspection was but reported to the Administrator. They were informed that the door did not sound when the resident or staff went out the door. No one knew what happened. They stated they had asked if the door was pushed open or if someone had unlocked it and was informed no one had unlocked it but the resident went out if it. They were not aware the door keypad was green when the staff went through the egress door. They were unsure if anyone observed the camera footage following the elopement. They would normally look at the camera as part of an investigation and it would be in the investigation summary if they had. They stated they wrote the investigation summary but was only involved in the direct nursing portion. They did not know if staff had the codes to the egress doors prior to the incident but they should not have. They did not know what happened to allow the resident to get outside through the door. They assumed it was a door malfunction because the alarm did not sound. It was not a door that people went in and out of. During a follow up interview on 5/2/2024 at 3:55 PM, they stated they did not take a formal statement of the family visitors who witnessed the resident outside or leave out the egress door.</p> <p>During an interview on 5/2/2024 at 10:41 AM, the Administrator stated they were informed of the elopement when it happened. The resident went out the back door on the South unit (the egress door). Staff was unaware how the resident got outside, and the door had not alarmed when the resident exited. Staff had gone out the same door when they retrieved the resident but had not informed them that the door was unlocked and did not alarm when the staff went through the door. They were not informed the keypad for the door had a green light or that the nursing Supervisor put in the code to relock the door which turned the keypad light red. The Maintenance Director had told them everything was functioning normally when they checked the door. They determined it was a malfunction with the door system as there was no other cause and it would be in the investigation. They were unsure if a vendor came to look at the system. They did not check the cameras and was unsure if the door was visible on the cameras. They could not determine how long the door was unlocked or unalarmed.</p> <p>10NYCRR 415.4(b)</p>		

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NAME OF PROVIDER OR SUPPLIER  Alpine Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  755 E Monroe Street Little Falls, NY 13365	
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(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 - Minimal harm or potential for actual harm</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** 48895</b></p> <p>Based on observations, record review, and interviews during the recertification and abbreviated (NY00309906) surveys conducted [DATE]-[DATE], the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 1 resident (Resident #70) reviewed. Specifically, Resident #70 was not provided anti-nausea medications when needed. Additionally, there was emesis (vomit), feces, and a full urine bag visible at the resident's bedside.</p> <p>Findings include:</p> <p>The facility policy, Quality of Care, dated ,d+[DATE] documented that based on the comprehensive assessment of a resident, the facility would ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's personal preferences. Residents would have an individualized plan of care that was consistent with their needs/goals for care and professional standards of practice.</p> <p>Resident #70 had diagnoses including end stage renal disease (kidney disease), bladder injury, and heart failure. The [DATE] Minimum Data Set assessment dated documented the resident was cognitively intact, required maximum assistance for toileting hygiene, had an indwelling catheter and an ostomy for urinary devices, and was incontinent of bowel.</p> <p>The comprehensive care plan initiated [DATE] documented the resident had an activities of daily living self-care performance deficit and decreased physical mobility due to activity intolerance, limited mobility, and pain. Interventions included extensive assistance of 1 for personal hygiene and toileting, place on toilet every morning and as needed.</p> <p>The [DATE] physician #13 progress note documented the resident was status post cystectomy (bladder removal) and ileal conduit (creation of urostomy, or tubing for urine to exit the body) with abdominal wall reconstruction.</p> <p>A [DATE] physician order documented ondanestron (anti-nausea medication) 4 milligrams every 12 hours as needed for end stage renal disease for 14 days.</p> <p>The [DATE] licensed practical nurse #23 progress note document the resident had liquid emesis 3 times during the shift before dinner. Ginger ale was offered, and the resident refused dinner. There was no documented evidence the medical provider was notified of the emesis to re-evaluate the need for a new order for ondansetron (previous order expired on [DATE]).</p> <p>A [DATE] physician order documented ondansetron 4 milligrams give 1 tablet every 8 hours as needed for nausea and vomiting.</p> <p>The [DATE] physician #13 progress note documented the resident was nauseous which was possibly secondary to their end-stage kidney disease. The anti-nausea medication was increased to 8 mg every 8 hours as needed. The resident's prognosis was extremely poor, with less than 6 months due to underlying end-stage kidney disease, for which they did not want dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A [DATE] physician order documented ondansetron 8 milligrams every 8 hours as needed for nausea and vomiting.</p> <p>The [DATE] at 2:15 PM registered nurse #12 progress note documented the resident had complaints of nausea but had no emesis at the time of the assessment.</p> <p>The ,d+[DATE] Medication Administration Record did not include documentation ondansetron was administered to the resident on [DATE] after they had complained of nausea.</p> <p>During an observation on [DATE] at 11:37 AM and 12:26 PM, Resident #70 was in their room, nude, with a full urine collection bag on the fall mat with the urine window of the bag facing upward. There was a feces soiled brief on the fall mat, and a gray basin approximately one quarter full of vomit. The resident's bare backside was visible from the doorway and to the resident's roommates. At 12:35 PM, the resident had a blanket covering their lower body, no shirt, a completely full urine collection bag on the fall mat with the urine window of the bag facing upward, a feces soiled brief was on the fall mat, and a gray basin approximately one quarter full of vomit.</p> <p>The ,d+[DATE] Certified Nurse Aide documentation for Output in cc's documented that Resident #70's urine bag was emptied on [DATE] at 6:47 AM and 2:40 PM.</p> <p>During an observation on [DATE] at 12:52 PM, Resident #70's lunch tray was in their room, with one bite taken from the entree and an empty coffee cup. The resident stated their stomach hurt too much to eat. They stated they had medication for their stomach, and they had asked for it.</p> <p>The ,d+[DATE] medication administration record did not document ondansetron was administered on [DATE]. There were no corresponding nursing progress notes referencing the resident's complaints of their stomach hurting.</p> <p>During an observation on [DATE] at 8:37 AM, Resident #70 was sitting up on the side of their bed. The urine collection bag was on the floor uncovered. The collection bag contained approximately 1200 milliliters of yellow urine. The spout to the urine bag was folded under the resident's right foot.</p> <p>During an interview on [DATE] at 9:02 AM, certified nurse aide #16 stated urine bags should be emptied every shift. They stated they cared for Resident #70 on [DATE] and noticed the basin of emesis when they went into the resident's room after lunch. They did not tell anyone that the resident had vomited, as they were told that vomiting was normal for this resident, but they still should have reported it. The resident's urine bag was half full when they went into the room in the morning, about 9:00 AM, and they should have emptied it, but did not. They stated there was no feces soiled brief in the morning, but it was there after lunch at the side of the bed. It was not dignified to eat lunch with urine, feces, and emesis at the bedside. Having a full urine bag, a basin of emesis, and a feces soiled brief at the bedside was not the quality of life the certified nurse aide would want for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:39 AM, registered nurse Unit Manager #15 stated urine bags should be emptied at least twice a shift. The urine bag should be inside another bag to hide the contents, should never be on the floor, and the fall mat would be considered part of the floor. The urine bag should never be fully expanded with, it could burst, or backup the tubing and give the resident a urinary tract infection. If emesis was noted at the bedside, it should be reported to the nurse. It was not dignified to consume a meal with urine, feces, and emesis at the bedside. They reviewed the resident's electronic medical record, and stated the resident's urine bag was only emptied once on [DATE]. If a resident was checked and changed every 2 hours, staff should notice a full urine bag, a soiled brief, and a basin of emesis at the bedside. The resident should have received their anti-nausea medication if they had nausea and vomiting.</p> <p>During an interview on [DATE] at 12:59 PM, the Director of Nursing stated urinary catheter care was to be done every shift and included emptying the bag and placing it inside a privacy bag. Staff should be checking the urine bag every time they entered the room. If staff found a basin of emesis, they should notify a nurse immediately. It was not dignified to consume a meal with urine, feces, and emesis at the bedside. The resident's urine bag should never be on the floor and the fall mat was part of the floor. It should never be full expanded with urine. Full urine bags that were directly on the floor could potentially put weight on the catheter and be uncomfortable. The bag could burst and then it would be an infection control issue. A feces soiled brief at the bedside violated the dignity of the resident and was an infection control issue.</p> <p>During a telephone interview on [DATE] at 8:36 AM, licensed practical nurse #14 stated they were the resident's nurse on [DATE]. They stated the resident told them they were not feeling well after lunch. They noted the basin of emesis when they went to give them medication. They told the certified nurse aide about the emesis and was told that this resident vomited every day. They must have overlooked the order for the anti-nausea medication, as they were attempting to control the resident's pain. The resident should have been given anti-nausea medication on [DATE].</p> <p>During a telephone interview on [DATE] at 9:17 AM, physician #13 stated if a resident was consistently nauseous or vomiting, they expected nursing to complete an assessment and give the resident as needed medications as ordered. They relied on the nursing assessment to decide if additional interventions were needed. Resident #70 was on comfort care and if the resident stated they were nauseous, they expected the resident to receive the as needed anti-nausea medication.</p> <p>10NYCRR 415.12</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>48446</p> <p>Based on observation, record review, and interview during the recertification surveys conducted 4/29/2024-5/3/2024, the facility did not ensure that residents were free of any significant medication errors for 1 of 1 resident (Resident #5) reviewed. Specifically, Resident #5 was administered Humalog insulin (fast-acting insulin, starts working approximately 15 minutes after injection to lower blood glucose levels) and was not served their meal timely.</p> <p>Findings include:</p> <p>The facility policy Blood Glucose Management effective 7/2018 documented the facility provided residents with an appropriate plan to assist in the prevention of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). Additionally, the timing of dosing of insulin was critical to achieve desired blood sugar management and to prevent hypoglycemia due to insulin administration time versus food intake.</p> <p>The undated facility mealtimes for the dining room documented:</p> <ul style="list-style-type: none"> <li>- Breakfast was served 8:15 AM to 8:45 AM;</li> <li>- Lunch was served 12:15 PM to 12:45 PM; and</li> <li>- Dinner was served 5:15 PM to 5:45 PM</li> </ul> <p>Resident #5 had diagnoses including diabetes. The 2/2/2024 Minimum Data Set assessment documented the resident was cognitively intact, had diabetes, and received insulin.</p> <p>The comprehensive care plan initiated 4/2/2023 and revised 2/21/2024 documented the resident had diabetes and was started on insulin. Interventions included insulin with meals, insulin may be given in the dining room/near vicinity or other meal location with resident's permission during the meal.</p> <p>The 4/16/2026 physician order documented finger stick blood sugar before meals and at bedtime, call physician if below 60 milligrams/deciliter or above 450 milligrams/deciliter. Humalog insulin (fast acting insulin, 30 units with meals for diabetes.</p> <p>The 4/2024 medication administration record documented Humalog insulin inject 30 units subcutaneously with meals for diabetes at 6:00 AM, 12:00 PM, and 5:00 PM.</p> <p>During an interview on 4/30/2024 at 10:44 AM, Resident #5 stated they received their fast-acting insulin before breakfast, which was early so they did not have symptoms of hypoglycemia. They stated breakfast was scheduled to come between 8:15 AM and 8:45 AM, however, at times it was after 9:00 AM. Resident #5 stated that when they brought their concerns about mealtimes and insulin administration, the Assistant Administration told them to carry a snack.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 4/2024 medication administration record documented 30 units of Humalog Insulin was administered by licensed practical nurse #36 on 4/30/2024 at 7:39 AM and at 11:07 PM. The resident's blood glucose was 167 milligrams/deciliter at 7:30 AM and 158 miligrams/deciliter at 11:30 AM.</p> <p>During an interview on 4/30/2024 at 12:04 PM Resident #5 stated they were administered their fast-acting insulin at 11:15 AM when their blood sugar check was completed. They stated lunch was normally served between 12:00 and 12:30 PM.</p> <p>During an observation on 4/30/2024 at 12:44 PM, Resident #5 was served lunch, approximately 1 1/2 hour after their insulin was administered.</p> <p>During an observation and interview on 5/1/2024 at 7:48 AM Resident #5 was in the hallway wheeling themselves towards the dining room and stated they already received their insulin and had not had breakfast.</p> <p>During an observation on 5/1/2024 at 8:40 AM, Resident #5 was served their breakfast approximately an hour after the resident reported receiving their insulin. At 8:55 AM, Resident #5 stated they ate the eggs and did not eat the pancake because they were full. They stated they had eaten 2 bags of chips they carried with them before breakfast, because they felt their blood sugar was too low.</p> <p>During an interview on 4/30/2024 at 2:11 PM, registered dietitian #32 stated fast-acting insulin should be given with meals to prevent hypoglycemia, chills, and shaking. Residents should be expected to carry a snack with them as many residents were confused.</p> <p>During an interview on 5/2/2024 at 8:22 AM, licensed practical nurse #7 stated they always waited for residents to have their breakfast tray in front of them before administering fast-acting insulin because they were afraid the resident's blood sugar could drop too low. Residents should eat within 10 minutes of fast-acting insulin administration. They administered fast-acting insulin to Resident #5 at 7:42 AM and was not sure if the resident had eaten. They stated the resident was at risk for hypoglycemia as they administered insulin prior to the resident being served breakfast.</p> <p>During an interview on 5/2/2024 at 1:37 PM, registered nurse Unit Manager #35 stated meal trays were often delivered late. Insulin should not be given until the meal was received and eaten. Residents sometimes refused meals and the nurse should wait to make sure the resident ate. They stated quick acting insulin worked within 15 minutes. If someone did not eat within 15 minutes of receiving quick acting insulin the insulin does not have food to work on and could cause hypoglycemia.</p> <p>During an interview on 5/2/2024 at 4:11 PM, the Director of Nursing stated they expected insulin to be administered with meals, but no earlier than 15 minutes before the meal was eaten as the resident could become hypoglycemic. Any time after 15 minutes was too early for insulin to be administered. During a follow up interview on 5/3/2024 at 11:09 AM, the Director of Nursing stated administering fast-acting insulin without food would be considered a significant medication error.</p> <p>During an interview on 5/3/24 at 9:11 AM the Medical Director stated regular insulin should be given 10-15 minutes before a meal. If the nurse was concerned about the resident not eating, they should wait until the resident had consumed about 1/3 of their meal to administer the insulin. If the insulin was administered outside the 10-15 minute window before eating this placed the resident at risk for hypoglycemia.</p> <p>(continued on next page)</p>		

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F 0760  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	10NYCRR 415.12(m)(2)

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>48446</p> <p>49831</p> <p>Based on observation and interview during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles and included expiration dates when applicable for 1 of 2 medication refrigerators (North Unit), 1 of 4 medication carts (North Unit), and 1 of 2 treatment carts (North Unit) reviewed. Specifically, the North Unit medication and treatment carts were unlocked and unattended; and there was an open vial of Purified Protein Derivative (used to diagnose tuberculosis) solution in the North Unit refrigerator that was not labeled with an opened date.</p> <p>Findings include:</p> <p>The facility policy Storage and Maintenance of Medications revised 10/2020 documented medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medications with shortened expiration dates (i.e., insulin, and ophthalmic drops, etc.) must be dated when opened. Medication must be checked regularly for expiration dates and deterioration.</p> <p>During an observation on 4/29/2024 from 12:55-1:06 PM the North Unit medication cart was unlocked and unattended. At 1:06 PM licensed practical nurse #7 locked the medication cart.</p> <p>During an observation of the North Unit medication refrigerator on 4/30/2024 at 8:45 AM with registered nurse #35, there was an open vial of Purified Protein Derivative in the refrigerator. There was no opened date documented on the box or on the vial.</p> <p>During an observation on 4/30/2024 at 8:53 AM the North Unit treatment cart was unlocked. The top drawer of the cart contained bacitracin (antibiotic ointment), moisturizing cream, medical honey, scissors, Santyl (an enzymatic ointment used to remove dead tissue), antifungal cream, and triple antibiotic cream.</p> <p>During an observation on 4/30/2024 at 9:59 AM, the North Unit treatment cart was unlocked.</p> <p>During an interview 5/2/2024 at 8:22 AM licensed practical nurse #7 stated the treatment cart should never be unlocked and unattended because residents could get into medications and eat the creams. If they ate the creams, they could get sick. They did not lock the medication cart on 4/29/2024 because the meal was delivered, and they went to pass trays. They noticed the medication cart was unlocked, but they were not sure how long it had been unlocked. Multidose medications (vials) were good for 30 days once opened and should be labeled the day they were opened. If the medications were not labeled, they should not be administered. If a medication was open and did not have a date on it, they would take it to the Director of Nursing for replacement.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 5/2/2024 at 11:49 AM, the North Unit medication cart was unlocked and unattended. At 11:51 AM, licensed practical nurse came out of a resident room and locked the medication cart.</p> <p>During an interview on 5/2/2024 at 1:37 PM, registered nurse Unit Manager #35 stated they expected treatment carts and medication carts to always be locked so residents and unauthorized staff could not get into them.</p> <p>During an interview on 5/2/24 at 4:11 PM the Director of Nursing stated medication and treatment carts should be locked and parked at the nursing desk when not in use. Bandages, creams, scissors, bacitracin, antifungal, cortisone cream, triple antibiotic were some items stored in the treatment carts. The carts should be locked for safety. Purified Protein Derivative should be dated when opened and discarded after 30 days.</p> <p>10NYCRR 483.45 (g)(h)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>27522</p> <p>48052</p> <p>48446</p> <p>49831</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation and interview during the recertification and abbreviated (NY00309906 and NY00338730) surveys conducted 4/29/2024-5/3/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and appetizing for 1 of 2 test trays (4/29/2024 lunch meal) reviewed. Specifically, the lasagna served at the 4/29/2024 lunch meal was burnt; and 7 of 7 anonymous residents at the Resident Council meeting complained of food not being flavorful and not being served at palatable and appetizing temperatures.</p> <p>Findings include:</p> <p>The undated facility policy, Taste Testing, documented that all food should be taste tested prior to meal service. The cook was responsible for tasting all food prior to it being served to residents. Any food that did not pass the taste test due to seasoning, toughness, color, or other negative factors would not be served until the problem was corrected.</p> <p>During an interview on 4/29/2024 at 10:52 AM, Resident #21 stated the food lacked flavor and was not served hot. They received a bowl of cereal and toast with butter for breakfast and the toast was cold.</p> <p>During a resident group interview on 4/29/2024 at 2:00 PM seven anonymous residents in attendance stated the food was often overcooked and lacked flavor, and hot items were often cold.</p> <p>During an interview on 4/29/2024 at 2:13 PM, Resident #5 stated the food was not cooked well, was sometimes burnt, and lacked flavor.</p> <p>During an observation on 4/30/2024 at 12:30 PM, a food tray arrived at Resident #77's room. The tray was tested , and a replacement tray was requested for Resident #77. The meat lasagna was 152 degrees Fahrenheit (acceptable) and the bottom of the lasagna appeared burnt and blackened and did not have an appetizing appearance.</p> <p>During an interview on 4/30/2024 at 12:58 PM, Resident #1 stated the food was not good, lacked flavor, and was not warm.</p> <p>During an observation and interview on 4/30/2024 at 1:01 PM, Resident #5 stated the food was hot today, but the bottom of the lasagna was burnt. Resident #5 showed the corner of the lasagna that was burnt.</p> <p>During an interview on 4/30/2024 at 1:15 PM, certified nurse aide #18 stated they observed burnt food served to the residents. They stated Resident #11's lasagna was burnt and they did not eat it.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Alpine Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 755 E Monroe Street Little Falls, NY 13365	

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/2024 at 1:23 PM, licensed practical nurse #19 stated residents complained to them about burnt food.</p> <p>During an interview on 5/1/2024 at 9:11 AM certified nurse aide #10 stated the residents always complained about the food being burnt, or too cold. Sometimes it was difficult to cut the food because it was too hard.</p> <p>During an interview on 5/1/2024 at 1:10 PM, Assistant Food Service Director #27 stated they tried to make every monthly resident council meeting, and residents had complained about the food. They stated residents told them the food was overcooked but not burnt. They had not heard comments about burnt food during the 4/30/2024 lunch meal. They told the cooks in the past not to overcook the resident's food. It was important that appetizing and palatable food was served to residents.</p> <p>During an interview on 5/2/2024 at 8:22 AM licensed practical nurse #7 stated the residents frequently complained about the food being burnt and cold.</p> <p>10NYCRR 415.14(d)(2)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27522</p> <p>48895</p> <p>Based on observation and interview during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, the main kitchen had outdated and undated food, an unclean stove/oven/flattop cooking area, an unclean walk-in freezer, a leaking dish machine, missing tiles at the bottom of the handwash sink, an unsecured wall covering, and a plate warmer cord that was in disrepair.</p> <p>Findings include:</p> <p>The undated facility policy, Cleaning of Counters and Food Contact Surfaces, documented the cleaning procedure was to thoroughly saturate a cleaning rag with cleaning solution, ring out the excess, and wipe down the counter of food contact surface; this removed visible dirt and debris. For sanitizing, the procedure was to thoroughly saturate a second rag with sanitizing solution and apply it to the counter of food contact surface liberally and allow to air dry.</p> <p>The undated facility policy, Cleaning and Mopping of Floors ([NAME] Tile and Walk in Cooler) documented all floor areas of the department would be swept and mopped three times daily.</p> <p>The Cleaning Schedule for Saturday 4/27/2024 documented that Cook #31 was to de-ice the freezer door and freezer floor, wipe down the dessert rack, and wash garbage cans. Cook #31 only initialed next to the tasks for wiping down the dessert rack and the garbage cans.</p> <p>The Dietary Department Daily Cleaning &amp; Closing Checklist for week ending 5/4/2024 documented Cook Supervisor #30 signed off for the following:</p> <ul style="list-style-type: none"> <li>- the range ovens were cleaned and turned off;</li> <li>- the microwave was cleaned;</li> <li>- the toaster was cleaned;</li> <li>- the mixer was cleaned;</li> <li>- the slicing machine was cleaned and assembled;</li> <li>- the can opener was run through the dish machine;</li> <li>- the pot sinks were clean, and the counter was cleaned;</li> <li>- the food in the refrigerator was covered, labeled, and dated;</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- the perishables were discarded from the refrigerator after the third day;</li> <li>- all garbage was removed from the kitchen;</li> <li>- and the kitchen door was locked.</li> </ul> <p>The following observations of the main kitchen were made on 4/29/2024 between 10:00 AM and 11:00 AM:</p> <ul style="list-style-type: none"> <li>- in the reach-in refrigerator, there was jelly in a plastic container with an opened label date of 4/16. This jelly was from another shelf stable jelly container and was poured into this container.</li> <li>- the front section and the back of the stove/oven/flattop combo unit was unclean.</li> <li>- the shelf over the stove/oven/flattop combo unit was sticky and had miscellaneous food debris on it.</li> <li>- there was a 1/4 full container of ham-based paste on the shelf over the stove/oven/flattop combo unit that did not have an open date.</li> <li>- a metal wall cover near the handwash sink was not secured to the wall and was missing three screws.</li> <li>- the bottom of the wall near the handwash sink had chipped and missing wall tiles.</li> <li>- the floor under the walk-in freezer was not clean and had miscellaneous debris on it.</li> <li>- the ceiling in dish machine area was stained and unclean.</li> <li>- the electric wire that entered the plate warmer was wrapped with electrical tape.</li> <li>- the dish machine had a section that was leaking water out of the side, with a plastic bucket underneath to collect the water.</li> </ul> <p>During an interview on 5/2/2024 at 12:30 PM, the Director of Environmental Services stated that ceilings would be cleaned as needed, or when the kitchen staff or maintenance staff identified an issue. They stated that they would also clean the floors in the kitchen if asked.</p> <p>During an interview on 5/2/2024 at 12:40 PM, the Assistant Food Service Director stated they were not aware of the kitchen environmental issues identified during the first tour of the main kitchen. They stated that it was part of their job to check and maintain a clean kitchen environment. The Assistant Food Service Director stated there were different daily cleaning schedules for the cooks and the rest of the dietary staff, and that these forms were required to be initialed after completion each day. They stated the cook was responsible for cleaning the stove/oven/flattop combo unit area, and the other food service workers were responsible for cleaning the floor of the walk-in freezer and other areas within the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/2/2024 at 1:05 PM, cook supervisor #30 stated that the oven/stove and the shelf above it should have been cleaned daily. After looking at pictures taken from the first day of survey, this area did not look like it had been cleaned for a couple of days. They stated they had worked the closing cook shift on 4/28/2024 and had not cleaned the back wall of the stove/oven/flattop combo unit or the front knobs of this device. Cook supervisor #30 viewed the Closing Cook Cleaning Checklist dated 4/28/2024 and verified the presence of their initials.</p> <p>During an interview on 5/2/2024 at 1:15 PM, cook #31 stated the last time they were the closing kitchen staff they had not cleaned the walk-in freezer floor, and had never cleaned the walk-in freezer floor since they were hired in July 2023. They stated they had not initialed the Cleaning schedule for: Saturday, task to de-ice the walk-in freezer, as they had not completed that task. Cook #31 stated they were asked every day by the Food Service Director or the Assistant Food Service Director if the kitchen was clean, had been asked to make sure that the walk-in cooler and walk-in freezer was swept, and was never asked to clean under the racks within the walk-in freezer. They stated that sometimes they would use a degreaser to clean the back of the stove/oven/flattop combo unit, and that the back of the stove/oven/flattop combo unit was sometimes clean. Cook #30 stated the front knob section was part of the stove/oven/flattop combo unit, and that they had last cleaned this part of the oven a couple of weeks ago.</p> <p>During an interview on 5/2/2024 at 1:35 PM, the Assistant Food Service Director stated the shelf over the stove/oven/flattop combo unit area looked like it had not been cleaned for a couple of days. They stated that the Cleaning schedule for: Saturday, included a task to de-ice the walk-in freezer, and they assumed that staff would keep the floor clean as the word cleaning was in the title. The Assistant Food Service Director was aware that Cook #31 was initialing the walk-in freezer daily checklist and was not aware that the section not initialed by Cook #31 meant that it had not been completed.</p> <p>10NYCRR 415.14(h)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48446</p> <p>Based on observation, record review, and interviews during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 licensed practical nurses (licensed practical nurse #7) observed during medication administration. Specifically, licensed practical nurse # 7 did not perform hand hygiene after removing their gloves during medication administration.</p> <p>Findings include:</p> <p>Licensed practical nurse #7's education records documented:</p> <ul style="list-style-type: none"> <li>- on 4/28/2022 they completed a personal protective equipment and hand hygiene competency.</li> <li>- on 10/17/2022 they completed a handwashing quiz. Licensed practical nurse #7 documented handwashing was the single most important means of preventing the spread of infection. Appropriate hand hygiene must be done when visibly soiled, when removing gloves, after using the bathroom, and before meals.</li> <li>- on 6/5/2023 they demonstrated competency with hand hygiene.</li> </ul> <p>During an observation on 5/2/2024 at 8:00 AM licensed practical nurse #7 did not perform hand hygiene between administering medications to Resident #68 and administering medications to Resident #18. Licensed practical nurse #7 applied gloves and cleaned the glucometer (measures blood glucose) for Resident #18. After the glucometer was cleaned, licensed practical nurse #7 removed their gloves and put on another pair of gloves to perform the fingerstick on Resident #18.</p> <p>During an interview on 5/2/2024 at 8:15 AM, licensed practical nurse #7 stated they did not wash or sanitize their hands between administering medications to Resident #68 and Resident #18 or between changing gloves and they should have. They stated they had annual training on infection control and knew the importance of hand hygiene. They stated if hand hygiene was not practiced both residents and staff can become ill from the spread of germs.</p> <p>During an interview on 5/2/2024 at 4:11 PM the Director of Nursing stated all staff were trained annually on infection control. They expected hands to be washed or sanitized after contact with a resident, when soiled, and after removing gloves. If staff did not wash hands between resident contact or after removing gloves it could cause the spread of an infection to the residents, staff, visitors, and families.</p> <p>10NYCRR 415.19(a)(1-3)(b)(2)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27522</p> <p>48052</p> <p>Based on observation, record review, and interview during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not maintain an effective pest control program so that the facility was free of pests for 2 of 2 nursing units (North and South Units) and the main kitchen. Specifically, there was evidence of ants and house flies on the South Unit, and fruit flies on the North Unit and in the main kitchen.</p> <p>Findings include:</p> <p>The facility policy, Pest Control, effective 10/2017, documented the facility provided a safe and sanitary environment by preventing the entry of insects and rodents into the facility. This reduced the threat of infection and disease caused by pests. A licensed pest control company was contracted by the facility and provided most of the insect and rodent control. The Environmental Services Director was responsible to schedule monthly inspections and to arrange for an on-call pest control agent for an emergency. Any staff who noticed an insect or rodent infestation should notify maintenance and it should be logged in the logbook.</p> <p>Pest control vendor records dated 3/7/2024, 4/4/2024, and 4/11/2024 documented ants as a targeted treatment pest. There was no documented target treatment for flies or fruit flies.</p> <p>The facility pest sighting memo had no documented sightings of flies or fruit flies from 11/15/2023 to 4/28/2024. Ant sightings were documented:</p> <ul style="list-style-type: none"> <li>- on 1/5/2024 in the break room.</li> <li>- on 1/12/2024 in room [ROOM NUMBER] by housekeeping.</li> <li>- on 2/10/2024 in room [ROOM NUMBER].</li> <li>- on 2/16/2024 at 9:50 AM in room [ROOM NUMBER] by housekeeping</li> <li>- on 2/18/2024 in the hallway between rooms [ROOM NUMBERS].</li> <li>- on 3/6/2024 in room [ROOM NUMBER]</li> <li>- on 4/27/2024 at 12:21 PM in room [ROOM NUMBER]C and in the hallway between rooms [ROOM NUMBERS] by housekeeping.</li> <li>- on 4/28/2024 at 9:30 AM in room [ROOM NUMBER] by housekeeping.</li> </ul> <p>Fruit Flies</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observations on 4/29/2024, between 10:00 AM and 11:00 AM, there were 25 fruit flies in the main kitchen dish machine area. There was 1 fruit fly on a hallway wall near resident room [ROOM NUMBER], 1 fruit fly on a hallway wall over the access door to the staff lounge, and 1 fruit fly on the ceiling in the main dining room.</p> <p>During observations on 4/30/2024, between 12:50 PM and 1:05 PM, there was one fruit fly on a hallway wall near resident room [ROOM NUMBER], one fruit fly on a hallway wall near the staff lounge, and one fruit fly on the ceiling in the main dining room.</p> <p>Ants</p> <p>During observations on 4/30/2024 at 9:12 AM, and on 5/1/2024 at 8:23 AM, a puzzle table between resident rooms [ROOM NUMBERS] had ants walking on it.</p> <p>House Flies</p> <p>During an observation on 4/29/2024 at 11:49 AM and at 12:20 PM, the windowsill of resident room [ROOM NUMBER] had dead house flies.</p> <p>During an observation on 4/29/2024 at 12:35 PM, the day room where a resident was eating had a house fly flying around.</p> <p>During an interview on 5/2/2024 at 4:10 PM, the Director of Maintenance stated when staff verbally told them about a pest sighting, a pest control vendor was called to come onsite. They stated all staff had been trained to contact the maintenance department if a pest was seen. The Director of Environmental Services stated it was not acceptable for a fly to land on a resident's tray of food while they were eating. They stated they could not determine if the fruit flies found in the main kitchen had been there prior to the first day of survey. The Director of Environmental Services stated that a pest control vendor came onsite monthly, and that the vendor investigated all parts of the facility.</p> <p>10NYCRR 415.29(j)(5)</p> <p>48895</p>		