STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335611	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Island Center for Nursing and Rehabilitation	490 Pelham Road New Rochelle, NY 10805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record reviews and interviews conducted during the recertification survey from 6/10/24-6/14/24, the facility did not ensure that for 1(Resident #57) of 5 residents reviewed for environment, they were provided with reasonable accommodations of needs and preferences. Specifically, the call bell system designated for Resident #57 whom has left sided weakness, was observed not within the resident's reach, on multiple occasions. The findings are: The undated facility policy titled Resident Call System documented the purpose was to ensure that residents had a means of direct communication between the resident and his/her caregivers. Resident #57 was admitted to the facility with diagnoses including but not limited to cerebral vascular accident, dementia, difficulty in walking, and hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side. The Quarterly Minimum Data Set, dated dated dated [DATE], documented the resident had moderately impaired cognition, was dependent on staff with toileting and transfers, and required moderate assistance with bed mobility. The comprehensive care plan dated 10/9/23, documented the resident was high risk for falls related to gait/balance problems, incontinence, and left sided weakness; and interventions included that Resident #57 would have a working and reachable call light. The comprehensive care plan dated 9/16/22, documented the resident had an Activity of a Daily Living self-care performance deficit related to activity intolerance, dementia, limited mobility, and limited range of motion; interventions included to encourage Resident #57 to use the bell to call for assistance. On 06/10/24 at 08:24 AM, Resident #57 was observed in bed and the call bell was observed on left side of bed hanging from siderail. Resident #57 was unable to reach for the call bell and stated that they could not use their left hand due to a having had a stroke. On 06/11/24 at 12:48 PM, Resident #57 was observed sitting on the right side of their bed in their wheelchair with left arm secured in wheelchair armrest strap. The call bell was observed across the bed, towards the left side, and was not within the resident's reach. Resident #57 was unable to stretch over and reach the call bell. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/24 at 10:55 AM, Resident #57 was observed in bed. The call bell was observed sitting on the nightstand, and not within of reach of resident. Resident #57 stated that when they needed help, they pushed the button and demonstrated that they were unable to reach for the call bell. Resident #57 stated that staff always put the call bell on the left side of the bed and stated that it was difficult to reach due to left sided weakness and that the call bell would be much better if placed within reach on their stronger side. During an interview on 06/13/24 at 10:56 AM, Registered Nurse #2 observed the call bell on Resident #57's night stand out of the resident's reach and stated that the call bell must be always in reach of resident while in their room. They also stated that the call bell should have been placed on the right side of resident because the resident had left sided weakness. During an interview on 06/13/24 at 11:11 AM, Certified Nurse Aide#13 stated that residents were always to have their call bell within reach and that they did not notice Resident #57's call bell was not in reach. During an interview on 06/13/24 at 05:10 PM, the Director of Nursing stated that Resident #57's call bell should always be in reach of the resident and that the resident did utilize their call bell. The Director of Nursing also stated that the call bell should be placed on the right side of the bed, within reach, due their left sided weakness. 10NYCRR 415.5(e)(1)

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observations, record reviews and interviews conducted during the recertification survey from 6/10/2024 to 6/14/2024, the facility did not ensure the development of comprehensive person-centered care plans that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment for 3 (Residents #47, #51, and #66) of 35 residents reviewed for comprehensive care plans. Specifically, (1) for Resident #47, the facility did not ensure a comprehensive care plan was developed to address the use of indwelling urinary catheter; and the use of a left resting hand splint, (2) for Resident #51, the facility did not ensure a comprehensive care plan was developed to address the use of bilateral palm guards and soft hip abductor cushion at all times, and (3) for Resident #66, the facility did not ensure a comprehensive care plan was developed to address the toileting schedule put into place to achieve or maintain as much normal bladder/bowel function as possible. This is evidenced by: An undated Policy and Procedure titled 'Care Planning' documented that a comprehensive care plan shall be developed for each resident that includes measurable, objective and timetables to meet the residents medical, nursing, mental and psych-social needs. 1) Resident #47 had diagnoses which included heart failure, obstructive uropathy, and peripheral vascular disease. An admission Minimum Data Set (an assessment tool) dated 5/4/2024 documented the resident was cognitively intact. The resident required substantial assistance with eating and was dependent on staff for all other areas of activities of daily living. The resident had a urinary catheter. The physician order dated 4/28/2024 documented a Foley (urinary catheter) for urinary retention, 16 French (size) with 10 cubic centimeter (cc) balloon, may use leg bag when out of bed, to change the Foley every 28 days and as needed, and to assess urine in bag. The physician order dated 5/24/2024 documented a left resting hand splint use at all times, remove and release for care and skin checks. During an observation on 06/11/24 at 09:25 AM, the resident was observed without their resting splint on their left hand. The resident's urinary catheter bag was observed hanging from their bed, with a privacy cover in place. During an observation on 06/12/24 at 02:48 PM, the resident was in bed asleep. The resident's hand splint was observed on dresser and not on the resident. During an observation on 06/13/24 at 11:23 AM, the resident was observed in bed not wearing their resting hand splint. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medical record including the current comprehensive care plan and the Kardex (instructions for direct care staff) revealed no documentation to address the left resting hand splint or the use of a urinary catheter. During an interview on 06/13/24 at 12:11 PM, Certified Nurse Aide #7 stated the resident wore a hand splint but refused to wear it when in bed. Certified Nurse Aide #7 stated they knew the resident had a catheter and they emptied it. During an interview on 06/13/24 12:09 PM, the Director of Nursing stated the care plan for a urinary catheter was not developed and should have been. They stated there should have been a care plan for the left-hand splint, and they were not sure why it was not there. They stated they usually put any splints or positioning devices on the ADL care plan. They stated the Nurse Manager was responsible for developing care plans. 2) Resident #51 had diagnoses which included adult failure to thrive, muscle wasting and atrophy, and cerebral infarction. The 5 day Minimum Data Set (resident assessment tool) dated 5/30/24 documented the resident had severely impaired cognition and was dependent on staff for other activities of daily living. The physician's order dated 6/3/24 documented bilateral palm guard at all times, remove/release for ADL. Soft hip abductor cushion at all times, remove/release for ADL care and skin checks. When observed on 06/11/24 at 07:45 AM, 06/11/24 at 10:46 AM, 06/11/24 at 11:54 AM, and 06/12/24 at 09:49 AM, Resident #51 was in their bed without palm guards and the soft hip abductor. The soft hip abductor was observed laying on the top of the resident's nightstand. A review of the care plan on 6/11/24, revealed the bilateral palm guard and soft hip abductor cushion at all times were not documented. On 06/12/24 at 10:28 AM during an interview and observation, Registered Nurse #15 stated they knew the Resident #51 well and was not aware the resident had orders for the soft hip abductor and palm guards. Registered Nurse #15 pulled the linen that covered the resident to check the palm guards, which the nurse and surveyor did not observe. There was no hip abductor observed in place either. Registered Nurse #15 and the surveyor observed the hip abductor lying on the resident's nightstand. Registered Nurse #15 stated they did not know why the device has not been applied to the resident. They said that they saw the soft hip abductor on the night stand earlier when they started the shift, but they did not question why this hip abductor was not applied for the resident. Registered Nurse #15 searched the nightstand drawers and was unable to find palm guards. Registered Nurse #15 checked the Kardex (care instructions for direct care staff) and did not find the palm guards and soft hip abductor. On 06/12/24 at 10:33 AM during an interview, Registered Nurse Manager #16 stated once the rehab department created the order, the night Supervisor or a day Nurse Manager documented on the care plan, which would be reflected on the Kardex. Registered Nurse Manager #16 observed Resident #51's care plan and stated the palm guards and hip abductor were not on the care plan and should have been. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident #66 was admitted with diagnoses including but not limited to anxiety disorder, history of falling, lack of coordination, and osteoarthritis. The Quarterly Minimum Data Set, dated dated dated [DATE], documented that Resident #66 had intact cognition, required supervision with bed mobility, toileting, and transfers, and was frequently incontinent of bowel and bladder. The comprehensive care plan titled Activity of a Daily Living self-care performance deficit related to impaired balance, limited mobility dated 4/20/22, documented interventions including a toileting schedule for every two hours and as needed. The comprehensive care plan titled bladder incontinence related to impaired mobility and medications side effect, dated 4/20/22, documented goals to include that resident would remain free of complications related to urinary incontinence such as skin breakdown and urinary tract infection through the next review date, with interventions including to check the resident every 2 - 4 hours and as needed, and as required for incontinence. Review of the certified nurse aide Kardex (care instructions) documented Resident #66 was on a toileting schedule and was to be toileted every 2 hours and as needed. Review of the certified nurse aide documentation revealed that there was no evidence that toileting was being done. On 06/11/24 at 12:42 PM, Resident #66 was observed in her room and there were 3 unused green briefs observed in a pink basin on their bed. Resident #66 stated that the briefs were always in their room and the staff left the briefs for the resident to use. On 06/10/24 at 08:28 AM, Resident #66 was observed in her room sitting in her wheelchair. There were unused green briefs observed on her nightstand. Resident #66 stated that the certified nurse aides taught them how to put their brief on by themselves so that they don't have to call for help to be assisted with changing soiled briefs. Resident #66 stated that the that staff has told her that they are independent and that they are unaware that they are on a toileting schedule. Resident #66 stated that they are unsteady on their feet and that they need assistance with incontinence cares. During an interview on 06/14/24 at 11:01 AM, Registered Nurse Unit Manager #18 stated that Resident #66 was on an every 2 hour and as needed toileting schedule. Registered Nurse Unit Manager #18 stated that they were the one that implemented and updated the care plans and that the toileting schedule was not showing up for the certified nurse aides to document because in the edit intervention section in the care plan the box Intervention will appear on the documentation record, was not checked off. During an interview on 06/13/24 at 05:10 PM, the Director of Nursing stated that all care plans must be reviewed and updated quarterly and as needed. The Director of Nursing stated that all if a resident was on a toileting schedule it must be in the care plan and carried over to the certified nurse aide documentation so that they could document. The Director of Nursing stated that if the toileting scheduled was showing in the Kardex, the certified nurse aides should have been able to document and that it was an error on their part. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.11(c)(1) 48847 49255

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review and interviews conducted during the recertification survey from 6/10/24 to 6/14/24, the facility did not ensure that the Comprehensive Care Plans were reviewed and revised in a timely manner for 1(Resident #57) of 5 residents reviewed for Unnecessary Medications. Specifically, Resident #57 was no longer receiving Lorazepam effective 8/4/23 and Apixaban effective 4/8/22 which was replaced with Xarelto on 4/8/22, and the Care Plans were not updated and revised to reflect the discontinuations and the changes with the medications. The findings are: The undated facility policy titled Care Planning Process documented that the facility shall have a care planning process in place which includes: integrating assessment findings in care Planning, developing and interdisciplinary care plan, regularly reviewing and revising the care plan, providing, and documenting the care. When a change in a resident's status is noted during the course of a resident's treatment, the specific focus, goal, and/or interventions related to the change must be updated by the responsible discipline to reflect the change in the resident's status. Resident #57 was admitted to the facility with diagnoses including but not limited to cerebral vascular accident, dementia, and hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side. The Quarterly Minimum Data Set, dated dated dated [DATE], documented the resident had moderately impaired cognition. The resident required supervision with eating, was dependent with toileting and transfers, and required moderate assistance with bed mobility and Resident #57 received an anxiety medication. The Care Plan titled The resident is on Anticoagulant therapy (Apixaban) related to diagnoses of bilateral pulmonary emboli, and history of deep vein thrombosis dated 9/9/21, was not reviewed and revised to reflect the discontinuation of Apixaban effective 4/8/22, and the implementation of Xarelto which began on 4/8/22. The Care Plan titled The resident uses anti-anxiety medications (Lorazepam) related to anxiety disorder dated 2/23/23 which documented interventions to give anti-anxiety medications ordered by physician, was not reviewed, and revised to reflect that Resident #57 was no longer receiving anti-anxiety medications specifically Lorazepam, as of 8/4/23. During an interview on 6/12/24 at 12:00 PM, Registered Nurse Unit Manager #18 stated that Resident #57 was no longer receiving anti-anxiety medications and that Lorazepam had been discontinued. Registered Nurse Unit Manager#18 stated that they reviewed and updated the Care Plans every 3 months and as needed, and that the anti-anxiety medication Lorazepam and the anti-coagulant Apixaban should have been removed from the Care Plan. During an Interview on 6/12/24 at 03:00 PM, the Director of Nursing stated that Care Plans must be updated by nurses and that if a resident was no longer receiving a medication, the Care Plan should be revised. The Director of Nursing stated that Care Plans were supposed to be reviewed quarterly and as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.11(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43478 Based on interview and record review conducted during the recertification and abbreviated surveys (NY00330768) from 6/10/24 to 6/14/24, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice for 1 of 6 residents (Resident #340) reviewed for skin impairments. Specifically, the Treatment Administration Record for Resident #340 revealed the treatments ordered by the physician were not administered as per order. The findings are: The undated facility policy, 'Skin Integrity' documented that the resident with pressure ulcers/injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers/injuries from developing. Resident #340 was admitted with diagnoses which included Diabetes Mellitus, COVID-19, and Pneumonia. On 10/20/23, a new diagnosis of orthopedic aftercare following surgical amputation was documented. The admission Minimum Data Set (resident assessment tool) dated 8/29/23 documented intact cognition. Resident required 1-person extensive assistance with bed mobility and toilet use and personal hygiene and bathing, 2-person extensive assist with transfers and dressing, dependent with locomotion, limited assistance with eating. The 5-day Minimum Data Set (resident assessment tool) dated 10/23/23 documented intact cognition. Resident required supervision with eating, partial/moderate assistance with oral hygiene and upper body dressing and bed mobility, substantial/maximal assistance with toileting hygiene and lower body dressing and transfers. Surgical wound present on admission, and surgical wound care was documented. The 'Actual Impairment to Skin Integrity care' care plan dated 9/5/23 documented Diabetic right toes. The interventions included to apply treatments to site as ordered. The physician's orders documented: 10/21/23 'Cleanse right foot Trans Metatarsal Amputation with normal saline solution, pat dry, wrap with Kerlix/gauze, then tape every day shift, for wound care', discontinued 12/7/23. 11/19/23 'Monitor surgical site right foot Trans Metatarsal Amputation for bleeding, drainage, signs and symptoms of infection. Notify RN/MD' discontinued 12/7/23. 12/09/23 'Cleanse with normal saline solution, pat dry then wrap with Kerlix, every day shift, for wound care' start date, discontinued 12/27/23. 12/07/23 'Monitor surgical site right foot Trans Metatarsal Amputation for bleeding, drainage, sign and symptoms of infection. Notify RN/MD' discontinued 2/1/24. 12/28/23 'Cleanse right foot Trans Metatarsal Amputation with normal saline solution, pat dry then wrap with Kerlix, every day shift, for wound care' discontinued 2/1/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Skin/Wound Care Notes dated 10/21/23 documented follow-up from readmission, skin assessment done. Noted surgical site on right foot status post Trans Metatarsal Amputation, measurement 13.5 cm with 15 sutures, clean, dry and intact. Cleanse surgical site with normal saline solution, pat dry, then apply dry protection dressing. The Nursing Skin/Wound Care Notes dated 10/24/23 documented resident was not seen by wound specialist during wound rounds, transfer of care to Vascular as per wound specialist. The November 2023 Treatment Administration Record documented 'Cleanse right foot Trans Metatarsal Amputation with normal saline solution, pat dry, wrap with Kerlix/gauze, then tape, every day shift, for wound care' start date 10/21/23, discontinued 12/7/23. The treatment was not signed as administered on 11/22/23. The December 2023 Treatment Administration Record documented 'Cleanse right foot Trans Metatarsal Amputation with normal saline solution, pat dry then wrap with Kerlix, every day shift, for wound care' start date 10/21/23, discontinued 12/7/23. The treatment was not signed as administered on 12/2, 12/3, 12/4, or 12/6/23. The December 2023 Treatment Administration Record documented 'Cleanse with normal saline solution, pat dry then wrap with Kerlix, every day shift, for wound care' start date 12/09/23, discontinued 12/27/23. The treatment was not signed as administered on 12/14, 12/16, 12/17, or 12/18/23. The December 2023 Treatment Administration Record documented 'Monitor surgical site right foot Trans Metatarsal Amputation for bleeding, drainage, signs and symptoms of infection. Notify RN/MD' start date 11/19/23, discontinued 12/7/23. The treatment was not signed as administered on 12/2, 12/3, or 12/6/23. The January 2024 Treatment Administration Record documented 'Cleanse right foot Trans Metatarsal Amputation with normal saline solution pat dry then wrap with Kerlix, every day shift, for wound care' start date 12/28/23. The treatment was not signed as administered on 1/1/24, 1/3/24, 1/7/24, 1/13/24, 1/14/24, 1/22/24, 1/24/24, 1/25/24, or 1/28/24. The January 2024 Treatment Administration Record documented 'Monitor surgical site right foot Trans Metatarsal Amputation for bleeding, drainage, signs and symptoms of infection. Notify RN/MD' start date 12/07/23. The treatment was not signed as administered on 1/1/24, 1/3/24, 1/7/24, 1/13/24, 1/14/24, 1/22/24, 1/24/24, 1/25/24, or 1/28/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 1:25 PM during an interview, the Director of Nursing stated the nurse on duty who performed the treatment was responsible for documenting in the Treatment Administration Record, and if the treatment was not administered, the nurse was responsible to document the reason why the treatment was not administered. The Director of Nursing stated the Registered Nurse Unit Manager was responsible to assure that the treatments were administered as ordered for the nurses on their shift. The Director of Nursing stated that during the week, the treatment nurse was responsible for administering the treatments, and in the event that a treatment nurse was not available, it was the responsibility of the Unit Manager during the week and the Supervisor on the weekends to administer the treatments. The Director of Nursing checked the resident's electronic health record and stated there were no documented Nurse's Note dated in November, December, or January documenting the reasons for not administering treatments on the dates not documented as administered in the November, December, and January Treatment Administration Records. On 6/11/24 at 2:26 PM during an interview, Registered Nurse #2 stated they were assigned to administer medications on 12/2 and 12/3/23. They stated Resident #340 was alert and usually asked staff to apply the treatments if the treatments had not been administered yet. Registered Nurse #2 stated they administered the treatments but they forgot to sign the Treatment Administration Record. They stated they knew that treatments should have been documented in the Treatment Administration Record. On 6/11/24 at 2:38 PM during an interview, Registered Nurse #3 stated they were assigned to administer medications on 12/4/23. They stated they were not responsible to administer treatments on 12/4/23 because the Registered Nurse Unit Manager was responsible to administer treatments during the week. Registered Nurse #3 stated Resident #340 was alert and usually asked staff to have their treatment applied if the treatments had not been administered yet. Registered Nurse #3 stated that on 1/13 and 1/14/24 they were assigned to administer medications and there was no treatment nurse that weekend. They stated it was their responsibility to apply the treatments and document in the Treatment Administration Record. They stated they did not remember whether or not they administered Resident #340 treatments on 1/13 and 1/14/24. On 6/11/24 at 2:58 PM during an interview, Registered Nurse Supervisor #4 stated they were the Registered Nurse Supervisor on 1/3 and 1/28/24. They stated they were responsible to administer treatments on those days because the medication nurse asked for their assistance because the medication nurse did not have time to administer treatments. Registered Nurse Supervisor #4 stated Resident #340 was alert and usually asked staff to have their treatment applied if the treatments had not been administered yet. Registered Nurse Supervisor #4 stated that on 1/3 and 1/28/24 they administered the treatments to Resident #340 and they were responsible to document in the Treatment Administration Record but they forgot. On 6/11/24 at 3:06 PM during an interview, Registered Nurse Unit 1 [NAME] Manger #5 stated that on 1/7/24 they were supervising and they were responsible for administering treatments to major wounds if the unit medication nurse asked them for assistance with administering treatments. Registered Nurse Unit 1 [NAME] Manger #5 stated that on 1/24 and 1/25/24 they were performing their routine responsibilities as a unit manager and they had limited time and they were only responsible to administer treatments to major wounds if there was no treatment nurse that day and if the medication nurse asked them for assistance. Registered Nurse Unit 1 [NAME] Manger #5 stated that Resident #340's wound was considered a major wound and they thought they administered the treatments on the days mentioned above, but they could not be sure. They stated that they were responsible to document the treatments in the Treatment Administration Record if they had administered them. (continued on next page)

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	335611	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Island Center for Nursing and Rehabilitation	490 Pelham Road New Rochelle, NY 10805

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 3:24 PM during an interview, Registered Nurse/Treatment Nurse #6 stated that on 12/14/23 they were not working as the treatment nurse because they were assigned to administer medications and they were not responsible to administer treatments on that day because it was a weekday, and the Registered Nurse Unit Manager was responsible for administering the treatments on weekdays. Registered Nurse #6 stated that on 12/16 and 12/17/23 they were not working as the treatment nurse because they were assigned to administer medications, and they were therefore not responsible for administering treatments on that day. Registered Nurse #6 stated that the Registered Nurse Supervisor was responsible for administering the treatments on 12/16/23 and 12/17/23. Registered Nurse #6 stated they notified the Registered Nurse Supervisor that they did not have time to administer Resident #340 treatments. 10NYCRR 415.12

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47626 Based on observation, record review and staff interviews during the recertification survey from 6/10/24 to 6/14/24, the facility did not ensure that needed services, care and equipment were provided to assure that residents with limited range of motion and mobility maintained or improved function based on the residents' clinical condition for 2 of 4 residents (Resident #51 and Resident #46) reviewed for position and mobility. Specifically, 1. Resident #51 was observed on 3 occasions without bilateral palm guard and soft hip abductor in place, and 2. Resident #46 was observed without bilateral resting hand splints or palm guard in place. Findings include: The undated Policy and Procedure titled, Adaptive Equipment Device, documented splinting and orthopedic management is a therapeutic procedure designed to prevent worsening contractures of a joint, to increase range of motion, and /or to prevent skin breakdown. 1. Resident #51 had diagnoses which included adult failure to thrive, muscle wasting and atrophy, and cerebral infarction. The 5 day Minimum Data Set (resident assessment tool) dated 5/30/24 documented the resident had severely impaired cognition and was dependent on staff for activities of daily living (ADL). The physician's order dated 6/3/24 documented bilateral palm guard at all times, remove/release for activities of daily living, and soft hip abductor cushion at all times, remove/release for ADL care and skin checks. A review of the care plan on 6/11/24, titled ADL Self Care Performance Deficit revealed that the bilateral palm guard and soft hip abductor cushion interventions were missing. On 06/11/24 at 07:45 AM, 06/11/24 at 10:46 AM, 06/11/24 at 11:54 AM, and 06/12/24 at 09:49 AM, Resident #51 was observed in their bed without the palm guards and soft hip abductor in place. The soft hip abductor was observed laying on the top of the resident's nightstand. On 06/12/24 at 10:14 AM during an interview, Certified Nurse Aide #14 stated they were not aware of Resident #51's palm guards and soft hip abductor. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/24 at 10:28 AM during an interview and observation, Registered Nurse #15 stated that they worked on the floor two- three- days a week and knew the Resident #51 well. The nurse stated that they were not aware the resident had orders for the soft hip abductor and palm guards. They stated that palm guards and other positioning devices would come from rehab department orders. Registered Nurse #15 pulled the linen that covered the resident to check the palm guards, which the nurse and surveyor did not observe. There was no hip abductor observed in place either. Registered Nurse #15 and the surveyor observed the hip abductor lying on the resident's nightstand. Registered Nurse #15 stated they did not know why the device has not been applied to the resident. They said that they saw the soft hip abductor on the night stand earlier when they started the shift, but they did not question why this hip abductor was not applied for the resident. Registered Nurse #15 searched the nightstand drawers and was unable to find palm guards. Registered Nurse #15 checked the Kardex (care instructions for direct care staff) and did not find the palm guards and soft hip abductor. On 06/12/24 at 10:33 AM during an interview, Registered Nurse Manager #16 stated once the rehab department created the order, the night Supervisor or a day Nurse Manager documented on the care plan, which would be reflected in the Kardex. Registered Nurse Manager #16 observed Resident #51's care plan and stated the palm guards and hip abductor were not on the care plan and should have been. On 06/12/24 at 01:54 PM during an interview, Assistant Rehab Coordinator #17 stated once the Rehab Department recommended devices or treatment, they endorsed devices for the staff on the floor to use. They stated they provided in-service on how to correctly apply palm guards and had a sign-in sheet. 2. Resident #46 had diagnoses which included Quadriplegia, diabetes insipidus, and traumatic brain injury. The Annual Minimum Data Set (an assessment tool) dated 3/30/2024 documented the resident had severely impaired cognition, received 100% of nutrition via a gastric tube and was dependent on staff with all activities of daily living care. A review of the Care Plan; ADL dated 2/23/23 documented assistive device bilateral palm guards at night. Bilateral resting hand splints during the day, remove / release ADL and skin checks A review of the Kardex documented bilateral resting hand splints during the day, remove / release for ADL care and skin checks. Bilateral palm guards at night remove release for ADL care and skin checks. A review of the Physician's Orders dated 3/26/24 documented bilateral resting hand splints during the day, bilateral palm guards use during night. During observations on 6/10/2024 at 7:00 AM, 06/12/24 at 2:46 PM, and 6/13/2024 at 12:00 PM, Resident #46 was in bed without hand splints or palm guards in place. During an interview with Certified Nurse Aide # 8 on 06/13/24 at 12:50 PM, they stated the therapy department was responsible for putting on the resident's splints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 06/13/24 at 01:00 PM, they stated the therapy staff put on the residents' splints. They stated the nursing staff did not put splints on and they were unaware Resident #46 did not have their splints on. During an interview with Occupational Therapist #9 on 06/13/24 at 04:47 PM, they stated therapy staff was responsible to put on the residents splints. They stated that Resident #46 could be resistant. They stated Resident #46 had them on but they were not able to put them on earlier this week. 10 NYCRR 415.12 (e)(2) 49255

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, interviews, and record review conducted during the recertification survey from 6/10/24-6/14/24, the facility did not ensure all residents were provided the appropriate treatment and services to achieve or maintain as much normal bladder/bowel function and prevent urinary tract infections to the extent possible for 1(Resident #66) of 1 residents reviewed for bladder/bowel. Specifically, Resident #66 was not toileted every 2 hours and as needed as per their plan of care. The findings are: Resident #66 was admitted with diagnoses including but not limited to anxiety disorder, Charcot's joint/right ankle and foot (limited mobility), and osteoarthritis. The Quarterly Minimum Data Set, dated dated dated [DATE], documented Resident #66 had intact cognition; required supervision with bed mobility, toileting, and transfers; and was frequently incontinent of bowel and bladder. Physician orders dated 6/6/24 documented Ciprofloxacin HCL 500 mg-give 1 tablet by mouth two times a day for urinary tract infection for 5 days. Physician orders dated 3/25/24 documented transfer out of bed to wheelchair with supervision. The comprehensive care plan titled Activity of a Daily Living self-care performance deficit related to impaired balance, limited mobility dated 4/20/22 documented interventions including a toileting schedule: every two hours and as needed. The comprehensive care plan titled bladder incontinence related to impaired mobility and medications side effect dated 4/20/22 documented goals to include that resident would remain free of complications related to urinary incontinence such as skin breakdown and urinary tract infection through the next review date, with interventions including to check the resident every 2 to 4 hours and as needed, and as required for incontinence. Review of the certified nurse aide Kardex (care instructions) documented Resident #66 was on a toileting schedule and was to be toileted every 2 hours and as needed. Review of the certified nurse aide documentation revealed no evidence that scheduled toileting was being done. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/24 at 08:28 AM, Resident #66 was observed in her room sitting in her wheelchair. There were unused green briefs observed on her nightstand. When interviewed during the observation, Resident #66 stated that the certified nurse aides taught them how to put their brief on by themselves so that they did not have to call for help to be assisted with changing soiled briefs. Resident #66 stated the staff told them that they were independent. Resident #66 was unaware that there was a toileting schedule. Resident #66 stated they were unsteady on their feet and that they needed assistance with incontinence cares. Resident #66 stated that they sometimes put their brief on the wrong way and the urine flowed out into their clothes and on their bed. On 06/11/24 at 12:42 PM, Resident #66 was observed in her room and there were 3 unused green briefs observed in a pink basin on their bed. Resident #66 stated that the staff left the briefs in the room for them to use. During an interview on 06/14/24 at 10:56 AM, Staff #10 (certified nurse aide) stated that sometimes the resident was incontinent of bowel and bladder. Staff #10(certified nurse aide) stated that they never asked the resident if they needed assistant with the bathroom because Resident #66 did not tell staff when soiled. Staff #10 stated they were aware that the resident was to be toileted every 2-3 hours and as needed as per the Kardex but had not documented the toileting because there was no place to document. Staff #10(certified nurse aide) stated that normally when a resident was on a toileting schedule, they documented in the certified nurse aide care guide. During an interview on 06/14/24 at 11:01 AM, Staff #18(Registered Nurse Unit Manager) stated that Resident #66 was on a every 2 hour and as needed toileting. Staff #18 stated that they were the one that implemented and updated the care plans. They stated the toileting schedule was not showing up for the certified nurse aides to document as it was note entered in the computer correctly. Staff #18 stated that Resident #66 could have possibly gotten a urinary tract infection due to poor incontinence care. 10 NYCRR 415.12(d)(2)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on interview and record review conducted during a recertification survey from 6/10/24-6/14/24, the facility did not provide an influenza vaccination for 1 (Resident #19) of 5 residents reviewed for Influenza vaccination after screening and consent was obtained. Specifically, Resident #19 had consent for Influenza vaccine dated 11/29/23 and did not receive the vaccine for the 2023-2024 flu season. Findings include: The facility policy titled Influenza and Pneumococcal Immunizations for Residents, updated April 2020, documented it was the policy of the facility to ensure that residents receive Influenza and Pneumococcal immunizations in accordance with State and Federal regulations and national guidelines. Resident #19 was admitted [DATE] with diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and Morbid Obesity. The Minimum Data Set (MDS, a resident assessment tool) dated 11/16/23, documented the resident was cognitively intact, required supervision for eating, partial assistance for personal hygiene and substantial assistance for toileting. The resident had a signed consent for the Influenza immunization dated 11/29/23. The consent documented the resident agreed to receive the vaccine. The Physicians orders dated 12/1/23 documented Afluria Quadrivalent Pre-filled syringe .5 cc intramuscularly one time only. The resident's December 2023 Medication Administration Record documented the Influenza vaccine as the physician ordered but there was no documented evidence the vaccine was given. During an interview with the Infection Preventionist on 6/13/24 at 3:59 PM, they stated they were responsible for making sure residents received vaccines that were ordered by the physician. The nurses gave the vaccines as ordered and they follow up to make sure it was given. In this case the resident had been in and out of the hospital and they just lost track of this resident. During an interview with the Director of Nursing on 6/14/24 at 10:33 AM, they stated the process was to get as much information about vaccine history on admission and call the families for consents and declinations. The Director of Nursing stated tracking immunizations was very important and needed priority to ensure the record was accurate. 10NYCRR 415.19