STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335665	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terence Cardinal Cooke Health Care Center	1249 Fifth Avenue New York, NY 10029

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50894 Based on observation, record review, and interviews conducted during the Recertification Survey from 10/21/2024 to 10/28/2024, the facility did not ensure that residents are treated with respect and dignity and cared for in a manner that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. This was evident in 1 (Resident #28) of 1 resident reviewed for dignity. Specifically, Resident #28 was observed wearing the same outfit two days in a row. The findings are: The facility policy titled Resident [NAME] of Rights with a revision date of 02/24/2023 documented that residents have a right to be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in care of their personal needs. Resident #28 was admitted to the facility with diagnoses that include Hypertension, Hemiparesis and Diabetes Mellitus. The Quarterly Minimum Data Set (a resident assessment tool) dated 09/29/2024 documented that Resident #28 had intact cognition and impaired vision. The Minimum Data Set assessment documented that Resident #28 required dependent level assistance with lower body dressing and putting on footwear and substantial assistance with upper body dressing. The Resident Property List dated 05/24/2024 documented that Resident #28 had 1 pajama, 2 slippers, 1 sweater / cardigan, 2 sweatpants, and 4 t-shirts. On 10/22/2024 at 10:39 AM, Resident #28 was interviewed and stated they did not have enough clothing and that the shirt they were wearing was for men's. They stated they did not have any shoes and that the few clothing they have were not comfortable. At the time, Resident #28 was observed wearing a multi-colored plaid button up shirt, light blue jeans, and yellow socks with no shoes on. On 10/23/2024, Resident #28 was observed, sitting in a wheelchair in the hallway close to the nursing station, wearing the same outfit that they were wearing on 10/22/2024. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 02:42 PM, Certified Nursing Assistant #10 was interviewed and stated that they were aware that Resident #28 did not own many clothes. They stated that they attempted to get the Resident more clothing the weekend before by accessing the facility's donation closet, but that there was only one pair of pants that fit the Resident and that there were no shirts or shoes in the Resident's size. Certified Nursing Assistant #10 stated they had assisted the Resident with getting dressed in the morning of 10/23/2024. They stated that they obtained the clothing from the Resident's closet and was unaware that the Resident had worn those clothing the day before. On 10/24/2024 at 03:03 PM, Social Worker #2 was interviewed and stated that they were unaware that Resident #28 did not own enough clothing. They stated that Certified Nursing Assistants would typically be the ones to identify if a resident needed clothing due to their involvement in getting the residents dressed. They stated that if a Certified Nursing Assistant noticed that the resident did not have enough clothing, the procedure would be for the Certified Nursing Assistant to visit the facility's donation closet to obtain clothing. If there are not sufficient options in the donation closet, the facility's social workers would assist the resident with purchasing clothing items. Social Worker #2 stated they were unaware that Resident #28 was wearing clothing multiple days in a row but that it would be against their policy for a resident to wear clothing multiple days in a row without washing them unless it was the resident's preference. On 10/24/2024 at 03:15 PM with Resident #28's permission, Social Worker #2 and the State Surveyor made observations of the Resident's room and closet. The Resident's closet contained no clothing and no shoes. The laundry bin in the room contained unwashed clothing. Social Worker #2 stated that Resident #28 did not appear to own any shoes and did not have any clean clothing. On 10/25/2024, the Director of Social Services was interviewed and stated that they were not aware that Resident #28 did not own shoes and that Resident did not have an adequate supply of clothing until Social Worker #2 made them aware on 10/24/2024. They stated that clothing needs are identified through grievances filed by residents, quarterly care plan meetings, or staff members noticing that a resident does not have an adequate amount of clothing. The Director of Social Services stated that Certified Nursing Assistant #10 should have notified the nurse or social worker of the resident's lack of clothing when they observed it. They stated that they were not sure how Resident #28's lack of clothing was not rectified sooner but that they believed it was a breakdown in communication among staff. 10 NYCRR 415.5 (a)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on record review and interviews conducted during the Recertification and Abbreviated (NY00349557) Survey, the facility failed to ensure that a resident was free from sexual abuse. This was evident in 2 (Residents #447 and #463) of 6 residents reviewed for abuse out of 37 total sampled residents. Specifically, on 07/26/2024 at approximately 6:00 PM, Certified Nursing Assistant #4 observed Residents #447 and #463 lying in bed with no undergarments. Resident #447's hand was observed touching Resident #463's private area. The findings are: The facility policy titled Clinical, Resident Abuse Reporting and Investigation Protocol with a revision date of 06/27/2024 documented the facility will protect residents and ensure freedom from abuse, mistreatment, neglect, misappropriation of property, exploitation corporal punishment, and involuntary seclusion. The Accident/Incident Investigation Form dated 07/26/2024 at 6:00 PM documented that the Certified Nursing Assistant on duty found Resident #447 and Resident #463 both half-naked in bed, in Resident #447's room. Resident #447 was found touching Resident #463's private area. Resident #447 stated they did not do anything, while Resident # 463 was unable to relate the incident due to impaired cognition. A written statement by Certified Nursing Assistant #4 dated 07/26/2024 documented that at 6:00 PM, Certified Nursing Assistant #4 went to Resident #447's room to deliver the Resident's dinner and found Residents #447 and #463 half-naked. The written statement documented that Resident #447 was seen touching Resident #463's private area. A written statement by Licensed Practical Nurse #2 dated 07/26/2024 documented that they were called by Certified Nursing Assistant #4 to Resident #447's room and upon arrival, they observed Resident #447 fixing their clothes and went to the sink to wash their hands. Resident #463 was observed in bed, half-naked with their incontinent briefs and pants on the floor. Resident #447 stated I did not do anything. Resident #463 did not respond, was observed calm and with no visual discomfort. The facility's Internal Investigation dated 08/01/2024 completed by the Administrator concluded that based on their investigation, the incident was an interaction between 2 cognitively impaired residents with no negative outcome and there was no credible evidence of abuse, neglect, or mistreatment. The conclusion also documented that the interdisciplinary team confirmed that the incident was unpredictable and unprovoked between 2 cognitively impaired residents. Both residents were assessed by social work with no negative findings. Resident #447 had diagnoses which included Non-Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Essential Hypertension. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual Minimum Data Set assessment dated [DATE] documented that Resident #447 had severely impaired cognition and behaviors of wandering which occurred 4 to 6 days but less than daily. The Minimum Data Set documented these wandering behaviors placed the resident at significant risk of getting to a potentially dangerous place and significantly intruded on the privacy or activities of others. A comprehensive care plan dated 05/11/2024 and was last reviewed on 09/03/2024, documented Resident #447 was at risk for victimization. The facility interventions documented were to identify triggers for behaviors and develop interventions to address, to provide calm approach, talk in soothing manner, recognize that resident's cognitive status may inhibit understanding of behaviors exhibited and/or demonstrated towards them. A physician's progress note dated 07/27/2024 documented Resident #447 was seen and examined, and no injury was noted. Resident #447 denied any sexual action against anyone and does not know what they were talking about. A Psychiatry note dated 07/31/2024 documented Resident #447 was seen for significant issue of touching another resident. Resident #447 denied being in bed or touching Resident #463. Resident #447 was not manic or psychotic and behavior probably related to poor intellectual capacity and judgement. Resident was alert and oriented to self only and had diagnosis of Dementia secondary to medical condition of subdural hematoma and nontraumatic subarachnoid hemorrhage with behavioral disturbance. Resident #463 had diagnoses which included Non-Alzheimer's Dementia, Anemia, and History of Falling. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #463 had severely impaired cognition and behaviors of wandering daily. A comprehensive care plan dated 05/10/2024 and was last reviewed on 08/13/2024 documented that Resident #463 was at risk for victimization. The facility interventions documented were to involve in activities keeping with interests and providing emotional support. A physician's progress note dated 07/27/2024 documented that Resident #463 was seen and examined, and no injury was noted to genital area and there was no rectal bleeding or pain. A Psychiatry note dated 08/15/2024 documented Resident #463's insight and judgement was poor. Resident #463's ability to make decisions regarding health needs, discharge, and Power of Attorney was severely limited and Resident #463 was unable to understand and answer questions. During an interview on 10/25/2024 at 4:42 PM, Certified Nursing Assistant #4 stated that on the date of the incident, they were distributing meals to residents. They stated when they went to Resident #447's room, they saw Residents #447 and #463 in bed. They stated Resident #463 was naked from the waist down and that Resident #447 was not touching Resident #463. They stated they were not sure if Resident #447 was naked, but the Resident was pulling their pants while they were in bed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent interview with Certified Nursing Assistant #4 on 10/25/2024 at 5:37 PM, the State Surveyor clarified the discrepancy between Certified Nursing Assistant #4's written statement and what they stated during the earlier interview. Certified Nursing Assistant stated they do not remember if Residents #447 and #463 were touching each other. They stated they remembered Residents #447 and #463 were lying in bed, Resident #463's incontinence briefs and pants were on the floor and that Resident #447 stood up pulling their pants when they entered the room. During an interview on 10/25/2024 at 6:25 PM, Licensed Practical Nurse #2 stated Certified Nursing Assistant #4 called them to Resident #447's room and when they arrived in the room, they observed Resident #447 standing and pulling their pants up. Resident #463 was calmly lying in Resident #447's bed naked from the waist down. During an interview on 10/25/2024 at 5:19 PM, Registered Nurse #1 stated they were the nursing supervisor for the evening shift on the day of the incident. Registered Nurse #1 stated they received a call from Licensed Practical Nurse #2 stating that Resident #463 was in Resident #447's bed. Registered Nurse #1 stated that the Certified Nursing Assistant reported that Resident #447 was touching Resident #463 in the genital area. They stated that the residents were immediately separated and that they assessed Resident #467's private area with no discharge or bleeding. Registered Nurse #1 stated they called the police and explained what happened to the physician. During an interview on 10/28/2024 at 10:13 AM, the Psychiatrist stated that both residents had prior consults pertaining to their capacity, but they did not assess Residents #447 and #463 for capacity to consent to sexual involvement. The psychiatrist stated that capacity to consent to sexual activity must be first requested before they assess residents for it. They stated they think the reason the facility did not request for capacity to consent to sexual activity was because the facility do not suspect sexual involvement. During an interview on 10/28/2024 at 2:28 PM, the Director of Nursing stated that the Certified Nursing Assistant reported that 2 demented residents were in the room, both with their incontinence briefs down, and that Resident #447's hand was close to Resident #463's perineal area. The Director of Nursing stated that they cannot conclude that Residents #447 and #463 had sexual intercourse. However, the Director of Nursing stated that touching another resident's private part was sexually inappropriate, but since Residents #447 and #463 were cognitively impaired, they would not say that it was abuse but rather an inappropriate behavior. During an interview on 10/28/2024 at 11:22 AM, the Administrator stated they received a call from Registered Nurse #1 on 07/26/2024 at about 6:45 PM stating that Residents #447 and #463 were in bed together. The residents were immediately separated. The Administrator further stated the psychiatrist determined neither resident has decision making capacity and there was no evidence based on Registered Nurse Supervisor #1's assessment that sexual activity occurred between Resident #447 and Resident #463. 10 NYCRR 415.4(b)(1)(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** 50894 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 a person-centered Comprehensive Care Plan was developed and implemented to meet the resident's goals, and address the resident's medical, physical, mental and psychosocial needs. This was evident in 1 (Resident #28) of 2 residents reviewed for care planning out of 37 total sampled residents. Specifically, Resident #28 who had a diagnoses and was receiving treatment for Glaucoma, had no comprehensive care plan developed to address the Resident's impaired vision. The findings are: The facility's policy titled Comprehensive Care Plan with a revision date of 06/23/2020 documented that the comprehensive care plan will include measurable objectives and timetables to meet the resident's medical, nursing, psychosocial needs, cultural, and trauma informed care if appropriate that are identified from the comprehensive assessment. The policy documented that the comprehensive care plan will be initiated by the interdisciplinary team members on admission and quarterly, readmission, significant change or any change in resident's plan of care. The policy documented that all disciplines are responsible for reviewing the comprehensive plan of care and documenting interventions. Resident #28 was admitted to the facility with diagnoses that include Hypertension, Diabetes Mellitus, and Glaucoma. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #28 had intact cognition and impaired vision. The Physician's Order dated 05/25/2024 and was renewed on 09/30/2024 documented that the Resident #28 had orders to take Latanoprost 0.005%, instill 1 drop into both eyes at bedtime for bilateral absolute glaucoma. A review of Resident #28's comprehensive care plan revealed that a care plan was not developed to address the Resident's impaired vision and diagnosis of Glaucoma. On 10/24/2024, the Director of Nursing was interviewed and stated that the admission nurse is responsible for creating care plans relevant to concerns present on admission. They stated that if there was a change in condition requiring a new care plan, the nurse working that shift with the resident would be responsible for completing that care plan. The Director of Nursing stated that a care plan for impaired vision should have been completed for residents with visual impairments. The Director of Nursing was unable to confirm which nurse would have been responsible for creating this care plan for Resident #28. 10 NYCRR 415.11(c)(1)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894 Based on observation, record review, and interviews conducted during the Recertification Survey from 10/21/2024 to 10/28/2024, the facility did not ensure each resident received food that accommodated resident allergies, intolerances, and preferences. This was evident in 1 (Resident #841) of 3 residents reviewed out of 37 total sampled residents. Specifically, Resident #841, who had a documented allergy to fish and fish containing products, received a lunch tray containing fish. The findings are: The facility policy and procedure titled Special Food Needs, Swallowing/chewing difficulties, and Food Allergies with a revision date of 01/2024 documented that all food and beverages served will be assessed and determined safe for residents with special dietary needs, including those with food allergies. The policy documented that all new residents, diet order changes, and allergy information is printed via the network printer to the diet office. The Diet Clerk is responsible for entering the resident's name, room number, diet, and allergies into GeriMenu. A meal ticket should be printed prior to the next meal to ensure all residents receive a tray with the correct room number, diet, and allergy information. Resident #841 had diagnoses of Type 2 Diabetes Mellitus, Hypertension, and Anxiety. The 10/18/2024 physician progress notes documented that Resident was alert and oriented to person, place, and time. The Admission Nutrition Risk assessment dated [DATE] documented that Resident #841 had food allergies to fish and fish containing products. A care plan on allergies was initiated for Resident #841 on 10/21/2024. The facility interventions include alerting appropriate discipline for any drug and food allergy. On 10/21/2024 at 12:43 PM, Resident #841 was observed in their room refusing a lunch tray that contained fish on it, stating that they cannot eat fish. The lunch meal ticket dated 10/21/2024 included with the tray documented that the tray included fish seasoned with lemon and pepper. On 10/24/2024 at 02:19 PM, Certified Nursing Assistant #11 was interviewed and stated that they worked with Resident #841 on 10/21/2024 during the day shift. They stated that their job responsibilities included serving residents trays during mealtime and that on 10/21/2024, they brought Resident #841 their lunch tray. They stated that when serving meals, Certified Nursing Assistants are responsible for reading the meal ticket to ensure that all food on the tray is safe for residents to consume based on the allergies listed on the tray. Certified Nursing Assistant #11 stated that they did read the ticket prior to serving the tray to Resident #841, and that as soon as they placed the tray in front of the resident, the resident notified them that the tray contained fish, which they could not eat. Certified Nursing Assistant #11 stated that they removed the tray from the resident's room and notified the kitchen of the error and requested a new meal for the resident. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 2:32 PM, Registered Dietician #2 was interviewed and stated that their job responsibilities include interviewing residents upon admission to confirm any food allergies that they have, inputting dietary orders, and inputting care plans related to nutrition. They stated that they completed Resident #841's admission nutrition assessment, and that Resident #841 is allergic to fish and fish products. They stated that the allergies inputted in the electronic medical record is connected to the system used by the kitchen staff, and it would be the kitchen staff's responsibility to ensure that the information appeared on the meal tickets. On 10/25/2024 at 11:32 AM, the Clinical Nutrition Manager was interviewed and stated that they were aware that Resident #841 had received fish on 10/21/2024 despite them having a documented allergy to fish. They stated that meal tickets are printed through the computer system, GeriMenu. They stated that the diet clerk was responsible for reviewing the allergies placed by the admission nurse or dietician in the electronic medical record and transmitting those allergies into Geri Menu. They stated that the diet clerk failed to transfer the allergy information from the electronic medical record to GeriMenu and that is what led to the food services staff to serve the Resident fish. The Clinical Nutrition Manager stated that the diet clerk who was responsible for inputting this information was unavailable to be interviewed by the surveyor. On 10/28/2024 at 1:51 PM, The Director of Nursing was interviewed and stated that the allergies are printed on each unit and posted in the nursing station. They stated that residents' allergies are also printed on their meal tickets. The Director of Nursing stated that in this situation, Resident #841's allergies were not listed on the meal ticket and although the Certified Nursing Assistant verified with the resident, the lunch tray should have not reached the Resident's room. 10 NYCRR 415.14(d)(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44472 Based on observation, record review, and interviews conducted during the Recertification Survey from 10/21/2024 to 10/28/2024, the facility did not ensure infection control practices and procedures were maintained. This was evident in 2 (Resident #208 and Resident #269) of 4 residents reviewed for Infection Control out of 37 total sampled residents. Specifically, 1.) Licensed Practical Nurse #6 failed to perform hand hygiene and glove changes while performing wound treatment for Resident #208 and 2.) Enhanced Barrier Precautions were not maintained when Licensed Practical Nurse #5 flushed Resident #269's indwelling urinary catheter. In addition, Licensed Practical Nurse #5 failed to clean / sanitize the Resident's bedside table after using it for the procedure. The findings are: 1.) The facility policy titled Pressure Ulcer Protocol with a revision date of 03/2020 documented that the purpose of the policy is to promote the healing of pressure ulcers that are present including prevention of infection to the extent possible. Resident #208 was admitted to the facility with diagnoses that included Multiple Sclerosis, Functional Quadriplegia and Diabetes Mellitus Resident #208's physician's orders dated 08/24/2024 included wound care treatment on the day shift to sacral pressure ulcer, to cleanse wound with normal saline, pat dry, apply calcium alginate with honey to the wound bed, then apply skin prep to the edges of the wound & apply bordered foam. A comprehensive care plan for Stage 4 sacral pressure ulcer stage 4 was initiated for Resident #208 on 06/24/2024. The documented goal was for the pressure ulcer to not deteriorate and that the wound will be free of signs and symptoms of infection. The facility interventions include daily wound assessment during treatment care and to apply local treatments as ordered by the physician. On 10/25/2024 at 12:32 PM, Licensed Practical Nurse #6 was observed administering treatment to Resident # 208's Stage 4 sacral pressure ulcer, assisted by Certified Nurse Assistant #13. Licensed Practical Nurse #6's failed to perform hand hygiene and did not change their gloves after removing the old dressing. The Licensed Practical Nurse then took a pen and wrote the date on the new dressing, and then applied the new dressing on the wound, while wearing the same gloves. In addition, Licensed Practical Nurse #6's gown was not properly secured and was falling off from their shoulder, with part of the gown, touching Resident #208's lower leg. On 10/25/2024 at 12:57 PM, Licensed Practical Nurse #6 was interviewed and stated they forgot to wash their hands after removing the soiled dressing. They stated they broke the infection control practice by not washing their hands after removing the soiled dressing and by not properly securing their gown while doing the treatment. On 10/28/2024 at 12:03 PM, the Infection Preventionist, who was also the Administrator, was interviewed and stated they will conduct in-service education for staff on infection control practice, especially when doing treatment for pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/28/2024 at 02:05 PM, the Director of Nursing was interviewed and stated in-service education are being done to all staff regarding infection control and preventions and they will conduct audits to ensure the staff is doing appropriate treatment to all pressure ulcers. 44864 2.) The facility policy titled Enhanced Barrier Precautions with a last reviewed date of 03/28/2024 documented that Enhanced Barrier Precautions expand the use of personal protective equipment and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi drug resistant organisms to staff hands and clothing. The policy further stated that nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with multi drug resistant organisms. Resident #269 was admitted to the facility with diagnoses that include Neurogenic Bladder and Quadriplegia. The Quarterly Minimum Data Set (a resident assessment tool) dated 09/10/2024 documented Resident #269's cognition was intact. The Minimum Data Set further documented that Resident #269 was dependent on staff for eating, bed mobility, transfers, and toilet use and had an indwelling catheter. The physician's orders dated 03/31/2024 had documented orders for Enhanced Barrier Precautions and to flush Foley catheter with 60 milliliters normal saline every shift. On 10/24/2024 02:55 PM, Licensed Practical Nurse #5 was observed flushing Resident #269's Foley catheter. Licensed Practical Nurse #5 entered the room with supplies in their hands and placed them on the Resident's bedside table. Licensed Practical Nurse #5 then washed their hands, donned a pair of gloves, and told Resident #269 that they were going to flush their urinary catheter. Licensed Practical Nurse #5 then moved the bedside table closer to the right side of the bed opened the package, placed a drape under the Foley catheter, and proceeded to flush the Foley catheter using the pistol syringe. Licensed Practical Nurse #5 then discarded the supplies in a bag and rested it on the table. Licensed Practical Nurse #5 disposed the plastic bag and took off their gloves and placed it in the garbage bag in the resident's room. Licensed Practical Nurse #5 washed their hands, then placed the bedside table in front of the Resident#269 and turned off the Resident's overbed light. Licensed Practical Nurse #5 washed their hands and left the Resident's room. Licensed Practical Nurse failed to don a gown prior to the procedure and failed to clean Resident #269's bedside table after the procedure. On 10/24/2024 at 03:05 PM, Licensed Practical Nurse #5 was interviewed and stated that they probably should have worn a gown when flushing Foley catheter. The Licensed Practical Nurse also stated that Resident #269 does not use their bedside table, so they do not need to clean the bedside table after use. On 10/24/2024 at 3:35 PM, the Clinical Administrator was interviewed and stated that nurses must use personal protective equipment when flushing a resident's Foley catheter. The Clinical Administrator also stated that tables must be lined before using it for the procedure and must be cleaned after use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335665	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terence Cardinal Cooke Health Care Center	1249 Fifth Avenue New York, NY 10029

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/2024 at 04:06 PM, the Chief Clinical Officer was interviewed stated that Enhanced Barrier Precautions is to be used for wounds and for procedures involving Foley Catheters. They stated that any area that is used for preparing, must be sanitized before and after, and that a clean barrier or drape should have been used for the bedside table. 10 NYCRR 415.19(a)(1-3)