STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335659	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fordham Nursing and Rehabilitation Center	2678 Kingsbridge Terrace Bronx, NY 10463

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on interview and record review conducted during the Recertification Survey from 10/21/2024 to 10/28/2024, the facility did not ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for 1 (Resident #209) out of 5 residents reviewed for Accidents out of 37 total sampled residents. Specifically, the facility did not report an incident when Resident #209 was found on the floor with laceration on the hand and a head contusion, to the New York State Department of Health. The findings are: The facility's policy and procedure titled, Reporting and Investigation of Resident Abuse, Neglect, Misappropriation/Exploitation and Mistreatment reviewed 10/2022 documented the facility shall ensure that alleged violations involving mistreatment, neglect, or abuse including significant injuries of unknown source are reported immediately to the Administrator of the facility or designee. When required by regulation, the facility shall ensure timely notification to the Department of Health. Resident #209 admitted to the facility with diagnoses of Hypertension, Hyperlipidemia and Non-Alzheimer's Dementia. The Minimum Data Set, dated dated dated [DATE] documented cognition is severely impaired; had short-term memory problem. Resident #209 is dependent on staff assistance to roll left and right, sit to lying and lying to sitting on side of bed, and chair to bed transfer. The Comprehensive Care Plan for Actual Fall revised 9/18/2024 documented Resident #209 had an unwitnessed fall on 9/15/2024 with injuries. The Nursing Note dated 9/15/2024 documented, Resident #209 was found on side of bed on floor, unable to determine cause of fall due to language barrier. Resident was noted with contusion to right posterior head and skin tear to the right hand. Physician was notified and ordered the resident transfered to the hospital. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order dated 9/15/2024 documented Resident #209 to transfer to hospital for status post fall with injury. The Occurrence Investigation Form completed 9/15/2024 documented on 9/15/2024 at 10 AM, Resident #209 was found on floor by the bed; noted contusion to right posterior head and skin tear to the right hand. It documented that it was an unwitnessed occurrence. Resident #209 did not provide any explanation/statement about the occurrence. The review of Accident Report and Investigation Forms revealed there is no documented evidence that Resident #209 provided a statement about the incident that occurred on 9/15/2024. The Hospital Discharge Summary dated 9/18/2024 documented Resident #209 was admitted following a fall with head trauma at the nursing home. Resident noted with hematoma on right side of scalp and skin tear to right hand. Resident was treated with staples to the scalp and skin tear with Steris strips. The facility's Investigation Summary documented that on 9/15/2024 at 10 AM, Certified Nurse Aid responded to a noise and observed Resident #209 on the floor beside the bed. Resident #209 was unable to provide any information regarding the fall secondary to their cognition. Upon assessment, Resident #209 was noted with a contusion to their scalp and skin tear to the right hand. Resident was transferred to the hospital and was treated with staples applied to the scalp, adhesive strips to the hand. The investigation concluded that resident rolled out of bed sustaining injuries to head and hand due to poor awareness of the bed boundaries. There was no abuse, neglect or mistreatment that occurred to Resident #209. It further documented that as a result of this investigation, this incident will not be reported to Department of Health. The investigation summary with conclusion was signed by Director of Nursing Services and Administrator on 9/18/2024. There was no documented evidence the facility reported Resident #209's unwitnessed fall incident, resulted in injuries, to the New York State Department of Health. On 10/24/2024 at 2:56 PM, Director of Nursing Service stated they will report alleged violations involving mistreatment, neglect, or abuse to New York State Department of Health. Director of Nursing Services stated this incident was not reported to New York State Department of Health because staff responded to a loud noise and saw Resident #209 on the floor in the room. This was an unwitnessed fall resulting in injuries. Director of Nursing Service stated Resident #209 went to the hospital for evaluation and returned to the facility with staples on the head and skin tear treated from the hospital. The investigation concluded that Resident #209 rolled out of the bed resulting in those injuries and that there was no suspicion of resident-to-resident altercation, or staff abuse. On 10/24/2024 at 4:19 PM, Administrator could not recall if they were on duty but stated they were notified about this incident immediately after it occurred on 9/15/2024. Administrator stated the incident was not reported to the New York State Department of Health because resident had a fall incident and ruled out that abuse occurred. 10 NYCRR 415.4(b)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on record review, and interviews conducted during the Recertification survey from 10/21/2024 through 10/28/2024, the facility did not ensure that the Minimum Data Set 3.0 (MDS) assessment accurately reflected a resident's status for 2 (Resident #170 and #79) residents out of total 38 sampled residents. Specifically, (1) Resident #170 who was not receiving anticoagulant medication was coded as receiving anticoagulant medication. (2) Resident #79 was coded as receiving hospice services after hospice services were ordered disconinued . The findings include are: The facility policy titled MDS Assessment Version 3.0 effective 10/2023 documented the facility will conduct initially and periodically a comprehensive, accurate, standardize reproducible assessment of each resident's functional capacity. The assessment must reflect the status of the resident including resident strengths and needs that must be addressed in an individualized care plan. The Minimum Data Set Assessment Version 3.0 Correction / Modification Policy dated effective 10/2023 documented any errors discovered in a completed Minimum Data Set must be corrected through the appropriate modification process, ensuring the resident clinical status is accurately reflected in the record. Modification request is used to correct an IQIES record containing incorrect Minimum Data Set item values due to transcription errors, data entry errors, software problems errors , item coding errors and /o other error requiring modification. A Minimum Data Set assessment can be modified or corrected if there are errors in the date before submission After submission if an error is found after the assessment is accepted by the State Minimum Data Set data base the facility must complete a Correctio request form to modify the assessment. Complete a significant correctio of a prior full assessment if needed within 14 days of identifying the error. A major cl error occurs when the resident's clinical status is not accurately represented in the Minimum Data Set. The Significant Correction of a Prior Full Assessment is a comprehensive assessment that requires completing the Full Minimum Data Set, Comprehensive Annual Assessment and Comprehensive Annua Assessment Summary. 1) Resident #170 admitted with diagnoses of Hypertension, Peripheral Vascular Disease, Cerebrovascular Accident and Hemiplegia or Hemiparesis. The Order Summary Report as of 08/2024 documented Resident #170 was ordered Clopidogrel Bisulfate Tablet 75 milligram - 1 tablet by mouth one time a day for blood clot prevention. The Medication Review Report dated 08/01/2024 to 08/31/2024, documented that Resident #170 received Clopidogrel Bisulfate Tablet 75 milligram tablets. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented in Section N: Medications under section N0415: coded that Resident #170 was taking anticoagulant medication. The Modification of Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented in Section N: Medications under section N0415: modified that Resident #170 was taking antiplatelet medication. The Modification of Minimum Data Set 3.0 (MDS) assessment under Section X - Correction Request was modified dated 10/22/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 11:00 AM, an interview conducted with the Minimum Data Set Coordinator and stated that Resident #170 was on antiplatelet medication and not an anticoagulant medication. The Minimum Data Set Coordinator stated the Minimum Data Set Assessor is responsible for the accuracy of the assessment. The Minimum Data Set Coordinator stated they are responsible for signing the completeness of the assessment. The Minimum Data Set Coordinator stated that they review the Minimum Data Set, dated dated dated [DATE] on 10/22/2024 and noticed that the medication, Clopidogrel Bisulfate was incorrectly coded, and they modified the assessment on 10/22/2024. The Minimum Data Set Coordinator stated they counselled the Minimum Data Set Assessor and provided with the lists of medications that required to be coded in Minimum Data Set. [NAME], [NAME] 2) Resident #79 diagnoses which include Dementia, Major Depression Disorder Recurrent Unspecified and Insomnia Unspecified. The Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] documented the Resident #79 had severely impaired cognition and documented in Section O: (Special Treatments and Programs) that Resident #79 was on hospice services. The Significant Minimum Data Set (MDS) 3.0 assessment dated [DATE] documented Resident #79 had severely impaired cognition and documented in Section O:(Special Treatments and Programs) that Resident #79 was on hospice services. This was done by Minimum Data Set Assessor #2. The Physician Order's Summary for Resident #79 was reviewed and documented orders for Hospice were from 11/29/2023 -05/13/2024. The Dietary Progress note dated 12/29/2023 documented resident #79 remains in hospice care. The Social Work Progress note dated 11/29/2023 documented that they were informed by the Hospice care representative that Resident #79 was admitted into Hospice care with a primary diagnosis of Vascular Dementia secondary to multiple Cerebrovascular accident and the interdisciplinary team was informed and resident care plan updated. The Social Work Progress note dated 2/27/2024 documented the Quarterly Care Plan meeting documented the resident representative and the Hospice social work in attendance, all questions addressed, and no concerns noted. The Medical Progress notes dated 3/6/2024, 4/4/2024 documented that Resident #179 was on hospice services. The Comprehensive Care Plan for Hospice effective 11/29/2023 with interventions assess and monitor resident for signs and symptoms or discomfort, encourage expressions of feelings related to diagnosis and disease progression, engage resident/family in discussion related to goals of care. obtain MD order for Hospice services. On 10/23/2024 at 11:20AM the Minimum Data Set Coordinator was interviewed and stated that they modified the Minimum Data Set for 08/07/2024 and it was modified due to a coding error. They completed Section X (Correction Request) on 10/23/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 11:49 AM, the Minimum Data Set Coordinator was interviewed and stated the last Quarterly Minimum Data Set on 10/07/2024. Resident #79 was not on hospice care at the time of the Minimum Data Set review. While reviewing the chart, they noticed that hospice was checked, and they submitted a correction for the Minimum Data Set. They completed the original Minimum Data Set, and it was incorrectly coded. The assessment should reflect the resident status as of the reference date of the Minimum Data Set. On a regular basis they look at audits of the Minimum Data Sets and the last audit was done for dialysis. They try to take last Minimum Data Sets coded and it is used for internal learning and education and talk to staff to improve in relation to their accuracy. We do it once a quarter, do reviews and look at special triggers (hospice, dialysis and do look backs to make sure it matches. On 10/24/2024 at 04:58 PM, the Minimum Data Set Assessor #1 stated when they complete Section O: Special Treatments and Programs. They go thru progress notes from the previous day of the Assessment Reference Date, consults for the reference and any pertinent information or labs or orders for the residents. They look at the medical provider notes in relation to hospice and nurse's notes if a resident is still under hospice care. We always get in-services or counseling if there are any updates for the section. The Minimum Data Set should be accurately coded to reflect the resident's chart and assessment and it should be accurate. Minimum Data Set Assessments are done in person or offsite. The assessment needs to be accurate so the resident will get the proper care that they need. They stated that they saw a note from the doctor and that's why they may have gotten confused. On 10/24/2024 at 05:04 PM, the Minimum Data Set Assessor #2 stated that they do a 14 day look back period based on the resident's assessment and Section O: Special Treatments and Programs Section O0110: Hospice Care. If the resident is on Hospice, then you have to click hospice on the assessment. You have to capture 14 days from the Assessment Reference Date. They look at the Hospice notes, documents such as physician orders and if the resident is still on hospice the box is checked. They also look at the medical provider notes in the last 30 to 60 days and nurse's notes in the last 14 days. We have to make sure it is accurate, since we are sending it to the Centers for Medicaid and Medicare Services, so they know the residents are on special care. They are provided in-services if there are new updates to the Minimum Data Set and perform webinar trainings also. On 10/24/2024 at 12:21 PM, Registered Nurse # 8 was interviewed and stated Resident #79 was on Hospice when they started working there but they are no longer on Hospice services. On 10/24/2024 at 11:45 AM, the current Attending Provider #1 stated that resident #79 was not on Hospice Services and they took over the resident's care in June 2024 and they used to be assigned to Attending Physician # 2. On 10/25/2024 at 11:22 AM Attending Physician #2 was interviewed and stated, They recall Resident #79 who had Advanced Dementia, and they were also on hospice services. The resident was losing weight and they were admitted to hospice services after a discussion with their family. They stated they communicated with the Hospice nurse in relation to recommendations and plan of care updates for Resident #79. They further stated that the Social Worker will confirm the resident was on hospice and there was an order in the resident's chart and the resident may have a Hospice assistant assigned. If a resident is on hospice they document this diagnosis in the notes. They stated, the unit they worked on changed between January to June 2024. The electronic medical record documents if a resident is on Hospice along with orders for advance directives and Hospice care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/2024 at 11:36 PM, The Social Worker #2 was interviewed ant stated that Resident #79 was on Hospice for a period of time. They were referred to hospice services on 11/2/2023 and accepted on 11/29/2023. The reason for the referral was Vascular Dementia due to multiple Cerebrovascular accidents and it was recommended by the interdisciplinary treatment team after discussion and the resident's representative who was in agreement. The attending physician sent the referral to Hospice provider on 11/27/2023 and the order was discontinued on 5/8/2024. They have communicated with the hospice social worker. 10 NYCRR 415.11 (b)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review and interviews conducted during Recertification Survey from 10/21/2024 to 10/28/2024, the facility did not provide, based on the comprehensive assessment, interests, and the preferences of each resident, an ongoing program to support residents in their choice of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not appropriately assess interests and activity preferences for non-English speaking resident and provide an ongoing program of activities designed to meet their interests for Resident #209. This was evident for 1 (Resident #209) resident reviewed for Activities out of 37 total sampled residents. The findings are: The facility's policy and procedure entitled Activity Recreation Program and Assessment revised 11/2016 documented that facility shall provide for an ongoing program of activities designed to meet the interest and the physical, mental, psychosocial well-being of each resident. Recreation Therapist shall complete a comprehensive assessment and develop a plan of care that reflect the resident's level of leisure and lifestyle satisfaction, response to recreational activity goals which is reviewed on a regular basis. Resident #209 admitted to the facility on [DATE] with diagnoses of Hypertension, Hyperlipidemia and Non-Alzheimer's Dementia. The Minimum Data Set, dated dated dated [DATE] documented Resident #209's preferred language is Mandarin and Resident/Designated Representative were not interviewed for Daily and Activity Preferences because resident is rarely/never understood, and family/significant other was not available. The Minimum Data Set, dated dated dated [DATE] documented Resident #209 has severely impaired cognition and requires substantial/maximal assistance to sit to lying and lying to sitting on side of bed, and chair to bed transfer. On 10/22/2024 at 11:42 AM, Resident #209 was awake, lying in bed with television on, not in their preferred language. The remote control was on the windowsill and not easily accessible for the resident. On 10/23/2024 at 10:18 AM, Resident #209 was awake, lying in bed with television on the same channel, not in their preferred language. There was no list of a channel guide for the resident in the room. On 10/24/2024 at 12:54 PM, Resident #209's family was interviewed who stated they are the designated representative to discuss about Resident #209. Designated representative stated that they have been contacted related to resident's treatment/care needs but never been contacted about resident's daily and activity preferences. Designated representative further stated that they were not aware that there were activity programs for residents in the facility. (continued on next page)

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	335659	A. Building B. Wing	10/28/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for Therapeutic Recreation initiated/last revised 6/28/2024 documented to establish/record the resident's prior level of activity involvement and interests by talking with the resident caregivers, and family on admission and as necessary. Invite/encourage the resident's family members to attend activities with resident to support participation. The Therapeutic Recreation Initial assessment dated [DATE] documented Resident #209 is long term, speaks Mandarin. The daily and activity preferences for Resident #209 were checked as no response because resident not able to communicate and family interview could not be completed. It indicated that resident's past/current activities obtained from the chart were inside the home, watching TV/movies, family centered activities, and solitary activities. The Therapeutic Recreation Assessments dated 9/23/2024 documented Resident #209/family member were unable to complete the interview. The daily and activity preferences were checked as no response. It documented staff interview indicated keeping up with the news is important for Resident #209's activity preference. The Therapeutic Recreation Activity Log from 10/1/2024 to 10/23/2024 revealed Resident #209 participated total of 1 activity program: 1 to 1 visit on 10/8/2024. The review of Therapeutic Recreation Notes from 10/1/2024 to 10/23/2024 revealed there was no documented evidence Resident #209 was offered any activities or that they refused the activity program. There was no documented evidence that Resident #209 and/or family member participated in the initial/quarterly assessment process and that ongoing assessment/program of activities that meet the resident's interests and functional capacity were provided for the resident. On 10/24/2024 at 12:04 PM, Certified Nurse Aid #1 stated Resident #209 is dependent for all ADL care and will require Hoyer lift to get out of bed. They further stated Resident #209 is mostly sitting in the bed and watches television. On 10/24/2024 at 11:39 AM, Licensed Practice Nurse #1 stated Resident #209 is assisted out of bed with Hoyer lift and sits in the dining room at times. They further stated they have not seen Resident #209 participating in any activity program with activity staff. On 10/23/2024 at 10:47 AM, Activities Aid stated resident #209 was transferred to this unit about a month ago. Resident #209 can express yes/no or simple terms in English but needs to be prompted for response. Resident #209 was assessed for their activity preferences using hand gestures and resident responded yes if they liked the activity. Activities Aid stated they don't recall calling the family or utilizing the translation service for resident's information because resident understood the simple words/gestures. Activities Aid stated Resident #209 does not really engage in any social activity so Activities Aid will visit resident in the room for 1 to 1 visits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/2024 at 9:48 AM, Recreation Director stated activity staff is responsible to introduce the activity programs and interview the resident/family member upon admission to gather information about resident's interests. Activity staff will also introduce different activity programs with the resident to assess their preferences and offer programs that resident can enjoy based on their participation and responses to the program. Recreation Director stated Resident #209's assessment was conducted with assistance of the interpreter hotline; however, the resident was unable to complete the interview due to confusion. Resident #209 did not answer questions as per interpreter, resident repeated the questions instead of answering. 10 NYCRR 415.5(f)(1)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on interview and record review conducted during the Recertification Survey from 10/21/2024 to 10/28/2024, the facility failed to ensure that the physician reviewed the resident's total program of care at each visit. This was evident for 1 (Resident #74) of 1 resident reviewed for an Optometry consult. Specifically, there was no documented evidence that the recommendations by the Optometrist to see the Ophthalmologist was carried out. Additionally, the Optometry consult was dated 04/05/2024 and attending physician reviewed and signed the consult on 09/07/2024 which was 5 months later then the consult date. The findings are: The facility policy titled Medical and dental Consults dated 05/2024 documented it is the policy of the facility to arrange for services of qualified professional personnel to render specific medical services. An order for consultation shall be placed in the electronic medical record (EMR) with the reason for consultation. Consultations shall be completed within 30 days of the initial order. The Licensed Nurse or Registered Nurse Supervisor documents in progress notes that resident was seen by the consultant and any recommendations. The medical provider reviews the recommendations of the consultant and indicates agreement or non-agreement. Resident #74 admitted with diagnoses including Hypertension, Peripheral Vascular Disease (a disorder of the blood vessels outside the heart), Renal Insufficiency, and Age-Related Nuclear Cataract, Bilateral. The Minimum Data Set assessment dated [DATE] documented Resident #74 has intact cognition. The Optometry Consult dated 04/05/2024 documented the diagnosis of Cataract NS (Nuclear Sclerotic) OD (right eye), OS (left eye) Moderate OD OS first study refer for CE (Cataract Extraction) monitor for progression. Referred to Ophthalmologist Cataract Surgery OD. The Optometry Consult dated 04/05/2024 was reviewed and signed by the attending physician on 09/07/2024 which was 5 months later than the consult date. A review of the nursing and physician progress notes dated 03/20/2024 through 04/15/2024 did not reveal documented evidence that Resident #74 's referral to Ophthalmology was carried out and there was no evidence of documentation that Resident #74 refused the recommendation from the Optometrist to consult with the Ophthalmologist. On 10/21/2024 at 2:49 PM, an interview conducted with Resident #74 who stated, they knew they had cataracts prior to admission to the facility and was seen by an eye doctor in the facility but there was no follow up done. (continued on next page)

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	335659	A. Building B. Wing	10/28/2024

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/2024 at 9:59 AM, an interview conducted with Nurse Practitioner who stated that they were not the one who signed the Optometry consult dated 04/05/2024 but they were aware when the Optometry consultation was made with the recommendation of referral to the Ophthalmologist. Nurse Practitioner stated that they discussed the recommendation with Resident #74, and they (Resident #74) preferred to be followed up from their outside Ophthalmologist. Nurse Practitioner stated they do not have documentation about their discussion with Resident #74. Nurse Practitioner stated that they talked to Resident #74 about the consult now and Resident #74 got an appointment on 11/15/2024 with the Ophthalmologist. On 10/28/2024 at 4:13 PM, an interview conducted with the Attending Physician who stated, they read and reviewed the Optometry consult signed by them. They stated that the consult also usually is reviewed by the Nurse Practitioner in the unit and if there were questions or clarifications with the consult, the Nurse Practitioner would notify them. They further stated that Resident #74 had an Optometry consult made but was not sure if the Nurse Practitioner made a referral to Ophthalmology as what was recommended in the Optometry Consult. They stated they did not speak to Resident #74 regarding the recommendation to see the Ophthalmologist. They stated they do not recall if there is a documentation about the recommendation for the Ophthalmology consult. Consults are usually documented by the Nurse Practitioner. They stated the Optometry Consult was performed on 04/05/2024. They further stated they reviewed and signed this Optometry Consult on 09/07/2024 which was 5 months later. On 10/28/2024 at 4:27 PM, an interview was conducted with the Medical Director who stated, the recommendation by the Optometrist in the Optometry Consult to see the Ophthalmologist should have been carried out. 10 NYCRR 415.15(b)(2)(iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335659	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observations, record review, and interviews conducted during the Recertification Survey from [DATE] to [DATE], the facility did not ensure infection control practices were followed. This was evident during the Dining Task for 1 of 5 dining rooms. Specifically, 1. The kitchen did not ensure that food items were discarded by the use/expiration date. This was evident for the Kitchen Task. 2. Certified Nursing Assistant #8 did not perform hand hygiene in between residents while assisting multiple residents with hand hygiene prior to lunch being served this was evident for the 5th floor. The findings are: The facility policy titled Standard Precautions for Infection Control that was revised on ,d+[DATE] and reviewed [DATE] documented, It is the policy of the facility to follow and apply standard precautions as infection prevention measure during all resident care regardless of suspected or confirmed infection status of the resident. Standard precautions is based on the principle that all blood, body fluid, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin and mucous membranes may contain transmissible infections agents. Hand hygiene before and after contact with the resident. 1. During observation of the kitchen task on [DATE] from 09:20 AM- 09:54 AM the following was observed: In the emergency food storage area they were 4 boxes of Chefler Foods mayonnaise containing 200 -, d+[DATE]-ounce pouches of mayonnaise with a use by date of 12 [DATE] and 1 box of mayonnaise with expiration date of [DATE]. On [DATE] at 12:20 PM, an interview was conducted with the storeroom person who stated they are in charge of the storeroom and the emergency food room. Last week or prior week they noticed a few expired items that included canned food and enteral feeding and the items were discarded. They saw the mayonnaise in the storage room ,d+[DATE] weeks ago. It was an old delivery, and they are not sure when it was received. They rotated items this month for all food items. The mayonnaise in individual packets are only placed in the storeroom. There should not be any expired food items in the storeroom. They use first in first out and they are in-serviced on it daily. It was a mistake that the expired food item was still there. On [DATE] at 09:18 AM, Food Service Supervisor # 1 was interviewed and stated; I look at items in the storeroom daily and I take expired items and throw them out. Last Friday was the last time I looked at the emergency food storage room and noticed expired items of mayonnaise and threw out on Monday. They stated that on Friday everything was good, and it was on Monday that they found the expired items. We cannot give expired food to the residents, and it will be bad if we give to the residents. They have to make sure food is in good condition. If it is one to two days before expiration date, we throw the food item out. The staff are in-serviced every time we receive items. We put the older items in the back and the dates to use up first. (continued on next page)

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	335659	A. Building B. Wing	10/28/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:21 AM, Food Service Supervisor # 2 was interviewed and stated that they look at the food items daily and at all items for meals. They look at the emergency food daily. No items were expired in the emergency food room that they noticed. They stated they were not informed of the expiration of the mayonnaise. They stated it was curious that they did not notice. The food items needed to be discarded so we won't get risk from expired items and so there is no cross contamination. They stated moving forward they are aware that they need to check more closely for dates of food products. On [DATE] at 11:27 AM, the Dietary Director was interviewed and stated; they look at the storeroom every 6 months and do a thorough check. They stated 1 to 2 times a month they look at food items. They did not notice the items before. We don't want to get anyone sick, and it is something we overlooked and when items come in and when expired. This is something that rarely happens. On [DATE] at 1:05 PM, the Infection Preventionist was interviewed and stated; they inspect the kitchen environment to include the storage room. They look at the expiration date of items in the kitchen storage room. They stated they have not looked at the emergency food. We cannot give expired food which can cause infections and diarrhea. The expiration date is very important. They stated they have not done an in-service on expired items for the kitchen. Mayonnaise if it is expired and not at the correct temperature can give bacteria and cause vomiting among residents. 2. During dining observation on [DATE] between 12:25 PM and 12:31 PM, Certified Nursing Assistant # 5 was observed passing out hand wipes from the dining table on the left side of the room to the right side of the room and assisting residents with hand hygiene by passing out the hand sanitizing wipes in the dining room with bare hands and assisting residents who needed assistance to clean their hands. Certified Nursing Assistant #5 assisted Resident #134 in cleaning their hands with wipes, Certified Nursing Assistant #5 then took additional clean hand wipes from the container and passed the wipes to additional residents who did not require assistance with hand hygiene and then proceeded to assist the following residents to perform hand hygiene with their bare hands, Resident #114's, #176's, 130's and #56. Certified Nursing Assistant #5 did not perform hand hygiene in between residents. On [DATE] at 12:54 PM, Certified Nursing Assistant #5 was interviewed and stated; they are aware that they did not do hand hygiene between residents and there was no reason why it was not done. They further stated that for infection control we don't want to cross germs from one resident to another. Certified Nursing Assistant #5 stated they were supposed to clean their hands in-between residents to prevent the spread of germs from one resident to another. They were supposed to clean their hands for infection control in between residents but they did not do so. On [DATE] at 03:50 PM, Registered Nurse #7 was interviewed and stated; that staff will prepare residents for dining by doing hand hygiene. If staff pick up hand wipes, they are to clean their hands. Residents should be given separate hand wipes. For infection control there are germs, and they can pass from hand to hand, so staff wash their hands before they assist residents. We might get another bacteria or germs from resident to control infection. We make sure we wash hands before touching another resident. We remind staff and staff are re-inserviced. (continued on next page)

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	335659	A. Building B. Wing	10/28/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 03:55 PM, Registered Nurse #8 was interviewed and stated; they are in the dining room during lunch to make sure that the certified nursing assistants wash their hands and kitchen staff washes their hands as well. Certified Nursing Assistants offer hand wipes to each resident in the dining room as well as residents in their rooms before meals. For infection control don't want to spread bacteria from resident to resident and from staff to protect self as well. There has been recent inservice on hand hygiene. On [DATE] at 12:58 PM, the Infection Preventionist was interviewed and stated; they do rounds in the mornings on all floors, they look at personal protective equipment supplies, before lunch and during dining. They observe cleaning of the dining room. They set up and randomly pick a floor for observing the cleaning of residents hands. They stated they have done in-services in relation to hand hygiene as needed. Hand hygiene is for us not to give residents an infection if they have an open site. They do random checks when they do rounds and knock on doors to observe staff are wearing the correct personal protective equipment. 10 NYCRR 415.19(b)(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observation, record review, and interview conducted during the Recertification Survey from 10/21/2024 to 10/28/2024, the facility did not ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident in 1 of 1 resident observed for tube feeding. Specifically, Enhanced Barrier Precautions were not maintained during tube feeding administration for residents with gastrostomy tubes. (Residents #187) The findings are: The Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memorandum titled Enhanced Barrier Precautions in Nursing Homes, Ref: QSO-24-08-NH dated 03/20/2024 documented that effective 04/01/2024, Centers for Medicare and Medicaid Services is issuing a new guidance for long term care facilities on the use of enhanced barrier precautions to align with nationally accepted standards. Enhanced Barrier Precautions recommendations now include use of enhanced barrier precautions for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. The new guidance related to enhanced barrier precautions is being incorporated into F880 Infection prevention and Control. The facility policy and procedure titled Enhanced Barrier Precautions effective 07/26/2024 documented all personnel which have direct contact with a resident with indwelling medical devices even if the resident is know to be infected or colonized with a multi drug resistant organism will observe Enhanced Barrier Precautions (EBP). Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities which provide opportunities for transfer of MDRO to staff hands and clothing. 1.) Resident #187 was admitted to the facility with diagnoses that include Dysphagia following Cerebral Infarction. The Annual Minimum Data Set assessment dated [DATE] documented that Resident #187 had moderately impaired cognitive skills for daily decision making and had a gastrostomy tube. A Physician's Order dated 07/10/2024, documented enhanced barrier precautions due to presence of feeding tube. 2.) Resident #60 was admitted to the facility with diagnoses that include Non-Alzheimer's Dementia and Dysphagia. The Minimum Data Set assessment dated [DATE] documented that Resident #60 had severely impaired cognitive skills for daily decision making and had a gastrostomy tube. (continued on next page)

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	335659	A. Building B. Wing	10/28/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 04/15/2024 documented enhanced barrier precautions during high contact resident care activities indwelling medical device gastrostomy tube. Order as of 10/16/2024 documented Enteral Feed four times a day, feed flushed 120 cubic centimeters water before and after. Enteral feeding every shift total formula 24 hours (960 ml rate of flow) 240 cubic centimeters four-time day bolus. Enteral feed every shift feed by pump bolus. Order as of 10/18/2024 documented - Four times a day bolus feeding Glucerna 1.5 240 cubic centimeters four times a day at 10 AM, 2PM, 6PM and 10 PM, 120 cubic centimeters before and after. The Nutritional assessment dated [DATE] documented the following goals include the resident will accept and follow Therapeutic/mechanically altered diet through the review date. Resident will accept and follow Supplement/Nourishment plan to aid with intake/healing/abnormal labs through the review date. Resident will tolerate tube feedings with no nausea, vomiting, diarrhea, constipation, aspiration, abdominal distension. Remain free of side effects/complications, through review date. Resident will maintain adequate nutritional and hydration status and stable weight without significant gain/loss, no signs and symptoms of malnutrition or dehydration, through review date. Resident will be provided and consume adequate fluids to maintain hydration, skin turgor and promote bowel regularity through review date. During medication administration observation on 10/24/2024 at 09:59 AM to 10:14 AM, Licensed Practical Nurse #2 was observed performing the administration of enteral feeding to Resident #187 via gastrostomy tube without wearing a gown. At 9:20 AM, Licensed Practical Nurse # 2 was observed taking a gown into resident #187 room, washed their hands in the sink, put gloves on, placing sterile drape to bedside table, 120 ml cup placed on sterile drape field, the 8 ounce carton box of Glucerna 1.5 carton was opened, the cup was filled with water from the sink, resident bed adjusted up toward the Licensed Practical Nurse #2 between knee and hip height. Gloves were removed and Licensed Practical Nurse #2 washed their hands in the sink and new gloves placed on hands, syringe from piston set reassembled 20 cc air placed and abdomen was auscultated. Free water was placed to gravity feed. No gown was worn by the nurse only gloves were worn. Feeding placed to gravity feed, additional feeding from carton placed in syringe to gravity feed. Licensed Practical Nurse #2 asked resident if they are having any pain at this time. The last among of the tube feeding was administered followed by free water for the Resident #187. the resident stomach to assess their bowel sounds, removed gloves and washed hands placed another pair of gloves on, they administered free water via large syringe and tube feeding and then free water flush after. Licensed Practical Nurse #2 did not put on the isolation gown while administering the free water or tube feeding for Resident #187. At the end of the enteral feeding Licensed Practical Nurse # 2 stated that they forgot to put on the isolation gown when doing the free water and tube feeding for Resident #187. The gastrostomy tube cap was replaced, and Resident #187 bed was adjusted down lower. Licensed Practical Nurse # 2 took their gloves off and washed their hands in the resident sink and they took the unused isolation gown with them. On 10/24/2024 at 10:11 AM, Licensed Practical Nurse #2 was interviewed and stated that they brought the isolation gown in the room but they forgot to put it on. The stated the required personal protective equipment includes a gown, gloves and mask for enteral feeding. They should wear the personal protective equipment to protect the resident from anything that they can carry on their uniform since Resident #187 has an opening on their body. Licensed Practical Nurse # 2 stated that their nerves got the best of them. They stated they had training on personal protective equipment 2 months ago and we have personal protective equipment on the unit. The had enhanced barrier training last week. They stated that they wear gloves all the time and wearing the gown slipped their mind and they understand that it is important to wear the personal protective equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 11:30AM, Registered Nurse #8 was interviewed and stated, that they inform staff about hand washing, personal protective equipment before they start working their shift. They let staff know that they need to wear personal protective equipment for residents on enhanced barrier protections. Patients on enhanced barrier protections have their door labeled. Personal protective equipment is adequate on the cart. For enhanced barrier protection staff should be wearing gloves and mask. There are two residents on the unit on enhanced barrier protection. They stated that they make rounds every hour. For infection control don't want to spread bacteria from resident to resident, staff to resident and to protect staff also. Residents on enhanced barrier protection are more prone to infection or bacteria because of open entry ways. On 10/28/2024 at 12:58PM, the Infection Preventionist was interviewed and stated, they do rounds daily in the morning on all floors and also check the personal protective equipment supplies on the unit and do rounds before lunch and before they leave for the day. For enhanced barrier precautions the staff are required to wear the following personal protective equipment (gown, gloves and surgical mask). Personal protective equipment should be used for us not to give resident an infection since they have an open site and no bacterial infection from our scrubs, and we have to protect the residents. They do random checks when they do unit rounds, and they check that staff are wearing the correct personal protective equipment. On 10/03/2024 at 08:29 AM, the Director of Nursing, who was also the Infection Preventionist, was interviewed and stated that enhanced barrier precautions are required when administering medications to residents with gastrostomy tubes. 10 NYCRR 415.19 (a)(1-3)