STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335653	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah Home & Hospital for Aged & Infirm	1516 Oriental Blvd Brooklyn, NY 11235

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48876 Based on observations, record review, and staff interviews conducted during the Recertification Survey from 10/8/2024 to 10/16/2024, the facility did not ensure that the survey results were posted in a place readily accessible to residents, visitors, or legal representatives where individuals wishing to examine survey results do not have to ask to see them. Specifically, the survey results were located inside a binder placed behind a glass partition at the Security desk. The finding is: The facility policy and procedure titled Right to Survey Results, reviewed 11/22/2023, documented that the facility will ensure that the resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of corrections in effect with respect to the facility. The Facility must: Have reports with respect to any surveys, certifications, and complaint investigations made respective to the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request. The facility will post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey of the facility in areas such as the lobby and the units. During multiple observations from 10/08/2024 to 10/15/2024, a sign was observed on the wall at the Security Desk stating that survey results were survey results were available at the security desk. The binder was not visible or accessible on the counter at the desk but was observed to be located inside a labeled binder located behind a glass partition at the security desk in the front lobby. In addition, there was no signage observed on the resident units indicating where survey results could be located in the facility. On 10/15/2024 at 3:00 PM, a binder labeled survey results was observed located in a bin on the side of the security desk in the front lobby. On 10/15/2024 at 3:05 PM, an interview was conducted with the Safety and Security Officer who stated that the survey results had been moved today from behind the glass partition at the security desk to a bin on the side of the security desk. (continued on next page)

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

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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/2024 at 3:10 PM, the Security Supervisor was interviewed and stated that on 10/14/2024, the book that contains the survey results was behind glass at the security desk. The Security Supervisor also stated that if someone wanted the book, they may feel that they must ask. On 10/16/2024 at 10:28 AM, an interview was conducted with the Administrator who stated that the previous placement of survey results, was a location behind glass at the security desk and in order for someone to have access, they would have to ask. The Administrator also stated that the location of the survey results as of 10/15/2024, had been moved to the side of the security desk at wheelchair height where no one will have to ask for access. 10 NYCRR 415.3(d)(1)(v)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50010 Based on record review and interview conducted during the Recertification survey conducted from 10/08/2024 to 10/16/1024, the facility did not ensure they provided the appropriate liability and appeal notice to Medicare beneficiaries at the termination coverage. This was evident for 1 (Resident #404) of 3 residents reviewed for Beneficiary Notification. Specifically, the Notice of Medicare Non-Coverage was not mailed out to Resident #404's designated representative on the same day that telephone notification was made. The findings are: The facility policy titled Notice of Medicare Non- Coverage (NOMNC) dated 4/9/2024 that a copy of the signed Notice of Medicare Non-Coverage will be provided to the beneficiary or representative. The policy also documented that in the event that the beneficiary is not able to comprehend the information in the Notice of Medicare Non-Coverage, the Notice of Medicare Non-Coverage notification must be delivered to the beneficiary's representative. If the Notice of Medicare Non-Coverage notification is unable to be personally delivered to the beneficiary's representative, the Minimum Data Set Coordinator shall telephone the representative to provide notice of when the beneficiary's services are no longer covered. The date of the telephone conversation is the date of the representative's receipt of the notice, and the Notice of Medicare Non-Coverage will be mailed to the representative by certified mail, return receipt requested, on the same date as the telephone conversation. The form instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 states that if the provider is personally unable to deliver a Notice of Medicare Non-Coverage to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise them when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Resident # 404 was admitted to the facility on [DATE]. Review of the Notice of Medicare Non-Coverage form dated 7/3/24, documented the last covered day for Medicare Part A Services was 7/9/24. The Notice of Medicare Non-Coverage form also documented that Resident #404's representative was spoken with by telephone and a copy of the notice was placed in the chart and given to Resident #404. The area for signature of Patient or Representative and date were blank. There was no documented evidence that the Notice of Medicare Non-Coverage form was mailed to Resident #404's representative after telephone notification was made. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/2024 at 02:13 PM, an interview was conducted with the Minimum Data Set Coordinator/Case Manager who stated that when residents are being discharged from skilled services, they look at the resident's cognitive status and if the resident is not able to understand the information they speak to family members. The Minimum Data Set Coordinator/Case Manager also stated that they ask the family members how they want to receive the information, whether they want it mailed or if they will come to the facility to pick it up. The Minimum Data Set Coordinator/Case Manager further stated that sometimes family members ask for the notice to be sent by email, but it is a waste of time to send by email as there are a lot of notices given. the Minimum Data Set Coordinator/Case Manager stated Resident #404's representative told them to leave the notice in Resident #404's room so that is what they did. On 10/09/24 at 02:19 PM, an interview was conducted with the Minimum Data Set Supervisor who stated that generally the Coordinator is responsible for providing notices and they only get involved if the Coordinator is not in or there is a large volume of notices to be given. The Minimum Data Set Supervisor also stated that when telephone notification is made, family members ask for the information to be left in the resident's room. The Minimum Data Set Supervisor further stated that when family members are told the notice will be sent Certified Mail, they say they are not going to pick up the mail. The Minimum Data Set Supervisor stated that they know that notices are supposed to be mailed on the same day but if they know the family members are coming to the facility they hold the letter and then give them the letter at that point. The Minimum Data Set Supervisor also stated that notices cannot be sent by email because of encryption which prevents family members from opening the emails. 10 NYCRR 415.3(g)(2)(i)

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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** 44843 Based on record reviews and interviews conducted during the Recertification survey from 10/8/2024 to 10/16/2024, the facility did not ensure that comprehensive care plans were developed and implemented to meet each resident's needs. This was evident for 1 (Resident # 64) of 5 residents reviewed for Unnecessary Medications. Specifically, a care plan for use of anticoagulant medication was not developed for Resident #64. The findings are: The facility policy titled Care Plan with creation date 8/6/2020 and last reviewed date 8/6/2024 documented the interdisciplinary team will conduct a comprehensive assessment upon admission to develop a comprehensive care plan for the resident. The policy also documented that the interdisciplinary team would ensure that the care plans include the appropriate treatments and services to attain or maintain a resident's highest practicable physical, mental, and psychological well-being. Resident #64 was admitted to the facility with diagnoses that included Chronic Atrial Fibrillation and Dysrhythmias. The Admission Minimum Data Set assessment dated [DATE] documented that Resident #64 had active diagnoses which included Atrial Fibrillation or Dysrhythmias and was taking an anticoagulant. The Physician's Orders documented Resident #64 was prescribed Pradaxa 75 mg capsule twice daily beginning on 08/07/2024. The Medication Administration Record dated August 2024 documented Pradaxa 75 mg capsule was administered to Resident #64 two times a day as ordered starting on 08/07/2024. There was no documented evidence a comprehensive care plan related to anticoagulant use was developed and implemented for Resident #64. On 10/11/2024 at 11:19 AM, Registered Nurse #1 was interviewed and stated the Registered Nurses on floor were responsible for creating the care plans related to residents' care according to their comprehensive assessment. Registered Nurse #1 also stated a resident taking anticoagulant medication should have a care plan to address the resident's needs and the interventions taken to meet these needs. Registered Nurse #1 further stated that Pradaxa was considered an anticoagulant which Resident #64 had been receiving twice daily since their admission to facility in August 2024. Registered Nurse #1 stated that they were not able to locate a care plan related to the anticoagulant use after reviewing Resident #64's medical record. Registered Nurse #1 also stated it was an error care plan to address use of anticoagulant for Resident #64 was not created. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/2024 at 12:05 PM, the Director of Nursing was interviewed and stated that they and the Registered Nurse managers on the units review the care plans for all newly admitted residents. The Director of Nursing also stated that a resident taking anticoagulant medication had to have a care plan in place to address the potential bleeding concern. The Director of Nursing further stated that Resident #64 was newly admitted in August 2024 and they and the Registered Nurse manager on the unit should have already reviewed Resident #64 care plans , and they were not able to find a care plan related to anticoagulant use in Resident #64's medical record. The Director of Nursing stated they were not able to explain why a care plan related to anticoagulant use was not created. 10 NYCRR 415.11(c)(1)

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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** 41709 Based on observation, interviews, and record reviews conducted during the Recertification and Complaint (NY00317447) survey from 10/08/2024 to 10/16/2024, the facility did not ensure resident's person-centered, Comprehensive Care Plans were reviewed and revised with each assessment and as needed to reflect the resident's changing needs. This was evident for 1 (Resident #389) of 5 residents reviewed for Unnecessary Medication, and 1 (Resident 84) of 4 residents reviewed for Abuse out of an investigative sample of 38 residents. Specifically, the Psychoactive Drug Use Comprehensive care plan for Resident #389 was not reviewed or revised after each assessment, and Risk for Victimization Comprehensive care plan for Resident # 84 was not review or revised after annual or quarterly assessments. The findings are: The facility policy titled Care Plan revised 08/06/2024 documented that the care plan is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly assessments. The policy further documented that the care plan should be reviewed and revised Quarterly, Annually, at a Significant change and medical status changes, with changes to the care plan as needed. 1. Resident #389 was admitted to the facility with diagnoses which included Non-Alzheimer's Dementia, Vascular Dementia with Psychotic features, and Depression. The Annual Minimum Data Set, dated dated dated [DATE] and the Quarterly Minimum Data Set, dated dated dated [DATE] documented that the resident had short and long-term memory impairment, no memory recall and was severely impaired-never/rarely made decisions. The Physician orders reviewed 09/30/2024 documented orders for Rexulti 1 mg tablet by oral route once daily for Vascular Dementia with Psychotic disturbances, Trazodone 50 mg tablet by oral route every night for Depression, Lexapro Escitalopram 10 mg tablet by oral route once daily for Depression, and Melatonin 3 mg tablet by oral route once daily at bedtime for Insomnia. The Comprehensive Care Plan titled Psychoactive Drug Use Etiology: Use of any medication that affects mood, function, behavior, or cognition as evidenced by: Psychoactive drug use dated was effective 01/14/2024 and last evaluation note was completed on 04/14/2024. Goal was maximizing functional potential and well-being while minimizing use of medication and side effects, all interventions implemented on 01/18/2024 included encourage verbalization of feelings, monitor for changes in behavior or mood, observe for any signs of decline in functional or cognitive status, psychiatry consultation. The Comprehensive Care Plan for Psychoactive Drug Use was last reviewed on 4/14/2024. There was no documented evidence that Resident # 389 Psychoactive Drug Use care plan had been reviewed and revised by the interdisciplinary team after the quarterly review assessments were completed on 09/19/2024 and 06/26/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 11:22 AM, an interview was completed with Registered Nurse #2, who was the Nursing supervisor for the Unit. Registered Nurse #2 reviewed Resident #389's medical record and stated that the care plan was not updated last quarter. Registered Nurse #2 also stated that the supervisors and Registered Nurses are all responsible for updating the care plans. Registered Nurse #2 also stated care plans are updated quarterly, annually, episodic due to behaviors and as needed. Registered Nurse #2 further stated that the night shift usually updates the Psychotropic care plans, and they are not sure why Resident #389's care plan was not updated. Registered Nurse #2 further stated that at times the updating of the care plan is missed although the care plan meeting was completed. Registered Nurse #2 gave no reason why the care plan was not updated. On 10/16/24 at 11:16 AM, an interview was completed with the Director of Nursing who stated that care plans are updated quarterly, annually, and as needed. The Director of Nursing also stated that the Registered Nurses on the units are responsible for initiating and updating all care plans, and that night shift is not the only shift responsible for updating the care plans, but all nurses on every shift are responsible for updating the care plans. The Director of Nursing further stated that they monitor that the supervisors and nurses are reviewing care plans by doing random audits on the units and gave no reason why this care plan for Resident #389 was not reviewed or revised timely. 44843 2. Resident # 84 (NY00317447) was admitted to the facility with diagnoses that included Alzheimer's Disease and Closed fracture of unspecified part of left clavicle. The Annual Minimum Data Set assessment dated [DATE] documented Resident #84 had moderately impaired cognition, had no behavior symptoms, and was always incontinent in of bladder. The Annual Minimum Data Set also documented that Resident #84 required supervision to walk in room and had not fallen since admission. The Comprehensive Care Plan related to Resident is at Risk for Victimization was initiated 3/23/2023 and was reviewed and updated on 06/16/2023 and 05/30/2024. A Nursing note dated 5/30/2023 documented that a Certified Nursing Assistant noticed Resident #84 had discoloration to the left shoulder when providing care to Resident #84. The note also documented that Resident #84 had pain at the left shoulder and left shoulder movement was limited. The note also documented Resident #84 stated they fell at night on 05/29/2023 when going to bathroom by themselves and had pain in the left shoulder. A Nursing note dated 5/30/2023 documented that Resident #84 was transferred to the hospital to rule out a left humerus fracture. The Hospital After Visit Summary dated 5/30/2023 documented that Resident #84 had a closed nondisplaced fracture of left clavicle. Quarterly Minimum Data Set assessments were completed on 09/06/2023, 11/27/2023, 02/21/2024, and 8/12/2024, and an Annual Minimum Data Set assessment was completed on 05/15/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the Comprehensive Care Plan titled At risk for Victimization was reviewed or revised after multiple Quarterly and Annual Minimum Data Set assessments had been completed. On 10/11/2024 at 10:13 AM, Registered Nurse #2 was interviewed and stated the Registered Nurses on the floor are responsible for reviewing and updating residents' care plans at least every 3 months and as needed. Registered Nurse #2 also stated that the electronic medical record system gave them alert when the care plans were due for review, and the Registered Nurse reviewing the care plans should either update the care plan, or document to continue current care plan if no change was required as evidence that the care plan was reviewed. After review of Resident #64's medical record, Registered Nurse #2 stated that there was no evidence that the care plan was reviewed between 6/17/2023 and 5/29/2024, and after 5/30/2024. Registered Nurse #2 further stated that they were not able to explain why the care plan was not reviewed and updated at least every three months. On 10/11/2024 at 10:39 AM, the Director of Nursing was interviewed and stated the registered nurses on the unit were responsible to review and update care plans at least every 3 months and as needed. The Director of Nursing also stated that the Registered Nurse is to document to continue the care plan if no change was needed. The Director of Nursing further stated that it was an error that the care plan was not updated at least every 3 months and after the Minimum Data Set assessments had been completed. The Director of Nursing also stated that the Registered Nurses were professional, and they did not monitor to see if the Registered Nurses reviewed and updated the care plans. 10 NYCRR 415.11(c)(2)(i-iii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709 Based on observations, record review, and staff interviews conducted during the Recertification survey between 10/08/2024 and 10/16/2024, the facility did not ensure that needed services, care and equipment are provided to assure that residents with limited range of motion and mobility maintain or improve function based on the residents' clinical condition. This was evident for 1 out of 3 residents reviewed for Position and Mobility, (Resident #382) out of 38 sampled residents. Specifically, Resident #382 had an order to apply bilateral splints to resident's hands to be worn at all times and was observed on multiple occasions without the device in place as per Physician's order. The findings are: The facility's policy and procedure titled Splint/Brace/Assistive devices dated 4/9/2024 documented the purpose is to ensure the correct application of the brace/splint. The policy further documented that the Certified Nursing Assistant applies the splint/brace as per instructions. Resident #382 was admitted to the facility with diagnoses that included Coronary Artery Disease, and Respiratory Failure, with Tracheostomy status. The Annual Minimum Data Set assessment dated [DATE] documented that Resident #382 was in a persistent vegetative state and was dependent on staff for all activities of daily living. On 10/08/24 at 12:10 PM and 10/08/24 at 02:45 PM, Resident #382 was observed in bed with contractures on both hands and there was no device observed in Resident #382's hands. On 10/10/24 at 09:58 AM, Resident #382 was observed in bed with eyes closed. Resident #382 hands had closed fists and there was no device observed in place. On 10/11/24 at 10:56 AM, Resident #382 was observed in bed on lying in bed on their back with tracheostomy in place receiving oxygen. Both of Resident #382's hands were resting on the upper part of their stomach. Resident #382's hands remained in a closed fist and no device was observed in either hand. The Physician's Order dated last reviewed 9/24/2024 documented apply bilateral splints to resident's hands. Wearing Schedule: At all times. Instructions: Remove every shift for skin inspection, and during meals as needed for feeding. Provide Range of Motion prior to splint/brace application. Goals: To promote optimal positioning and maintain joint integrity. The Comprehensive Care Plan titled Dressing/Grooming Self Care Deficit dated 10/28/2023 with last evaluation note dated 7/27/2024 included an intervention of apply bilateral Splints to resident's hands. The Occupational Therapy progress notes dated 11/09/2023 at 01:56 pm, documented Issued Bilateral hand splints to be worn at all times. Remove every shift for pressure relief. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Occupational Therapy progress note dated 01/29/2024 at 01:54 pm, documented applied bilateral splints to the patient's hands. The Occupational Therapy progress note dated 04/02/2024 at 03:13 pm, documented left message for daughter, bilateral resting hand splints applied. The Resident Nursing Instructions Record dated 10/2024 documented under section titled monitoring Nursing Rehabilitation Splint/Brace Notes: Apply bilateral Splints to resident's hands. Wearing Schedule: At all times. Instructions: Remove every shift for skin inspection, and during meals as needed for feeding. Provide Range of Motion prior to splint/brace application. Schedule: Every Day at 6:00 am-2:00 pm; 2:00 pm-10:00 pm; 10:00 pm-6:00 am On 10/11/24 at 11:06 AM, an interview was completed with Certified Nursing Assistant #6 who stated they are assigned to Resident #382. Certified Nursing Assistant #6 stated Resident #382 requires total assistance with all activities of daily living, and their hands are clenched like a fist and so something like a splint must be placed in Resident #382's hand. Certified Nursing Assistant #6 also stated they did not receive in-service on the splint, and they were not sure how long Resident #382 must keep the splint on, or when to take the splint off. Certified Nursing Assistant #6 further stated that they take the brace off when administering care, and when finished care with care they are supposed to put the splint back on. On 10/11/24 at 11:12 AM, Certified Nursing Assistant #6 and State Surveyor entered Resident #382's room where Resident #382 was lying in bed without splint devices in place. Certified Nursing Assistant #6 stated the bilateral splints were in Resident #382's Geri chair located at the foot of their bed. Certified Nursing Assistant #6 also stated they forgot to put the brace back on after completing care this morning, and they were leaving for lunch now and would replace splints for Resident #382 when they returned from their break. On 10/11/24 at 11:13 AM, Certified Nursing Assistant #6 exited Resident #382's room with the State Surveyor and did not apply the splints for Resident #382. On 10/11/24 at 11:37 AM, an interview was completed with Registered Nurse #4 who stated they are aware that Resident #382 should always have a splint in place which is to be removed for skin inspection and or skin care. Registered Nurse #4 was unable to explain why on multiple occasions the splint was observed not to be in in place. Registered Nurse #4 also stated they take the splint off every two hours, and at times every 15 minutes for skin inspection and that is the reason why the splint was off. Registered Nurse #4 reviewed the physician orders for Resident #382 and stated there was no order for 15 minutes and or two hours removal of splint, but there was an order to remove as needed. Registered Professional Nurse #4 then stated that they did remove the splint, but they will reapply the splint soon. Registered Nurse #4 stated skin checks are completed during activities of daily living and was unable to explain why the splint was not in place after activities of daily living care was completed this morning. (continued on next page)

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	335653	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah Home & Hospital for Aged & Infirm	1516 Oriental Blvd Brooklyn, NY 11235

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:15 AM, a follow up interview was completed with Registered Nurse #4, who stated they became aware that Resident #382 has a splint through the doctor's order. Once orders are in place, Occupational Therapy staff will come to the unit and show staff how to put the splint on and staff will follow the instructions. Registered Nurse #4 also stated the splint for Resident #382 is to be removed for skin inspection only, not for 15 minutes or every two hours as previously stated, and this was an error. On 10/11/24 at 11:44 AM, an interview was completed with Registered Nurse #3, who was the Unit Manager. Registered Nurse #3 stated any splints, rolls, or devices are ordered for the resident after Physical and or Occupational Therapy assessment. Registered Nurse #3 also stated that once the splint and or roll is recommended the physician is made aware and an order is placed in the medical record of the resident. Therapy will then come to unit to in-service staff on how to apply the splint. Registered Nurse #3 further stated as per the doctors' orders the splint is removed for skin inspection and meals, however Resident #382 feeds by G-Tube. Registered Nurse #3 stated the skin inspection is usually done during activities of daily living. Registered Nurse #3 also stated that the charge nurse monitors that the splint is in place and Registered Nurse #3 also monitors, by making rounds at times. Registered Nurse #3 stated that they make rounds in the mornings, afternoons, and as needed, and they ask the staff if there are any concerns. Registered Nurse #3 further stated the staff must follow the doctors' orders to remove splint for skin inspection only, and the nurse on the unit is to ensure that the staff is applying the splint. On 10/11/24 at 02:32 PM, an interview was completed with the Rehabilitation Director who stated all resident who have an assistive device such as splints, are evaluated by the Occupational Therapist, and if the Occupational Therapist deem the resident will benefit from a device such as a splint it will be ordered. An order will be obtained from the doctor and placed into the resident's medical record. Once the device is received and the medical order is in place, the Occupational Therapist will go to the unit and show the staff the splint and provide in-service to the staff on how to place the splint on the resident and when to take the splint off. The Rehabilitation Director also stated that all the instructions for putting on and removing the splint device are in the medical orders. The Rehabilitation Director further stated that the Rehabilitation staff do not document the in-service that is provided to staff on the unit, and they have no record of the in-service, but the therapist does go to the unit and shows staff how to apply the splint. The Rehabilitation Director stated that the splint is usually to be removed once per shift for skin inspection such as redness, and during meals. On 10/16/24 at 11:10 AM, an interview was completed with the Director of Nursing who stated after the Rehabilitation staff evaluates the resident's for the need for a splint or device, an order is placed in the medical record, and placed in the Certified Nursing Assistant Instructions and the Certified Nursing Assistant is then responsible for putting the splint on as per medical orders and recommendations as per Rehabilitation. The Director of Nursing also stated that once all orders and recommendations are in place, the Rehabilitation Therapist will go to the unit and in-service the staff on the use of the device. The Director of Nursing further stated the order to remove the splint every 15 minutes or every two hours depends on the resident, the physician order, and the therapy recommendations. The Director of Nursing reviewed the order for Resident #382 and stated that the order is remove every shift for skin inspection and for meals as needed. The Director of Nursing stated the nurse on the unit monitors and completes audits to monitor that splint is in place. 10 NYCRR 415.12(e)(2)