STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335681	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Neck Nursing & Rehabilitation Center	134 Great East Neck Road West Babylon, NY 11704

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00339563) initiated on [DATE] and completed on [DATE], the facility did not ensure each resident transferred to the hospital and discharged from the facility had documentation in the medical record of the attempts made by the facility to meet the needs of the resident before the resident was discharged to the hospital. This was identified for one (Resident #413) of three residents reviewed for death and the facility did not ensure each resident had documentation from a Physician of the necessity to transfer or discharge the resident. This was identified for two (Resident #413 and #414) of three residents reviewed for death. Specifically, Resident #413 suffered a cardiac arrest (occurs when the heart suddenly and unexpectedly stops pumping) in the facility and attempts of cardiopulmonary resuscitation and the use of an automated external defibrillator were not documented in the resident's medical record. Additionally, Resident #413 and Resident #414 suffered a cardiac arrest and were transferred to the hospital. There was no discharge note written by the Physician for both residents. The finding is: The facility's policy titled Cardiopulmonary Resuscitation-Emergency Response Code Blue, dated ,d+[DATE] documented that the staff responding (to Code Blue) is responsible for documenting the interventions and outcome of the emergency response in the resident's medical record. The facility's policy titled Hospital Transfers, effective ,d+[DATE], documented that when nursing staff notices a change in the resident's condition indicating medical intervention, the charge nurse/nursing supervisor shall evaluate the resident and report their findings to the attending/covering physician. The Registered Nurse will document findings and actions in the medical record using the Situation, Background, Assessment, and Recommendation (SBAR) note or progress note. In addition, the Physician/Nurse Practitioner shall document the present medical condition in the space provided on the institutional transfer form. Registered Nurse/Nursing Supervisor shall document a transfer note in the Situation, Background, Assessment, and Recommendation (SBAR) form. Resident #413 was admitted to the facility with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Depression. The [DATE] Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan titled Resident Does Not Have Advanced Directives (legal documents to make provisions for future health care decisions in the event the individual is unable to make such decisions for themselves) in place, initiated on [DATE] documented to educate the resident on advanced directives and give the resident an opportunity to enact an advanced directive. A Situation, Background, Assessment, and Recommendation (SBAR) note dated [DATE] at 2:15 PM, created by Registered Nurse #3, documented Resident #413 had a cardiac arrest and respiratory arrest (no breathing). The resident was unresponsive. The resident was a full code (cardiopulmonary resuscitation can be used). Nurse Practitioner #1 was notified with an order to call Emergency Medical Services (911) and transfer the resident to the hospital. The section titled Nursing Notes in the Situation, Background, Assessment, and Recommendation (SBAR) form was blank. There was no documentation in the medical record that cardiopulmonary resuscitation was initiated for Resident #413. Additionally, there was no documentation from the Physician regarding the resident's transfer/discharge or disposition after the resident was transferred to the hospital. Registered Nurse #3 was interviewed on [DATE] at 11:57 AM and stated they were no longer employed at the facility and did not recall Resident #413. Registered Nurse #3 stated if the resident was a full code, the facility staff would have initiated cardiopulmonary resuscitation and documented it in the resident's medical record. Assistant Director of Nursing #1, the Nurse Educator, was interviewed on [DATE] at 12:34 PM and stated there should absolutely be notes written detailing what actions were taken by facility staff during a full code. If staff initiated cardiopulmonary resuscitation and used an automatic external defibrillator, this should be documented. Licensed Practical Nurse #2, the medication nurse, was interviewed on [DATE] at 1:37 PM and stated on [DATE], they found Resident #413 unresponsive and called Code Blue; a lot of staff responded, and they (Licensed Practical Nurse #2) initiated the cardiopulmonary resuscitation. Staff also attempted to use the automatic external defibrillator but there was no shock advised. Cardiopulmonary resuscitation was continued until the emergency medical services arrived and then they took over. The emergency medical services transported the resident to the hospital. Licensed Practical Nurse #2 stated they did not write a progress note because the nursing supervisor usually writes the notes. The Registered Nurse is responsible for completing the Situation, Background, Assessment, and Recommendation (SBAR) form which should include all interventions that were applied before the resident's transfer to the hospital. If a resident is pronounced dead at the hospital, the nursing supervisor gets a call from the hospital and should then write a progress note to document the resident's disposition. Nurse Practitioner #1 was interviewed on [DATE] at 8:15 AM and stated they did not write a transfer/discharge note for Resident #413 because they (Nurse Practioner #1) were not there at the time the Emergency Response Code was called. Nurse Practitioner #1 stated they would not write a note if they were not present. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician #3, the attending Physician, was interviewed on [DATE] at 10:30 AM and stated they did not write a discharge summary or note in Resident #413's medical record because they did not see the resident and were not involved with the Emergency Response Code. Physician #3 stated the emergency room called them and told them that the resident expired in the emergency room . If they were present during the Emergency Response Code, they would have written a note. Physician #3 stated that a discharge note is more important when a resident is being discharged to the community. The facility has a protocol for when a resident is being discharged home, I am not sure about a discharge to the hospital. The Director of Nursing Services was interviewed on [DATE] at 12:10 PM and stated they did not know if the facility protocol requires the doctor to write a note when a resident is transferred to the hospital. The Medical Director was interviewed on [DATE] at 8:30 AM and stated that doctors should write a note when a resident is transferred or discharged to the hospital. Any resident who gets discharged from the facility must have a discharge summary. Resident #414 was admitted with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Hypertension. The [DATE] Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A Comprehensive Care Plan titled Resident Does Not Have Advanced Directives (legal documents to make provisions for future health care decisions in the event the individual is unable to make such decisions for themselves) in Place, initiated [DATE] documented to educate the resident on advanced directives and give the resident an opportunity to enact an advanced directive. A nursing progress note for Resident #414 dated [DATE] at 9:55 AM documented the resident was found unresponsive to verbal and tactile stimuli, no pulse, and no respiratory movement. The resident was a full code. Code Blue was initiated at 8:40 AM and 911 was called. An automated external defibrillator was applied, and shock was advised one time. Emergency medical technicians arrived at the facility at approximately 8:51 AM. The resident left the facility via ambulance at 9:30 AM. A nursing progress note dated [DATE] at 10:56 AM documented writer called the hospital and spoke with a Physician who stated the resident arrived at the hospital in cardiac arrest and was pronounced dead at 9:52 AM. There was no documentation in Resident #414's medical record from the resident's physician regarding the resident's transfer/discharge. Physician #1, Resident #414's attending physician, was interviewed on [DATE] at 12:02 PM and stated they were away in February 2024 when Resident #414 expired. Physician #2 was covering their residents. Physician #1 stated there should be a Physician discharge note in place that includes the reason the resident went to the hospital and the outcome. The Director of Nursing Services was interviewed on [DATE] at 12:10 PM and stated they did not know if the facility protocol requires the doctor to write a note when a resident is transferred to the hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician #2 was interviewed on [DATE] at 12:36 PM and stated they usually write discharge summaries for residents who are under their care. Resident #414 was not their resident and perhaps Physician #1 missed documenting the discharge summary since they (Physician #1) were away. The Medical Director was interviewed on [DATE] at 8:30 AM and stated that doctors should write a note when a resident is transferred or discharged to the hospital. Any resident who gets discharged from the facility must have a discharge summary. 10 NYCRR 415.3(i)(1)(ii)(a)(b)

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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** 28670 Based on record review and interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure that a person-centered care plan for each resident that includes measurable objectives and timeframes to meet each resident's medical and nursing needs was implemented as identified in the comprehensive assessment. This was identified for one (Resident #71) of five residents reviewed for Respiratory Care. Specifically, Resident #71 had a physician's order to drain fluids from the abdominal cavity on the 7:00 PM - 7:00 AM shift via a Peritoneal (abdominal) Pleurex catheter (a thin, flexible tube that is inserted into the abdominal cavity to drain fluid) due to the diagnosis of Ascitis (a condition where fluid builds up in the abdomen between the lining of the abdomen and the abdominal organs). A review of the resident's medical record from 7/1/2024 to 7/12/2024 and from 8/1/2024 to 8/3/2024 revealed no documented evidence that the abdominal fluid was drained as per the physician's orders for a total of 11 out of 15 opportunities. The finding is: The facility's policy for Peritoneal Drainage System- Pleurex Catheter dated 4/2023 documented to chart the resident's response to the procedure and the volume of Ascites fluid drained. Resident #71 was admitted with diagnoses that included Cirrhosis of the Liver and Ascites. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 14, which indicated the resident had intact cognition. The resident had no behavioral problems and did not reject care. A Comprehensive Care Plan dated 4/7/2023 and last reviewed on 7/31/2024 documented alteration in gastrointestinal status related to the disease process. Interventions included to discuss with the resident, family, or caregivers any concerns, fears, or issues related to gastrointestinal distress. Drain Ascites fluid via peritoneal drain every 12 hours, no more than 500 milliliters of fluid each drain, elevate the head of the bed to semi-Fowler's (patient lies on their back with their head and upper body raised at a 30-45 degree angle on the bed) position as needed. A physician's order dated 6/28/2024 documented to drain of the Peritoneal (abdominal) Pleurex Catheter up to 500 milliliters of fluid every day for abdominal discomfort and distension. The Treatment Administration Record for July 2024 was reviewed on 8/7/2024 and revealed there was no documented evidence of the amount of fluid drained from the Peritoneal Pleurex Catheter on 7/1/2024, 7/2/2024,7/5/2024, 7/6/2024, 7/7/2024, 7/8/2024, 7/9/2024, and 7/11/2024. A review of the medical record revealed that Resident #71 went to the hospital on 7/26/2024 and returned on 7/31/2024. A Physician's order dated 8/1/2024 documented to drain Left Chest Pleurex Catheter up to 500 cubic centimeters daily in the evening for Pleurex Catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Treatment Administration Record for August 2024 was reviewed on 8/7/2024 and revealed there was no documented evidence of the amount of fluid drained from the Pleurex Catheter from 8/1/2024 to 8/3/2024. Physician #2 was interviewed on 8/8/2024 at 11:37 PM and stated they have been caring for Resident #71 for the past three years. The resident has Ascites due to Cirrhosis of the Liver. Physician #2 stated that if too much fluid was drained from the Pleurex Catheter, the resident could develop Hypotension (low blood pressure). Registered Nurse #16, who was assigned to Resident #71 on 7/5/2024, 7/9/2024, and 7/11/2024, was interviewed on 8/8/2024 at 12:27 PM. Registered Nurse #16 stated they usually document the amount of fluid drained from the Pleurex Catheter on the Treatment Administration Record. Registered Nurse #16 stated they were supposed to document the amount of fluid drained from the Pleurex Catheter on the Treatment Administration Record. Registered Nurse #17, who was assigned to Resident #71 on 7/2/2024, 7/6/2024, 7/7/2024, 7/8/2024, and 8/3/2024, was interviewed on 8/8/2024 at 1:48 PM. Registered Nurse #17 stated Resident #71 had a Pleurex Catheter and they had drained no more than 500 cubic centimeters of fluid from the Pleurex Catheter daily during the 7:00 PM to 7:00 AM shift. Registered Nurse #17 stated they did not know why the drainage amount was not documented on the Treatment Administration Record on 7/2/2024, 7/6/2024, 7/7/2024, 7/8/2024, and 8/3/2024. The Director of Nursing Services was interviewed on 8/8/2024 at 1:52 PM and stated that the nurses must document the amount of fluid drained from the Pleurex Catheter on the Treatment Administration Record. 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. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure comprehensive care plans were reviewed and revised by the interdisciplinary team to reflect each resident's preferences and status after each assessment. This was identified for one (Resident #116) of two residents reviewed for Communication. Specifically, Resident #116's comprehensive care plan for Communication documented that the resident was hard of hearing in the left ear. The comprehensive care plan was not updated to indicate the resident used a hearing aid and preferred keeping the hearing aid at the bedside. The finding is: The facility's policy titled Care Planning Process, effective 7/2022 documented the facility shall have a care planning process that is person-centered, which includes integrating assessment findings in care planning, providing services to attain or maintain the resident's highest physical, mental, and psychosocial well-being, and regularly reviewing and revising the care plan. The comprehensive care plan shall include the resident's preferences and is revised by members of the interdisciplinary team based on changing goals, preferences, and needs of the resident and in response to current interventions. Resident #116 was admitted with diagnoses including Morbid Obesity, Bipolar Disorder, and Chronic Obstructive Pulmonary Disease. The 5/1/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident had moderate difficulty with hearing and did not use a hearing aid. A Comprehensive Care Plan, titled Communication Problem Related to Deafness, effective 10/27/2023 and last updated 8/5/2024, documented the resident was was hard of hearing in the left ear and was able to lip read. the interventions included audiology consult as ordered. The care plan did not include use of a hearing aid. Certified Nursing Assistant #1 was interviewed on 8/5/2024 at 10:41 AM and stated they did not know the resident used a hearing aid. Certified Nursing Assistant #1 stated they have to speak loudly with the resident for the resident to understand them. The Kardex (nursing care instructions for Certified Nursing Assistant) dated 8/4/2024 instructed the Certified Nursing Assistant to assist the resident with the hearing aid and keep the hearing aid in the medication cart. Resident #116 was observed on 8/5/2024 at 10:45 AM with Certified Nursing Assistant #1 present. The resident was in bed sleeping and was awakened by Certified Nursing Assistant #1. A message (communication) board was used to help communicate with the resident. The resident stated they use a hearing aid for their left ear and keep the hearing aid in their bag at the bedside. The resident stated they are completely deaf in the right ear. The resident stated they put the hearing aid in themselves and do not need staff assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #5, the medication nurse, was interviewed on 8/5/2024 at 11:07 AM and stated the resident was very hard of hearing; however, they did not know if Resident #116 used a hearing aid. Registered Nurse #6, the Minimum Data Set assessor, was interviewed on 8/5/2024 at 11:41 AM and stated they completed the 5/1/2024 Quarterly Minimum Data Set assessment, for Resident #116 and the resident was able to read lips and was able to understand what was being said to them. Registered Nurse #6 stated they had to speak loudly and clearly. Registered Nurse #6 stated the resident had a hearing aid but did not use the hearing aid during the assessment. Registered Nurse #6 stated any nurse involved with the resident's care, including the Minimum Data Set nurses, can update care plans. Registered Nurse #6 reviewed the resident's communication care plan and the Kardex and stated that the care plan and the Kardex were not consistent with the resident's communication status and preferences. The Director of Nursing Services was interviewed on 8/6/2024 at 12:00 PM and stated the comprehensive care plan and Kardex should reflect the resident's preferences, goals, and needs and everything should be consistent and current. 10 NYCRR 415.11(c)(2)(iii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00333364) initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain grooming, personal, and oral hygiene. This was identified for one (Resident #5) of five residents reviewed for pressure ulcers and one (Resident #132) of two residents reviewed for activities of daily living. Specifically, 1) on 8/7/2024, Resident #5's fingernails on both hands were observed to be long and dirty, with a brown substance under the nails and 2) on 8/2/2024, Resident #132's right palm was observed with dark crusty flakes and a musty odor was detected coming from their right hand. The findings are: The facility's policy titled Activities of Daily Living, effective 11/2018, documented the facility will provide the necessary care and services based on the comprehensive assessment of a resident and consistent with the resident's needs, choices, and preferences, to maintain or improve, the resident's ability to perform activities of daily living and to prevent decline unless it is unavoidable. Activities of daily living include hygiene, such as bathing, dressing, grooming, and oral care; individualized care plans are based on an accurate assessment of the resident's self-performance and the amount and type of support being provided. When a resident refuses to comply with activities of daily living, nursing staff shall solicit assistance from other disciplines to determine the cause for refusal, offer options and alternatives, and document refusal in the medical record. 1) Resident #5 was admitted with diagnoses including Schizophrenia, Parkinson's Disease, and Diabetes Mellitus. The 7/10/2024 significant change Minimum Data Set assessment documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident had mood concerns, including feeling down, depressed, and feeling bad about themselves nearly every day. The resident was dependent on staff for personal hygiene tasks. A comprehensive care plan titled Activities of Daily Living Self-Care Performance Deficit Related to Aggressive Behaviors, Limited Range of Motion, initiated 5/24/2024, documented the resident was dependent on staff for Personal Hygiene needs and will remain clean, neat, dressed appropriately, and free of body odor and that. The Kardex (nursing care instructions for Certified Nursing Assistants), as of 8/7/2024, documented that the resident was dependent on staff for personal hygiene needs and to observe the resident for proper hand hygiene. Under the Personal Hygiene heading, oral care was the only care area listed. Resident #5 was observed in bed on 8/7/2024 at 9:47 AM. The resident's fingernails on both hands were excessively long and dirty, with a brown substance under the nails. The resident stated they would like their nails trimmed. During an observation on 8/7/2024 at 9:53 AM with Certified Nursing Assistant #2 and Registered Nurse #7 (acting unit charge nurse) Resident #5's fingernails were observed to be long and dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #2, who was the resident's regularly assigned Certified Nursing Assistant, was interviewed on 8/7/2024 at 9:54 AM. Certified Nursing Assistant #2 stated the nurses were supposed to cut Resident #5's fingernails because the resident was Diabetic. Certified Nursing Assistant #2 stated the nurses see the resident every day, which is why they (Certified Nursing Assistant #2) did not report the resident's long fingernails to the nurse. Registered Nurse #7 was interviewed on 8/7/2024 at 9:55 AM and stated the nurses were responsible for cutting Resident #5 nails because the resident was Diabetic and any nurse could have cut the resident's fingernails. Registered Nurse #8, the medication nurse, was interviewed on 8/7/2024 at 10:03 AM and stated they administered the morning medications to Resident #5 and did not notice the resident's fingernails. Registered Nurse #8 then proceeded to check the resident's fingernails and stated the fingernails needed to be trimmed and cleaned. Registered Nurse #8 asked the resident if they wanted their fingernails trimmed and the resident responded yes. Assistant Director of Nursing Services #1, the nurse educator, was interviewed on 8/7/2024 at 11:06 AM and stated the staff members have to ask the resident if they want the fingernails cut; sometimes the resident refuses and gets aggressive. Assistant Director of Nursing Services #1 stated the refusals should be documented in the medical record. Assistant Director of Nursing Services #1 stated the resident's fingernails should be clean and neatly trimmed. A review of nursing progress notes from 8/1/2024 to 8/7/2024 revealed no documentation that Resident #5 refused to have their fingernails trimmed. The Director of Nursing Services was interviewed on 8/7/2024 at 12:54 PM and stated they had never heard that Resident #5 refused care. The Director of Nursing Services stated if the resident was refusing care, there should have been a care plan in place, and the staff should have determined how to maintain the resident's hygiene including nail care. 28670 2) Resident #132 was admitted with diagnoses that included Coronary Artery Disease, Peripheral Vascular Disease, and Non-Alzheimer's Dementia. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 00, which indicated severely impaired cognition. The resident had no behavioral symptoms, had impairment on both sides of upper and lower extremities, and was totally dependent on staff for all aspects of Activities of Daily Living. A Comprehensive Care Plan dated 9/13/2023 and last revised on 6/7/2024 documented the resident had a deficit in Activities of Daily Living, cognitive Impairment, Dementia, limited mobility, and limited range of motion. Interventions included for staff to maintain personal hygiene including combing the resident's hair, shaving, washing, and drying the resident's face and hands. The Kardex (nursing care instructions for the Certified Nursing Assistants), from 8/1/2024 to 8/10/2024 documented to observe the resident for proper hand hygiene. Under the Personal Hygiene heading, oral care was the only care listed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/1/2024 at 3:09 PM the resident was observed out of bed in their room resting in a Geri chair. The Therapy Carrot was observed on the resident's chest and not appropriately positioned in the resident's right hand. During an observation on 8/2/2024 at 3:15 PM, with the Wound Care Registered Nurse (acting Nurse Manager) and the Director of Rehabilitation Services, the resident's right hand Therapy Carrot was observed resting on the resident chest. The palm of the resident's right hand was observed with dark crusty flakes and a musty odor was detected from the resident's right hands. The Director of Rehabilitation Services stated that the Therapy Carrot should be appropriately placed in the resident's palm at all times to prevent contractures. The Director of Rehabilitation Services stated if the Certified Nursing Assistants were having difficulty placing the Therapy Carrot in the resident's hand, they should have reported the concern to the charge nurse or them (Director of Rehabilitation Services). The 7:00 AM - 3:00 PM assigned Certified Nursing Assistant #11 was interviewed on 8/5/2024 at 1:51 PM and stated they were having difficulty opening the resident's right hand but did not report it to the charge nurse. Certified Nursing Assistant #11 stated they asked another Certified Nursing Assistant (could not recall the name) to assist them with opening the resident's hand and the other Certified Nursing Assistant also could not open the resident's hand. Certified Nursing Assistant #11 stated they washed the outside of the resident's hand but were unable to wash the palm of the resident's right hand. The Director of Nursing Services was interviewed on 8/8/2024 at 12:59 PM and stated that after caring for the resident the Certified Nursing Assistant was responsible for ensuring that the Therapy Carrot was appropriately in the resident's right hand and that the nurses should monitor to ensure that the device was in place. The Director of Nursing Services stated if Certified Nursing Assistant #11 was having difficulty opening the resident's right hand, they (Certified Nursing Assistant #11) should have asked the nurse for assistance. The Director of Nursing Services stated that the resident's right hand should not have been left dirty. 10 NYCRR 415.12(a)(3)

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East Neck Nursing & Rehabilitation Center	134 Great East Neck Road West Babylon, NY 11704

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for three (Resident #5, Resident #94, and Resident #201) of five residents reviewed for Pressure Ulcers. Specifically, 1) Resident #5 had a Stage 4 pressure ulcer (full-thickness tissue loss with exposed bone, tendon, or muscle) at the sacrum (triangular bone in between the two hips). A comprehensive care plan intervention required that the resident be turned and positioned every two hours to offload (relieve pressure) from the sacra; ulcer. The resident was observed on multiple occasions on 8/6/2024 from 7:50 AM to 11:21 AM, lying flat on their back. The certified nursing assistant assigned to the resident stated the resident did not like to be on their side. The medical record lacked documented evidence that Resident #5 refused to turn and position or that the clinicians were notified of the resident's behavior to determine new interventions to offload the sacral region. 2) Residents #94 and Resident #201 had a physician's order for a low air loss alternating air mattress. During multiple observations, the adjustable weight setting for the air mattresses, which is meant to correspond to the resident's weight, was not set accurately. The finding is: The facility's policy titled Pressure Injury/Pressure Ulcer Assessment, Prevention, and Management, effective 3/24/2023 documented the facility shall provide care and services consistent with professional standards of practice to promote the healing of existing pressure injury/ulcer. Develop a positioning schedule and avoid positioning residents on existing pressure injuries; notify the wound care coordinator of any skin conditions or injuries. The Certified Nursing Assistant should report any changes or areas of concern to a nurse; redistribute pressure when in bed and position at least every two hours, and as needed. 1) Resident #5 was admitted with diagnoses including Schizophrenia, Parkinson's Disease, and Diabetes Mellitus. The 7/10/2024 Significant Change Minimum Data Set assessment documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident had one unhealed Stage 4 pressure ulcer and was dependent on staff for moving from side to side in bed. The nursing admission assessment dated [DATE] documented the resident had an unstageable (the wound is covered with dead tissue and the depth cannot be determined) pressure ulcer to the sacrum. The resident's Braden Scale (a scale used to predict pressure ulcer risk) score was documented as 16, which indicated the resident was at mild risk for developing pressure ulcers. A Comprehensive Care Plan titled Pressure Ulcer Related to Impaired Mobility, Stage 4 to Sacrum (post debridement), initiated on 5/27/2024, had an intervention to turn and position the resident every two hours and when needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Kardex (nursing care instructions for Certified Nursing Assistants) documented the resident has a pressure ulcer to the sacrum and to turn and position the resident every two hours and when needed. A wound physician consultation dated 5/29/2024 documented the resident had a sacrum Stage 4 pressure ulcer measuring 10.5 centimeters in length, 12.5 centimeters in width, and 4 centimeters in depth. The bone was palpable. Negative pressure wound therapy (wound vacuum) was started. A physician's order dated 6/28/2024 documented to cleanse the sacral ulcer with normal saline, pat dry, and then apply the wound vacuum at 125 millimeters of mercury, every Tuesday, Thursday, and Saturday. A wound physician consult dated 7/16/2024 documented that offloading the sacral area was difficult due to Parkinson's Disease. The resident was always on their back when the wound physician saw the resident. The Physician documented that the sacrum pressure ulcer was a Stage 4 ulcer, measuring 10 centimeters in length, 8 centimeters in width, and 2.5 centimeters in depth. During an observation on 8/6/2024 at 7:50 AM, Resident #5 was observed in bed on their back. During an observation on 8/6/2024 at 9:27 AM Resident #5 was observed in bed on their back. During an observation on 8/6/2024 at 10:45 AM Resident #5 was observed in bed on their back. During an observation on 8/6/2024 at 11:21 AM Resident #5 was observed in bed on their back. A review of the Certified Nursing Assistant Accountability for 8/6/2024 for the 7:00 AM- 3:00 PM shift revealed that Certified Nursing Assistant #2 documented they had turned and positioned the resident every 2 hours. There was no documentation in the accountability record indicating which side the resident was turned. Certified Nursing Assistant #2, the assigned Certified Nursing Assistant for Resident #5, was interviewed on 8/6/2024 at 11:29 AM. Certified Nursing Assistant #2 stated Resident #5 did not like to turn on their side. Certified Nursing Assistant #2 lifted the resident's sheet to show two pillows, one on the resident's left side torso and one on the resident's right side torso, and stated these pillows provided offloading. Upon observation, these pillows were keeping the resident positioned on their back and the resident's sacrum was directly placed on the bed, not offloaded. Wound Care Registered Nurse #1 was interviewed on 8/6/2024 at 11:46 AM and stated the resident was on a turning and positioning schedule and should be re-positioned every two hours on their left side, right side, and back. Wound Care Registered Nurse #1 stated there are times when the resident will be on their back but should not be on their back all the time. On 8/7/2024 at 9:03 AM Resident #5 was observed in bed. The resident was positioned on their left side with the sacrum completely offloaded from the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care Registered Nurse #1 was re-interviewed on 8/7/2024 at 9:07 AM and stated they spoke to Certified Nursing Assistant #2 and educated them about turning and positioning. Wound Care Registered Nurse #1 stated the resident needs to spend time off their back for optimal wound healing. Wound Care Registered Nurse #1 stated if the resident does not want to be on their side, or is uncomfortable, we have to keep encouraging and turning and positioning while keeping them as comfortable as possible, so the resident is not flat on their back. On 8/7/2024 at 9:47 AM Resident #5 was interviewed. Resident #5 stated they do not mind being on their side and staying on their back sometimes bothers them. The Director of Nursing Services was interviewed on 8/7/2024 at 3:11 PM and stated the staff must offload the affected areas using pillows to help the wound heal and determine how to make the residents comfortable if they are expressing discomfort. The Director of Nursing Services stated certified nursing assistants needed to be re-educated. 49245 2) The facility's policy and procedure titled, Air Mattress last revised in 10/2023 documented that the selection of the air mattress will be based on the individual's specific needs, including mobility levels, weight, and any pre-existing medical condition. The Wound Care Coordinator will conduct a monthly audit of the resident's weight and assessment of the staff's knowledge of operating the equipment. The operation manual for the low air loss alternating pressure relief air mattress documented instructions that included determining the patient's weight and setting the control knob to that weight setting on the control unit. -Resident #94 was admitted with diagnoses including End Stage Renal Disease, Acute Respiratory Failure, and Type 2 Diabetes. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #94 had moderately impaired cognition. Resident #94 had one Stage 4 (defined as full-thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer on the sacrum and an Unstageable (defined as full-thickness tissue loss in which the actual depth of the ulcer is completely obscured by an eschar [tan, brown or black] in the wound bed) wound on the right heel. A Comprehensive Care Plan (CCP) dated 6/15/2024 documented that Resident #94 had pressure ulcers on the sacrum and right heel related to immobility. Interventions included the use of an air mattress, offloading both heels with pillows when in bed, monitoring nutritional status, and administering medications as ordered. A physician's order dated 6/17/2024 documented the use of a Low Air Loss Alternating Pressure Mattress. A physician's order dated 6/17/2024 and renewed on 7/26/2024 documented cleaning the sacrum wound with DermaKlenz (a wound cleanser) and applying DermaBlue Foam (an anti-microbial, absorbent wound dressing) every Tuesday, Thursday, and Saturday and as needed everyday shift and cleaning the right heel with DermaKlenz (a wound cleanser) and applying Sting-Free Skin-Prep (a barrier between skin and adhesive) to the area everyday shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic medical record indicated that Resident # 94's most recent weight dated 7/26/2024 was 134 pounds. On 8/1/2024 at 12:10 AM, Resident #94 was observed in bed. The air mattress control knob was set at 300 pounds. On 8/2/2024 at 7:16 AM, Resident #94 was observed in bed. The air mattress control knob was set at 300 pounds. On 8/5/2024 at 11:00 AM, Resident #94 was observed in bed. The air mattress control knob was set at 300 pounds. -Resident #201 was admitted to the facility with Diagnoses including Hypertension, Muscle Weakness, and Alcohol Dependence with Intoxication. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #201 had intact cognition. The Admission Minimum Data Set (MDS) assessment documented that Resident #201 had one Unstageable (defined as full-thickness tissue loss in which the actual depth of the ulcer is completely obscured by an eschar (tan, brown, or black) in the wound bed) wound on the right hip. A Comprehensive Care Plan (CCP) dated 7/16/2024 documented that Resident #201 had a right hip pressure ulcer related to immobility and had interventions that included an air mattress, turning and positioning every two hours, and monitoring for changes in skin condition every shift. A physician's order dated 7/18/2024 documented cleaning the right hip with normal saline and applying Santyl Collagenase (an enzymatic debriding agent) ointment, then covered with bordered gauze daily. A physician's order dated 7/28/2024 documented an order for a Low Air Loss Alternating Pressure Mattress. A review of the electronic medical record indicated that Resident #201's most recent weight dated 7/18/2024 was 124 pounds. On 8/1/2024 at 10:42 AM, Resident #201 was observed in bed. The air mattress control knob was set at 250 pounds. On 8/2/2024 at 6:52 AM, Resident #201 was observed in bed. The air mattress control knob was set at 250 pounds. On 8/5/2024 at 8:00 AM, Resident #201 was observed in bed. The air mattress control knob was set at 250 pounds. Certified Nursing Assistant #6 was interviewed on 8/5/2024 at 11:15 AM and stated that when they took care of Resident #94 and #201, they did not touch the air mattress control knob. Certified Nursing Assistant #6 stated the weight setting was the responsibility of the nurses. Certified Nursing Assistant #6 stated they were only responsible for checking if the air mattress was deflated or unplugged. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #11, the Medication Nurse, was interviewed on 8/5/2024 at 11:30 AM and stated they did not check the air mattress weight setting for Resident #94 and #201. Registered Nurse #11 stated that the Wound Care Coordinator was responsible for checking and monitoring the air mattresses. The Wound Care Coordinator was interviewed on 8/5/2024 at 11:51 AM and stated when the air mattress is first installed, they set up the air mattress control knob according to the resident's weight and then spot-check the air mattress weight calibration occasionally. The Wound Care Coordinator stated they did not remember the last time they checked Resident #94 and Resident #201's air mattresses. The Wound Care Coordinator stated they did not have any documentation of the air mattress monitoring. The Wound Care Physician was interviewed on 8/5/2024 at 3:54 PM and stated the facility was responsible for monitoring the air mattresses. The Wound Care Physician stated the weight setting on the air mattress should correspond with the resident's weight. The Wound Care Physician stated the correct weight setting was essential otherwise the air mattress would be either too hard or too soft and could affect wound healing. The Director of Nursing Service was interviewed on 8/7/2024 at 11:30 AM and stated the Wound Care Coordinator was responsible for monitoring the air mattress and that the air mattress weight setting should correspond with the resident's actual weight. The Director of Nursing Service stated the Wound Care Nurse should have monitored Resident #94 and Resident #201's air mattress weight setting during wound care rounds. 10 NYCRR 415.12(c)(1)

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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** 28670 Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00333364) initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to prevent further decrease of range of motion. This was identified for one (Resident #132) of three residents reviewed for positioning and mobility. Specifically, Resident #132 had a physician's order for right hand Therapy Carrot (a nonsurgical device that helps position contracted hands) to be worn at all times. On 8/1/2024 and 8/2/2024 the resident was observed not wearing the right-hand Therapy Carrot as ordered by the Physician. The finding is: The facility's policy for Application and Management of Splint/Brace/Immobilizer dated 11/2017 documented the nursing staff is responsible for following the wearing schedule for the device and must complete a skin inspection every shift at a minimum unless ordered otherwise. Resident #132 was admitted with diagnoses that included Coronary Artery Disease, Peripheral Vascular Disease, and Non-Alzheimer's Dementia. A Quarterly Minimum Data Set assessment dated [DATE] documented the Brief Interview for Mental Status score was 00, which indicated the resident had severely impaired cognition. The resident had no behavioral symptoms, had impairment on both sides of upper and lower extremities, and was totally dependent on staff for all aspects of Activities of Daily Living. A physician's note dated 3/14/2024 documented Splint/Brace: Therapy Carrot to be applied to the right hand at all times by the Certified Nursing Assistant. The nurse is to spot-check for the placement of the Therapy Carrot every shift. A Comprehensive Care Plan for Activities of Daily Living dated 9/13/2023 and revised on 6/7/2024 documented interventions that included right-hand Therapy Carrot at all times to be applied by the Certified Nursing Assistant. Remove every shift for skin checks and hygiene. The Kardex (nursing care instructions for the Certified Nursing Assistants) from 7/1/2024 to 8/10/2024 documented Therapy Carrot to be applied to the right hand at all times by the Certified Nursing Assistant. The nurse is to spot-check for the placement of a Therapy Carrot every shift. Resident #132 was observed out of bed to a Geri-Lounge chair on 8/1/2024 at 3:09 PM. The resident's right hand was observed in a closed-fisted position and the resident was not able to open their right hand on command. The Therapy Carrot was observed not in the resident hand but was resting on top of the resident's torso. A subsequent observation was made on 8/2/2024 at 2:54 PM. The Therapy Carrot was observed on the resident's chest and not appropriately positioned in the resident's right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #5, who was assigned to Resident #132, was interviewed on 8/2/2024 at 3:04 PM. Licensed Practical Nurse #5 stated that the Therapy Carrot is used for the resident to keep the fingernails from pressing into the resident's palm. Licensed Practical Nurse #5 stated that Certified Nursing Assistant #11 was responsible for ensuring the Therapy Carrot was appropriately placed in the resident's right hand. During an observation on 8/2/2024 at 3:15 PM, with the Wound Care Registered Nurse (acting Nurse Manager) and the Director of Rehabilitation Services, the resident's right hand Therapy Carrot was observed resting on the resident chest. The palm of the resident's right hand was observed with dark crusty flakes and a musty odor was detected from the resident's right hands. The Director of Rehabilitation Services stated that the Therapy Carrot should be appropriately placed in the resident's palm at all times to prevent contractures. The Director of Rehabilitation Services stated if the Certified Nursing Assistants were having difficulty placing the Therapy Carrot in the resident's hand, they should have reported the concern to the charge nurse or them (Director of Rehabilitation Services). The Wound Care Registered Nurse was interviewed on 8/2/2024 at 3:20 PM and stated that they supervised the unit on 8/1/2024 and 8/2/2024. The Wound Care Registered Nurse stated they were not sure how to properly position the Therapy Carrot and would have to follow up with the Director of Rehabilitation Services to learn to properly position the Therapy Carrot in the resident's right hand. The 7:00 AM - 3:00 PM assigned Certified Nursing Assistant #11 was interviewed on 8/5/2024 at 1:51 PM. Certified Nursing Assistant #11 stated they were assigned to Resident #132 on 8/1/2024 and 8/2/2024. Certified Nursing Assistant #11 stated that the resident should use the Therapy Carrot device in the right hand at all times. Certified Nursing Assistant #11 stated that they were having difficulty opening the resident's right hand to insert the Therapy Carrot but did not report it to the charge nurse. The Director of Nursing Services was interviewed on 8/8/2024 at 12:59 PM and stated that after caring for the resident the Certified Nursing Assistant was responsible for ensuring that the Therapy Carrot was appropriately positioned in the resident's right hand at all times and that the nurses should monitor to ensure that the device was in place. 10 NYCRR 415.12(e)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and staff interviews during the Recertification Survey initiated on 8/01/2024 and completed on 8/08/2024, the facility did not ensure that each resident's receives adequate supervision and the resident's environment remained as free of accident hazards as possible to prevent accidents. This was identified for one (Resident #28) of seven residents reviewed for accidents. Specifically, Resident #28 was observed on 8/1/2024 with an Albuterol inhaler on their overbed table. There was no staff present in the vicinity. Additionally, Resident #28 did not have a physician's order for the use of the Albuterol inhaler or an order to self-administer medications. The finding is: Resident #28 was admitted to the facility with diagnoses including Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, and Type 2 Diabetes. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated that Resident #28 had intact cognition. The Quarterly Minimum Data Set documented that Resident #28 received antibiotic and antidepressant medications. A Comprehensive Care Plan (CCP) dated 2/26/2024 titled Chronic Obstructive Pulmonary Disease (COPD) documented interventions including medications as per physician's order and to monitor signs and symptoms of acute respiratory distress. The physician's order dated 2/2/2024 documented to administer Ipratropium-Albuterol Inhalation Solution 0.5-2.5 Milligrams/3 Milliliters (Ipratropium-Albuterol) 3 Milliliters inhale orally via nebulizer every 6 hours as needed for Chronic Obstructive Pulmonary Disease. During an observation on 8/1/2024 at 9:45 AM, Resident #28 was sitting in their bed with an overbed table in front of them. An Albuterol inhaler (medicine in an inhaler form used to treat Asthma) was observed on the overbed table. The Albuterol inhaler label was faded and hard to read. There was no staff member present in Resident #28's room at the time of the observation. A review of the resident's medical record indicated there was no physician's order for the Albuterol inhaler use prior to 8/1/2024 at 10:24 AM. Resident #28 was interviewed on 8/1/2024 at 10:00 AM and stated they got the Albuterol inhaler from home and have been using the Albuterol inhaler for a long time for their Asthma. Resident #28 stated they had the inhaler since they were admitted to the facility and were using the inhaler at least three times a day. A review of the physician's orders revealed Resident #28 did not have an order to self-administer their medications. A review of the electronic medical record revealed that Resident #28 was not assessed to self-administer their medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #12, the medication nurse, was interviewed on 8/1/2024 at 11:26 AM and stated they did not see any inhalers on the resident's over-bed table or the nightstand during the morning medication administration for Resident #28. Registered Nurse #12 stated that Resident #28 should not have medications stored in their room. The Assistant Director of Nursing Services was interviewed on 8/1/2024 at 11:45 AM and stated they did not know why Resident #28 had the Albuterol inhaler in their room. The Assistant Director of Nursing Services stated unless Resident #28 had a physician's order and was assessed by the facility to safely self-administer their medications, they should not have any medications left in their room. The Director of Nursing Services was interviewed on 8/7/2024 at 11:15 AM and stated that medications should not be left unattended in the resident's room. The Director of Nursing Services stated that Resident #28 had hoarding issues and the staff must have overlooked the Albuterol inhaler that Resident #28 was using. 10 NYCRR 415.12(h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/01/2024, and completed on 8/08/2024 the facility did not ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice. This was identified for two (Resident #42 and Resident #71) of five residents reviewed for Respiratory Care. Specifically, 1) Resident #42 had a physician's order to continuously receive oxygen therapy at 2 liters per minute. The resident was observed receiving an inaccurate amount of oxygen on 8/1/2024 and 8/7/2024. 2) Resident #71 had a physician's order for oxygen to be administered at 2 liters per minute via a nasal cannula. The resident was observed receiving an inaccurate amount of oxygen on 8/1/2024 at 10:30 AM and 2:34 PM. This is a repeat deficiency. The findings are: The facility's policy titled Oxygen Therapy dated 6/2017, documented the physician's order specifies the concentration, type, and duration of the (oxygen) therapy. The nursing staff will set up, check, and supervise all treatments. 1) Resident #42 was admitted with diagnoses including Parkinson's Disease with Dyskinesia (involuntary neurological movements), Osteoporosis, and Type Two Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15, which indicated the resident was cognitively intact. The Minimum Data Set documented Resident #42 used oxygen therapy during the look-back period. The Comprehensive Care Plan for Oxygen Therapy dated 7/11/2024 documented interventions that included administering oxygen therapy as ordered and checking the oxygen tank every shift. The current physician's orders documented to administer oxygen at 2 liters per minute via a nasal cannula continuously for shortness of breath. During an observation on 8/01/2024 at 11:11 AM, Resident #42 was observed in their bed. The resident was receiving 4 liters of oxygen per minute via a nasal cannula from an oxygen concentrator. Resident #42 was interviewed on 8/01/2024 at 11:11 AM and stated they used oxygen therapy daily. Resident #42 stated they did not change the oxygen flow rate setting because they were not able to access the oxygen concentrator. Resident #42 was observed in bed on 8/07/2024 at 10:18 AM. The resident was receiving 3 liters of oxygen a nasal cannula, from an oxygen concentrator. Registered Nurse #13 was interviewed on 8/07/2024 at 10:19 AM and stated Resident #42 should receive oxygen at 2 liters per minute as per their physician's orders. Registered Nurse #13 stated they did not change the resident's oxygen flow rate and did not feel that Resident #42 was able to change the oxygen settings either. (continued on next page)

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East Neck Nursing & Rehabilitation Center	134 Great East Neck Road West Babylon, NY 11704

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #7, the unit Charge Nurse, was interviewed on 8/07/2024 at 10:35 AM and stated nurses are expected to follow the physician's orders. If a resident needs an increased oxygen flow rate, the Physician should be notified. The Director of Nursing Services was interviewed on 8/07/2024 at 10:47 AM and stated they were unsure why the oxygen flow rate for Resident #42 was set at 3 liters today (8/7/2024) and 4 liters on 8/01/2024. If the resident requires more oxygen, nursing staff should call the Physician and follow the physician's orders. 28670 2) Resident #71 was admitted with diagnoses that included Cirrhosis of the Liver and Ascites (a condition in which fluid collects in spaces within your abdomen). A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 14, which indicated the resident had intact cognition. The resident had no behavioral problems and did not reject care. A Comprehensive Care Plan dated 7/31/2024 documented the resident received oxygen therapy related to shortness of breath. Interventions included to administer medications as ordered by the Physician, monitor for signs and symptoms of respiratory distress, and report to the Physician as needed. A physician's order dated 7/31/2024 documented to administer oxygen at 2 liters per minute continuously. During an observation on 8/1/2024 at 10:30 AM, Resident #71 was observed in bed asleep. The resident was receiving oxygen at 3 liters per minute via a nasal cannula from the oxygen concentrator. A subsequent observation was made on 8/1/2024 at 2:34 PM. The resident was in bed asleep and was receiving oxygen at 3 liters per minute via a nasal cannula. Licensed Practical Nurse #1 was interviewed on 8/1/2024 at 2:40 PM and stated they were responsible for checking that the oxygen was delivered to the resident as per the physician's orders. Licensed Practical Nurse #1 stated they should have checked the flow rate at the start of the shift to ensure Resident #71 was receiving the prescribed 2 liters of oxygen. The Director of Nursing Services was interviewed on 8/8/2024 at 1:05 PM and stated that the nurses were responsible for checking the oxygen flow rate to ensure the residents were receiving the correct oxygen flow rate as ordered by the Physician. The Director of Nursing Services stated the nurses should check that all residents are receiving the correct oxygen amount at the beginning of the shift and periodically throughout the shift. 10 NYCRR 415.12(k)(6)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024 the facility did not ensure that outside professional services were furnished timely. This was identified for one (Resident #222) of one resident reviewed for Dignity and for one (Resident #150) of five residents reviewed for Unnecessary Medications. Specifically, 1) Resident #222 was readmitted from the hospital on 7/13/2024 with a diagnosis of Traumatic Subarachnoid Hematoma (brain bleed). The hospital discharging physician recommended a follow-up with a Neurosurgeon within a week. The recommended consult was not completed as of 8/7/2024 when it was brought to the facility's attention by the Surveyor. 2) Resident #150 was admitted to the facility in November 2023. A physician's order dated 11/14/2023 documented that the resident was to be seen by the Psychiatrist for the Initial Evaluation. The Psychiatry consult/evaluation was not completed until 8/6/2024 when it was brought to the facility's attention by the State Surveyor. The findings are: The facility's policy titled Medical and Dental Consults last revised on 5/2023, documented that the facility will arrange services of qualified professional personnel to render specific medical services. An order for a consultation shall be placed in the electronic medical record (EMR) with the reason for consultation. For new admissions or readmissions, the Registered Nurse Supervisor will reconcile all hospital-scheduled outpatient appointments with the resident's attending physician and log in to the Hospital Consult Reconciliation Form. The attending physician will determine the need for further follow-up (agree, disagree, or use an in-house consultant). The Consult Coordinator will schedule the outpatient consults and arrange for transportation and escort if indicated. 1) Resident #222 was admitted with diagnoses including Traumatic Subarachnoid Hemorrhage (brain bleed), Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #222 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #222 received anticoagulant (blood thinner) medications. A Comprehensive Care Plan (CCP) titled, Anticoagulant Therapy dated 7/18/2024, documented the resident was at risk for bleeding, The interventions included reinforcing safety measures to prevent injury/bleeding and to administer medications ordered by the Physician. A review of the hospital Discharge Instructions dated 7/13/2024 documented that Resident #222 needed a follow-up consultation with a Neurosurgeon in one week due to a diagnosis of Traumatic Subarachnoid Hematoma (brain bleed). A review of the electronic medical record indicated no physician's order for a Neurosurgery consultation. A review of the electronic medical record revealed Resident #222 did not have a follow-up appointment or consult with the Neurosurgeon as recommended by the hospital. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #4 was interviewed on 8/5/2024 at 12:02 PM and stated they were one of the nurses who assisted in readmitting Resident #222 on 7/13/2024. Licensed Practical Nurse #4 stated they (Licensed Practical Nurse #4) only reviewed the medication list on the discharge summary from the hospital. Licensed Practical Nurse #4 stated it was Registered Nurse Supervisor #10 who reviewed the consult instructions for Resident #222. The Unit Clerk was interviewed on 8/5/2024 at 2:06 PM and stated they made appointments for any consultations needed for the residents after they received the consultation form from the nurses. The Unit Clerk stated they did not receive a consultation form to schedule a follow-up appointment with the Neurosurgeon for Resident #222. Registered Nurse #10, the nursing supervisor, was interviewed on 8/5/2024 at 2:21 PM and stated they admitted Resident #222 from the hospital on 7/13/2024; however, they did not see any recommendations from the hospital for a follow-up consult with a Neurosurgeon. Registered Nurse #10 stated they must have missed the recommendations documented on the discharge instructions from the hospital. Physician #2 was interviewed on 8/6/2024 at 10:30 AM and stated a Neurosurgery consult should have been completed for Resident #22 as per the hospital's recommendations. Physician #2 stated the facility was responsible for arranging for the consultation. The Director of Nursing Services was interviewed on 8/7/2024 at 11:30 AM and stated the nurses should have thoroughly checked the hospital discharge instructions for Resident #222 and ensured that the consultation form was completed and provided to the Unit Clerk to set up an appointment with the Neurologist as per the hospital discharge summary recommendations. 17732 2) Resident #150 was admitted to the facility on [DATE] with diagnoses including Atherosclerotic Heart Disease, Hypertension, and Major Depressive Disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive skills for daily decision-making. The Minimum Data Set assessment documented that the resident had been receiving an antidepressant medication for the last 7 days. The Physician's Order dated 11/11/2023, obtained by Licensed Practical Nurse #1, documented for the resident to receive Remeron (an antidepressant medication) 7.5 milligrams tablet- give 1 tablet by mouth at bedtime for Major Depressive Disorder. (This order was discontinued on 12/4/2023.) A review of the Psychiatry Consultation Form dated 11/11/2023, initiated by Licensed Practical Nurse #1, revealed that the Consultation Form was never completed by the Psychiatrist. The Physician's Order dated 11/14/2023, obtained by Registered Nurse #1, documented to obtain a Psychiatry Consult Initial Evaluation and follow-up. The Physician's Order dated 12/15/2023 last revised on 3/22/2024 documented to administer Mirtazapine (Remeron) 7.5 milligram - give one tablet by mouth at bedtime for Depression. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Psychiatry Consultation Form dated 7/25/2024, initiated by the Registered Nurse Consultant (Registered Nurse #2), revealed that the Consultation Form was never completed by the Psychiatrist. Registered Nurse #1 was interviewed on 8/6/2024 at 3:05 PM and stated after they (Registered Nurse #1) receive a Physician's Order for a Psychiatric Consultation, they are supposed to initiate a Psychiatry Consultation Form in the resident's Electronic Medical Record, print the resident's face sheet, and place the resident's face sheet in the Psychiatrist's folder which is kept at the reception desk in the lobby of the facility. Registered Nurse #1 stated when the Psychiatrist comes to the facility, they (Psychiatrist) take the face sheets of the residents needing Psychiatric Consultations out of the folder and go see them. Registered Nurse #1 stated that the Psychiatrist comes weekly to the facility, and they (Registered Nurse #1) did not know why Resident #150 was never seen by the Psychiatrist. Registered Nurse #1 stated they may not have opened another Psychiatry Consultation Form after obtaining the Physician's Order on 11/14/2023 because Licensed Practical Nurse #1 had already initiated one on 11/11/2023. Licensed Practical Nurse #1 was interviewed on 8/7/2024 at 9:35 AM and stated that when a resident is admitted to the facility on psychiatric medications, the Physician automatically orders a Psychiatric consultation request. Licensed Practical Nurse #1 stated that Resident #150's Physician must have given a verbal order for the resident to have a Psychiatric Consult, but they (Licensed Practical Nurse #1) must have forgotten to enter the Physician's Order into the computer on 11/11/2023 when the resident was admitted to the facility. The Psychiatrist was interviewed on 8/7/2024 at 10:45 AM and stated they usually do not see a newly admitted resident unless ordered to by the Physician. The Psychiatrist stated that either a Nurse calls them (Psychiatrist) or the resident's face sheet is left at the reception desk for them (Psychiatrist) when a resident needs a Psychiatric Consultation. The Psychiatrist stated that once they see a resident, they (Psychiatrist) will keep track of when the resident needs to be seen for a follow-up. The Psychiatrist stated they would not know when a Psychiatric Consultation Form was initiated unless the resident's face sheet was placed in their folder at the reception desk. The Psychiatrist stated they were never notified to see the resident for their initial Psychiatric Consultation. The Director of Nursing Services was interviewed on 8/7/2024 at 10:50 AM and acknowledged that Resident #15's initial Psychiatric Consultation was never done. The Director of Nursing Services stated that a Psychiatry Consultation should be completed as per the physician's orders. 10 NYCRR 415.26(e)(1)(i-iv)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on record review, and interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure medical records for each resident were complete and accurately documented. This was identified for one (Resident #90) of three residents reviewed for Choices. Specifically, Resident #90 had a physician's order for a finger stick blood glucose monitoring every morning. The Medication Administration Record did not include the finger stick blood glucose level results and the Vital Signs record had inconsistent documentation of the finger stick blood glucose level results. The finding is: The policy titled Blood Glucose Monitoring dated 7/2013 documented findings (of finger stick blood glucose levels) shall be documented in the medical chart. Resident #90 was admitted with diagnoses including Spinal Stenosis, Dementia, and Type two Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 12, which indicated the resident had moderately impaired cognition. The Comprehensive Care Plan for Diabetes Mellitus dated 5/20/2021 and last revised on 5/17/2024 documented interventions including monitoring finger stick blood glucose as ordered by the Physician. A physician's order dated 7/14/2024 documented to obtain finger stick blood glucose level every morning one time a day. The Vital Sign documentation record for July and August 2024 was reviewed. The Vital Sign record lacked documented evidence of finger stick blood glucose results on 7/15/2024, 7/19/2024, 7/20/2024, 7/21/2024, 7/23/2024, 7/24/2024, 7/25/2024, 7/26/2024, 7/27/2024, 7/28/2024, 7/30/2024, 7/31/2024, 8/01/2024, and 8/02/2024. The Medication Administration Record for July 2024 and August 2024 did not document morning finger stick glucose levels. The Assistant Director of Nursing Services #1, the Nurse Educator, was interviewed on 8/05/2024 at 10:43 AM and stated there should be a section on the Medication Administration Record to document the morning finger stick glucose levels. The Assistant Director of Nursing Services #1 stated Resident #90's Medication Administration Record did not include a space to document the finger stick blood glucose level and should have. The Director of Nursing Services was interviewed on 8/07/2024 at 10:49 AM and stated that the nurses are responsible for the resident's care and for documenting the finger stick blood glucose level in the Medication Administration Record to monitor the blood glucose level trends. 10 NYCRR 415.22(a)(1-4)

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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** 28670 Based on observation, record review, and interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024 the facility did not ensure that an infection prevention and control program designed to help prevent the development and transmission of infections was maintained. This was identified for one (Resident #6) of five residents reviewed for Pressure Ulcers. Specifically, during a dressing change observation of Resident #6's sacral wound, Registered Nurse #15 did not change their gloves and did not wash their hands after cleansing the sacral wound and before applying the treatment. The finding is: The facility's Hand Washing Protocol dated 11/2017 documented to perform hand hygiene before and after each resident/patient contact. The facility's Clean Dressing Change policy and procedure dated 5/2024 documented to cleanse the wound while maintaining an aseptic technique, pat dry with a clean gauze, and then perform hand hygiene. Don (put on) clean gloves before applying a dressing as ordered. Resident #6 was admitted with diagnoses that included Non-Alzheimer's Dementia, Coronary Artery Disease, and Diabetes Mellitus. A Significant Change Minimum Data Set assessment dated [DATE] documented the resident had short and long term memory problems. The resident had impairment on both lower extremities and was dependent on staff for bed mobility and transfer. The resident had one unhealed Stage III Pressure Ulcer (a full-thickness loss of skin that extends to the subcutaneous tissue but does not cross the fascia beneath it) that was not present on admission. A Comprehensive Care Plan for Pressure Ulcer dated 1/11/2024 and revised on 6/14/2024 documented that the resident has a Pressure Ulcer to the sacrum. Interventions included the use of an air mattress, turning, and positioning the resident every two hours and as needed. A Physician's order dated 7/19/2024 documented to apply Santyl Collagenase (an enzymatic debriding agent) Ointment 250 Unit/Gram. Clean the wound first by using Normal Saline. Apply Sting Free Skin Prep to peri-wound (surrounding skin) and allow to dry. Apply Santyl Collagenase ointment to the wound bed, then cover with bordered foam every day shift for diagnoses of Pressure Ulcer/Injury. A wound care observation was conducted on 8/8/2024 at 8:52 AM, with Registered Nurse #15. The Assistant Director of Nursing Services #1, the Nurse Educator, was also present in the room. Registered Nurse #15 washed their hand and donned (put on) clean gloves. Registered Nurse #15 cleansed the wound two times from the center of the wound to the outer area of the wound, using saline-soaked gauze. After cleansing the wound Registered Nurse #15 applied skin prep to the peri-wound area, then applied the Santyl Collagenase ointment to the wound bed without changing their gloves and washing their hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #15 was interviewed immediately after the observation on 8/8/2024 at 9:20 AM and stated they knew they were supposed to change their gloves and wash their hands after they cleaned the wound bed, and before they applied the treatment to the wound. Registered Nurse #15 stated they should have changed their gloves after cleansing the wound and applying the treatment. The Assistant Director of Nursing Services #1, the Nurse Educator, who was present during the wound care observation, was interviewed on 8/8/2024 at 9:28 AM and stated they educate nurses to change gloves and wash their hands after cleansing a wound. The Assistant Director of Nursing Services #1 stated after Registered Nurse #15 cleansed the wound they should have changed their gloves and performed hand hygiene before applying the treatment. The Director of Nursing Services was interviewed on 8/8/2024 at 10:48 AM and stated after Registered Nurse #15 cleansed the resident's sacral wound, they should have changed gloves, performed hand hygiene, and applied clean gloves before the wound treatment was applied. 10 NYCRR 415.19(a)(1-3) (b)(4)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, interviews, and record review during the recertification Survey and Abbreviated Survey (NY 00332930) initiated on 8/01/2024 and completed on 8/08/2024, the facility did not provide a safe, functional, sanitary, and comfortable environment. This was identified for two (Resident #131, Resident #5) of three residents reviewed for Environment. Specifically, the toilets that were mounted to the walls in Resident #131 and Resident #5's bathroom did not have appropriate support and reinforcement. The toilets were observed with wooden blocks underneath the toilet to provide support and reinforcement. The findings are: The facility policy titled Room and Unit Maintenance dated 9/2021 documented to maintain rooms and units within the facility in a manner that provides a safe, homelike environment. -Resident #131 was admitted with diagnoses of Morbid Obesity, Type Two Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15, indicating the resident had intact cognition. Resident #131 had no impairment in functional ability for toileting needs and utilized a wheelchair or walker for mobility. The Comprehensive Care Plan for Activities of Daily Living dated 7/25/2024 documented the resident required partial/moderate assistance with toileting. On 8/06/2024 at 11:15 AM Resident #131 was observed in a wheelchair coming out of their room. The resident's room had a bathroom with a toilet mounted to the wall. The toilet was supported by wooden blocks. Resident #131 was interviewed on 8/01/2024 at 10:50 AM and stated the wooden blocks holding up the toilet bowl had been there for months. -Resident #5 was admitted with diagnoses of Chronic Obstructive Pulmonary Disease, Type Two Diabetes Mellitus, and Schizophrenia. The Quarterly Minimum Data Set assessment, dated 7/10/2024, documented the resident had a Brief Interview for Mental Status score of 14, indicating the resident had intact cognition. Resident #5 was dependent and required 2 persons' assistance for toileting needs. During an observation on 8/01/2024 at 11:04 AM, Resident #5 was observed in their bed resting with the television on. The resident's room had a bathroom with a toilet mounted to the wall. The toilet was supported by wooden blocks. Resident #5 was interviewed on 8/01/2024 at 11:04 AM and was unaware of the wooden blocks underneath the toilet. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeper #1 was interviewed on 8/06/2024 at 11:29 AM and stated they did not know why Resident #131, and Resident #5's bathrooms have wooden blocks supporting the toilet. Housekeeper #1 stated they cleaned around the wooden blocks but did not move the blocks. The Director of Facility Management was interviewed on 8/07/2024 at 12:01 PM and stated the wooden blocks were placed under the toilet to provide support, due to the resident's weight. The Director of Facility Management stated they had ordered a bracket (wall-mounted toilet support) for properly supporting the toilet, but they were unsure why the brackets were not yet installed. The Director of Facility Management further stated that using the wooden blocks to support a toilet was unsafe for the residents, posed infection control issues, and was not a home-like environment. The Administrator was interviewed on 8/07/2024 at 2:38 PM and stated the wooden blocks were used to support the toilets. The Administrator stated as far as they knew, all wooden blocks were removed after the toilets were repaired. The Administrator stated using the wooden blocks in the resident's bathroom could pose an infection control issue, was unsafe for the residents, and was not a home-like environment. 10 NYCRR 415.29