STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335696	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gurwin Jewish Nursing and Rehabilitation Center	68 Hauppauge Road Commack, NY 11725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observations, record review, and staff interviews during the recertification survey initiated on 5/15/2024 and completed on 5/23/2024, the facility did not ensure that a person-centered care plan for each resident that included measurable objectives and timeframes to meet the resident's needs was developed timely and implemented accurately. This was identified for one (Resident #210) of five residents reviewed for Respiratory Care. Specifically, Resident #210 had a physician's order for oxygen therapy at one liter per minute via nasal cannula. During three seperate observations, Resident #210 was observed receiving oxygen at three liters per minute. Additionally, there was no documented evidence that a comprehensive care plan for the resident's Respiratory Status was developed in a timely manner. The finding is: The facility's undated Comprehensive Care Plan policy and procedure documented that the resident's Comprehensive Care Plan must address the main reason for admission and that the Comprehensive Care Plan and Discharge Plan must be initiated within one week of admission and 14 days of an initial or significant change in resident's condition. The team must initiate a Comprehensive Care Plan using the Care Assessment Areas Summary Sheet as the guideline. Within 21 days of Admission, the Comprehensive Care Plan must be finalized and there must be evidence that the Care Assessment Areas instructions were used in formulating the resident's care plan. Resident #210 was admitted to the facility with diagnoses that included Pulmonary Hypertension, Congestive Heart Failure, Non-Alzheimer's Dementia, and Atrial Fibrillation. The Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 3, which indicated severely impaired cognition. Section O of the Minimum Data Set assessment documented the resident received continuous oxygen on admission and while a resident. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident received oxygen therapy while a resident. Resident #210 was observed lying in bed, awake and responsive, on 5/15/2024 at 11:20 AM. The resident was receiving oxygen from an oxygen concentrator at 3 liters per minute via a nasal cannula. A Physician's order dated 10/10/2023 and last reviewed on 5/2/2024 documented to administer oxygen at one liter per minute via a nasal cannula every shift for shortness of breath. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Record dated 10/2023 and 11/2023 documented the resident was receiving oxygen at one liter per minute via nasal cannula for Shortness of Breath as indicated by the nurses' signature. The current Treatment Administration Record dated 5/2023 documented the resident was receiving oxygen at one liter per minute via nasal cannula for Shortness of Breath until 5/23/2024 when the Physician's order was changed to 2 liters per minute titrating up to 3 liters per minute. Resident #210 was observed on 5/23/2024 at 8:53 AM. Resident #210 was lying in bed and was receiving oxygen from an oxygen concentrator at 3 liters per minute via nasal cannula. Resident #210 was observed on 5/23/2024 at 8:58 AM with Licensed Practical Nurse #3. Resident #210 was lying in bed and was receiving oxygen from an oxygen concentrator at 3 liters per minute via nasal cannula. Licensed Practical Nurse #3 confirmed that the oxygen flow rate was set at 3 liters per minute. A Review of the medical record was conducted on 5/23/2024 and revealed that the care plan for the resident's Respiratory Status was not initiated until 5/23/2024. A Comprehensive Care Plan initiated on 5/23/2024 documented altered Respiratory Status and difficulty breathing related to shortness of breath. Interventions included administering medication as ordered; nebulizer treatments and oxygen therapy as ordered, and maintaining oxygen settings as per the Physician's order. During an interview with Registered Nurse #2 on 5/23/2024 at 1:11 PM, they stated that on admission the admitting Registered Nurse is responsible for initiating the care plans for the resident. Registered Nurse #2 stated when Resident #210 was admitted to the facility, a care plan for the need for oxygen therapy should have been initiated. During an interview with the Director of Nursing Services on 5/23/24 at 2:39 PM, they stated that the nurses should have ensured that Resident #210 received oxygen therapy as per the physician's order. The Director of Nursing Services stated if the resident needed a higher oxygen flow rate than what was ordered by the Physician, then the Physician should have been contacted to obtain a new order. The Director of Nursing Services stated that a care plan for oxygen use should have been initiated by the admitting Registered Nurse; however, the care plan can also be initiated by any Registered Nurse Manager or Supervisor. The Director of Nursing Services further stated that the comprehensive care plan for each resident must be completed before the initial care plan meeting is held. 10 NYCRR 415.11(c)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review, and interviews during the Recertification Survey and Abbreviated Survey (Complaint #NY 00321973) initiated on 5/15/2024 and completed on 5/23/2024, the facility did not ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments. This was identified for one (Resident #90) of two residents reviewed for abuse. Specifically, Resident #90 was involved in a resident-to-resident altercation on 8/11/2023 and sustained a 4-centimeter by 4-centimeter Hematoma (bruise) to their left forearm. The comprehensive care plan for Resident #90 was not reviewed or revised to reflect the altercation. The finding is: The facility's undated Comprehensive Care Plan policy documented to ensure the timeliness of each resident's person-centered comprehensive care plan and ensure the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and their needs. Following the annual or significant change Minimum Data Set (MDS 3.0) assessment, the care plan is updated to reflect the resident's status and the Interdisciplinary Team (IDT) will document that each care plan has been reviewed and revised, if applicable, and that all changes identified by the Quarterly Minimum Data Set 3.0 must be documented in the comprehensive care plan. Resident #90 was admitted to the facility with diagnoses that included Bipolar Disease, Hypertension, and Coronary Artery Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 10, which indicated the resident had moderately impaired cognition. The resident had no behavioral symptoms. The resident required limited assistance of one staff for walking on the unit and extensive assistance of one staff for locomotion on the unit. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident had short and long-term memory problems and had moderately impaired skills for making decisions. An annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognition. The resident had no behavioral symptoms and utilized a walker and wheelchair. A Comprehensive Care Plan dated 6/29/2023 documented that Resident #90 was involved in a resident-to-resident interaction. Interventions included staff encouraging peers to be in a different area on the unit and support to be provided to ensure the resident feels safe and not at risk of negative interaction with other residents. A Behavior note dated 8/11/2023 documented that Resident #90 was self-propelling their wheelchair up the hall, and as they passed Resident #148 was also self-propelling their wheelchair down the hall, Resident #148 began to hit Resident #90 with a rubber-soled shoe in the left arm. This act was witnessed by the charge nurse, and both residents were immediately separated. A Hematoma measuring four centimeters in length, four centimeters in width, and one centimeter in depth was observed. Ice was applied to Resident #90's left forearm. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's care plan for resident to resident altercation was conducted on 5/23/2024 and there was no documented evidence that the care plan was reviewed and revised at the time of the Quarterly care plan review for the 12/7/2023 and the 2/29/2024 assessments. An interview was conducted on 5/23/2024 at 1:55 PM with Social Work #1, and they stated that the Social Workers or nurses can update the care plans. Social Work #1 stated that either discipline should have updated the care plan to reflect the resident-to-resident altercation. An interview was conducted on 5/23/2024 at 2:50 PM with the Director of Nursing Services, they stated the care plan should have been revised by any Registered Nurse who was assigned to the resident's unit or by the Registered Nurse Risk Manager. The Director of Nursing Services stated the care plan should have been updated to reflect the altercation and any changes that were made to the plan of care. The Director of Nursing Services further stated that the care plan also should have been reviewed and updated after each Minimum Data Set assessment. 10 NYCRR 415.11(c)(2)(i-iii)

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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 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** 28670 Based on observations, record review, and staff interviews during the Recertification Survey initiated on 5/15/2024 and completed on 5/23/2024, the facility did not ensure that each resident who needs respiratory care is provided such care consistent in accordance with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (Resident #210) of five residents reviewed for Respiratory Care. Specifically, Resident #210 had a Physician's order for oxygen to be administered at one liter per minute via nasal cannula. On three separate occasions, the resident was observed receiving oxygen at three liters per minute. The finding is: The facility's oxygen policy and procedure dated 7/2023 documented to check the physician's order for the rate of flow and type of mask used. The policy also documented adjusting the liter flow gauge as per the physician's order. The facility's Physician Order policy dated 6/2023 documented that physician's orders must be entered in the Electronic Medical Record by the medical staff. Nurses will review and confirm the new orders and obtain clarification as needed. Resident #210 was admitted to the facility with diagnoses that included Pulmonary Hypertension, Congestive Heart Failure, Non-Alzheimer's Dementia, and Atrial Fibrillation. The Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 3, which indicated severely impaired cognition. Section O of the Minimum Data Set assessment documented the resident received continuous oxygen on admission and while a resident. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident received oxygen therapy while a resident. Resident #210 was observed lying in bed, awake and responsive, on 5/15/2024 at 11:20 AM. The resident was receiving oxygen from an oxygen concentrator at 3 liters per minute via a nasal cannula. A Physician's order dated 10/10/2023 and last reviewed on 5/2/2024 documented to administer oxygen at one liter per minute via a nasal cannula every shift for shortness of breath. Resident #210 was observed on 5/23/2024 at 8:53 AM. Resident #210 was lying in bed and was receiving oxygen from an oxygen concentrator at 3 liters per minute via nasal cannula. Resident #210 was observed on 5/23/2024 at 8:58 AM with Licensed Practical Nurse #3. Resident #210 was lying in bed and was receiving oxygen from an oxygen concentrator at 3 liters per minute via nasal cannula. Licensed Practical Nurse #3 confirmed that the oxygen flow rate was set at three liters per minute. A Comprehensive Care Plan dated 10/10/2023 and last updated on 2/29/2024 documented the resident has Congestive Heart Failure. Interventions including to check breath sounds; monitor and document labored breathing; monitor vital signs as per the Physician's order; and notify the Physician of significant abnormalities. There was no documented evidence of the resident's use of oxygen included in the care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan initiated on 5/23/2024 documented altered Respiratory Status and difficulty breathing related to shortness of breath. Interventions included administering medication as ordered; nebulizer treatments and oxygen therapy as ordered and maintaining oxygen settings as per the Physician's order. During an interview with Licensed Practical Nurse #3, the medication nurse, on 5/23/2024 at 9:05 AM, a review of the resident's physician's order was conducted by Licensed Practical Nurse #3. The physician's order indicated to administer oxygen at one liter per minute. Licensed Practical Nurse #3 stated at the start of their shift, they checked on Resident #210 and observed that the resident was receiving oxygen at three liters per minute via nasal cannula. Licensed Practical Nurse #3 stated they did not check the physician's order. Licensed Practical Nurse #3 stated they should have checked the physician's order to ensure the resident was receiving oxygen at the flow rate ordered by the Physician. During an Interview on 5/23/2024 at 9:15 AM with Registered Nurse #2, they stated that Licensed Practical Nurse #3 should have verified the physician's order to ensure Resident #210 was receiving the correct oxygen flow rate as per the physician's order. Registered Nurse #2 stated that the resident should have been receiving oxygen at one liter per minute. During an interview with the Education Coordinator on 5/23/2024 at 10:10 AM, they stated nurses are expected to administer oxygen as per the physician's orders. If the resident required three liters of oxygen instead of one liter, then the nurses should have notified the physician and obtained a new order. The Education Coordinator stated that the nurses are in-serviced upon hire, annually, and as needed regarding checking and following the physician's orders. During an interview with the Director of Nursing Services on 5/23/2024 at 2:39 PM, the Director of Nursing Services stated that the nurses should have confirmed the physician's order when administering oxygen therapy. The Director of Nursing Services stated that if there was a concern with the oxygen flow rate, the nurses should have called the Physician, verified the order, and followed the physician's order as written. During an interview with Nurse Practitioner #1 on 5/23/2024 at 3:15 PM, they stated the nurses are expected to follow the physician's order as written; however, if there were concerns with the order the nurses should verify the order with the Physician or the Nurse Practitioners. 10 NYCRR 415.12(k)(6)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observations, record review, and interviews during the Recertification Survey initiated on 5/15/2024 and completed on 5/23/2024, the facility did not ensure that the facility's medication error rate was not five percent or greater. This was identified for three of the 27 medications observed during the medication pass observation, resulting in an 11.11% medication error rate. Specifically, during a medication pass observation Resident #155 did not receive three of their 8:00 AM physician-ordered medications until 11:46 AM on 5/15/2024. The finding is: The Facility's Policy for Administering Medications revised on 1/12/2024 documented that medications should be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal). Resident #155 was admitted with diagnoses that include Dementia and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating the resident had intact cognition. The active Physician's Orders for May 2024 for Resident #155 documented to administer the following medications at 8:00 AM: -one Escitalopram Oxalate 10 milligram tablet by mouth once a day for Depression at 8:00 AM; -one Apixaban Oral 2.5 milligram tablet by mouth every 12 hours for history of venous Thromboembolism (blood clotting) at 8:00 AM; 2 oral puffs of Albuterol Sulfate Hydrofluoroalkane Aerosol Solution 108 (90 Base) micrograms/actuation pressurized inhalation four times a day for Chronic Obstructive Pulmonary Disease at 8:00 AM. During the medication administration task observation on 5/15/2024 at 11:46 AM, Registered Nurse #4 was observed administering one Escitalopram Oxalate 10 milligram tablet, one Escitalopram Oxalate 10 milligram tablet, and 2 oral puffs of Albuterol Sulfate Hydrofluoroalkane Aerosol Solution 108 (90 Base) micrograms/actuation pressurized inhalation to Resident #155 which were due to be administered at 8:00 AM as per the physician's orders. The medications were administered 2 hours and 46 minutes beyond their prescribed time. Registered Nurse #4 was interviewed on 5/15/2024 at 11:48 AM and stated that they were administering Resident # 155's 8:00 AM medications late because they got busy with other things. Registered Nurse #4 stated they should have administered the medications before 9:00 AM since the medications can be administered one hour before or one hour after the prescribed time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Chief Nursing Officer was interviewed on 5/23/2024 at 2:37 PM and stated that Resident #82's medications were administered late on 5/15/2024, which is not acceptable. The Chief Nursing Officer stated they expected the nurses to administer medications as per the facility policy which is one hour before and one hour after the scheduled time. Nurse Practitioner #1 was interviewed on 5/23/2024 at 3:06 PM and stated that it was not acceptable to administer the medications later than one hour past the prescribed time. Nurse Practitioner #1 stated Registered Nurse #4 should have notified Nurse Practitioner #1 about the delayed medications to determine if the time change was appropriate. 10 NYCRR 415.12(m)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 5/15/2024 and completed on 5/23/2024 the facility did not ensure that all drugs were labeled and stored in accordance with professional standards including the expiration dates. This was identified for 1) one (medication cart on Unit 2) of thirteen medication carts observed during the medication storage task, and 2) one (Unit 4 medication room) of seven medication rooms reviewed for the medication storage task. Specifically, 1) On 5/22/2024, Unit 2's medication cart was observed with an expired Fluticasone inhaler. The label on the inhaler had Resident #371's name with an expiration date of 5/15/2024. 2) On 5/22/2024, Resident #350's 50 cubic centimeter bag of intravenous antibiotic solution (Normal Saline with 1 gram of Ceftriaxone) was observed in the medication room refrigerator with an expiration date of 5/20/2024. The findings are: The Facility's policy titled, Dispensing Medication, revised 7/20/2022 documented that manufacturer's expiration date and package insert expiration rules apply for medications that are dispensed in original manufacturer packaging and an auxiliary label is placed on the original packaging with the new expiration date. The manufacturer's packaging insert for the Fluticasone inhaler documented the inhaler is good for six weeks once opened. The insert package suggested writing the discard date on the label. 1) Resident #371 was admitted with diagnoses including Anemia, Acute Respiratory Failure, and Asthma. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident had intact cognition. A Physician's order for Resident #371 dated 4/02/2024 documented to administer Fluticasone Furoate-Vilanterol Inhalation Aerosol powder breath activated 100-25 micrograms. One inhalation a day for Asthma. During the medication storage task with Licensed Practical Nurse #1 on Unit 2 South on 5/22/2024 at 11:56 AM, a Fluticasone inhaler was observed in the medication cart with an expiration date of 5/15/2024. The inhaler had a label with Resident #371's name. Licensed Practical Nurse #1 was interviewed on 5/22/2024 at 12:00 PM and stated the expired Fluticasone inhaler should not be stored in the medication cart. Licensed Practical Nurse #1 stated they would discard the expired inhaler and request a new Fluticasone inhaler for Resident #371 from the Pharmacy. Licensed Practical Nurse #1 stated the expiration date on the Fluticasone inhaler was 5/15/2024 and admitted to administering the inhaler medication to Resident #371 on 5/22/2024 from the expired inhaler. Licensed Practical Nurse #1 stated they should have checked the expiration date before administering the medication to the resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Assistant Pharmacy Director was interviewed on 5/22/2024 at 12:17 PM And stated the manufacturer's expiration date on the Fluticasone inhaler was 11/2025; however, the label added by the in-house Pharmacist indicated an expiration date that was 45 days from when the inhaler was first opened. The manufacturer requires that the inhaler be discarded 45 days after it was first opened. The Pharmacist had filled the medication order on 4/2/2024 when the resident was first admitted to the facility. The Pharmacy had only supplied one Fluticasone inhaler since the resident was first admitted to the facility which expired on 5/15/2024. The Chief Pharmacy Officer was interviewed on 5/22/2024 at 2:04 PM and stated when an inhaler is taken out of the original packaging, the inhaler should be discarded 45 days after opening as per the manufacturer because there of the potential contamination issue. The Chief Pharmacy Officer was re-interviewed on 5/23/2024 at 3:31 PM and stated the 4/02/2024 date on the label is when the Fluticasone inhaler was dispensed from the pharmacy to the nursing Unit. No other inhalers were dispensed for this resident after 4/2/2024 until 5/22/2024 when the expired inhaler was discovered. The Chief Nursing Officer was interviewed on 5/23/2024 at 2:38 PM and stated the medication nurse should have checked the expiration date before administration of the inhaler. The medication nurse should have discarded the medication and the resident should not have received the inhaler medication after the expiration date of 5/15/2024. 44925 2) The facility's policy titled Drug Storage revised on 1/12/2024 documented that nursing staff will check for pharmaceutical expiration dates and if expired, will return to the pharmacy for proper disposal or utilize the approved pharmaceutical waste disposal services. Resident #350 was admitted to the facility on [DATE] with diagnoses including Acute Pancreatitis, Cholangitis (an inflammation of the bile duct system), and Essential Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 11, indicating the resident had moderately impaired cognition. A Physician's order for Resident #350 dated 5/16/2024 documented Ceftriaxone Sodium Solution Reconstituted 1 gram; Use 1 gram intravenously every 24 hours for Urinary Tract Infection for seven Days from 5/16/2024 to 5/22/2024. On 5/22/2024 at 12:06 PM, Unit 4 North's medication storage room was observed with Licensed Practical Nurse #5. A bag containing 1 gram of Ceftriaxone Sodium Reconstituted Solution for intravenous use was observed in the medication storage refrigerator with an expiration date of 5/20/2024. Licensed Practical Nurse #5 stated they check for expired medication daily, but they did not notice the expired Ceftriaxone Sodium intravenous bag in the refrigerator. Licensed Practical Nurse #5 stated if they knew, they would have notified the Pharmacy to pick up the expired medication. Registered Nurse Manager #2 was interviewed on 5/23/2024 at 2:24 PM and stated that all nurses are responsible for removing expired medications from the medication storage room, including the refrigerator, and that the expired medications should not be stored in the unit refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Assistant Pharmacy Director was interviewed on 5/22/2024 at 2:04 PM and stated that expired medications should not be in the medication room refrigerator. The Assistant Pharmacy Director stated they were not notified of an expired intravenous antibiotic medication bag on Unit 4 North. The Chief Nursing Officer was interviewed on 5/23/2024 at 3:00 PM and stated expired medications should not be stored in the refrigerator. The Chief Nursing Officer stated the facility has an in-house pharmacy in the building and always has medications available if needed. 10 NYCRR 415.18(e)(1-4)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 17585 Based on observations, record review, and interviews during the recertification survey conducted 5/15/24-5/23/24, the facility did not ensure each resident was provided a nourishing, palatable, well-balanced diet that meets daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This was identified for one (Resident #36) of five residents reviewed for Nutrition. Specifically, Resident #36 verbalized disliking the food served to them and requested a burger as a preferred meal. The facility did not honor the resident's preference and only provided a burger meal once in three weeks. Finding include: The facility policy Nutritional Services revised in January 2024 documented that Residents are interviewed regarding food/beverage and meal preferences to provide an individualized and personal dining experience. These food/beverage and meal preferences are updated regularly. Food/beverage and meal preferences may include religious, ethnic, cultural, and/or usual eating patterns. Preferences will be honored and recognized by all staff and implemented in the best interest of the resident. The facility policy Resident food preferences revised in January 2018 documented Residents' individual choices are obtained that incorporate religious, cultural, and ethnic needs and preferences. Residents are served meals that offer choices, including portion size, and comply with food preferences. Choices of food substitutions are provided when the resident refuses the meal items served and should be of equal nutritional value to the planned menu item. The Dietitian/Designee would interview the resident within 24-48 hours of admission (not to exceed 72 hours over a weekend); obtain food and dining preferences, dislikes, allergies, and cultural, religious, and ethnic preferences; record the information in the resident's nutrition file, update preferences regularly, minimally quarterly. Resident # 36 has diagnoses including Liver Cirrhosis. The 4/11/2024 Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 13 indicating the resident had intact cognition. The resident had no behaviors and had a significant weight loss. The resident was interviewed during the initial screening on 5/15/2024 at 11:45 AM and stated they only eat breakfast and dislike all other food. A review of the resident's weights from 2/22/2024 to 5/12/2024 revealed the resident had a significant weight loss (more than 10 percent in 6 months). On 2/22/2024 the resident weighed 219 pounds and on 5/12/2024, the resident weighed 191 pounds indicating a 24.9% weight loss. The comprehensive care plan (CCP) for Advanced Directive revised 7/13/2023 documented the resident is capable of making their own decisions regarding medical decisions and has assigned (family member) as their decision maker. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335696	A. Building B. Wing	05/23/2024

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan (CCP) for Nutrition revised 5/2/2024 documented Resident #36 has the potential for weight changes & Dehydration related to cardiac status, edema with diuretic treatment, morbid obesity, Cirrhosis, significant weight loss, poor oral intake, noncompliant with recommended diet. Interventions include Nutrition /Nursing to provide cultural/religious, food/fluid, and mealtime preferences. The resident's dietary preference sheet documented the resident's preferences as follows: cheese quiche, grilled American sandwich on white bread, green steamed peas, Mediterranean stuffed peppers vegetarian, and burger beef on bun patty. The alternate menu offered to the resident included: Dairy Meal: tuna salad sandwich, egg salad sandwich, cheese sandwich, cottage cheese and fruit plate, and baked fish. The Meat Meal: turkey sandwich, chicken salad sandwich, bologna sandwich, salami sandwich, tuna salad sandwich, egg salad sandwich, roasted chicken, daily bread options include challah, kaiser, tortilla, wheat, white, and rye bread. A Nutrition/Dietary Note dated 4/26/2024 at 3:01 PM documented Resident #36 requested to speak to the writer (Registered Dietician) to discuss food quality and poor intake. The resident has had significant weight loss related to poor appetite and food dislikes. The resident stated food had no flavor. The resident was encouraged to ask the family to bring in seasoning shakers to add flavor. The resident refused. The resident discussed liking a burger with sliced onion and pudding with sugar. Pudding added to dairy meals with bedtime snacks. The menu profile updated and will discuss options with the kitchen staff to determine the availability of the beef burger. The resident was re-interviewed on 5/22/2024 at 12:00 PM and stated they stopped eating the facility's food. I only eat 2 hard-boiled eggs daily. They know my preferences and they do not provide it. They tell me to have my brother bring in food, I dislike the alternates. They want to give me drugs to stimulate my appetite but I refuse to take them. I am provided- tuna fish, cheese sandwich, and bologna that I cannot eat. I should have more choices to choose from. If they were to give me the food that I like, I would would eat it. During an observation on 5/22/2024 at 1:00 PM, Resident #36 was provided with a falafel sandwich meal. The resident disliked the sandwich and returned the tray with the Certified Nurse Assistant #2. The resident was re-interviewed on 5/23/2024 at 12:30 PM and stated they disliked the Falafel sandwich that was served on 5/22/2024 and could not eat it. They have no appetite and the food served at the facility does not stimulate their appetite. If they were given the food they liked, they would eat it. The resident further stated they had requested hamburgers as a preference over three weeks ago and they were offered the burger only once in the last three weeks. Dietician # 1 was interviewed on 5/22/2024 at 1:12 PM and stated Resident #36 disliked the food and had significant unplanned weight loss. Burgers are not on the alternate list and are only served once in the last few weeks. The day Resident #36 requested a burger they got the burger. Dietician # 1 stated they did not know if burgers could be provided to the resident more often and they did not ask food services to determine the availability. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical Nutrition Manager #1 was interviewed on 5/22/2024 at 3:13 PM and stated the facility can not serve meat on a dairy meal day. Every Wednesday and Friday the Lunch meal is always meat and the Dinner is always dairy, except on Wednesdays and Fridays. Clinical Nutrition Manager #1 stated that the dietician told them about the resident's preference for burgers and they called the kitchen and got the burger for the resident that day (could not recall when). Food Service Director # 1 was interviewed on 5/22/2024 at 3:17 PM and stated the facility follows kosher guidelines, No dairy for 6 hours after meat meal and no meat after dairy meal x 1 hour. Food Service Director # 1 stated they were not aware of the resident's preference for the burger. The last burger meal served was approximately two weeks ago. No one from the dietary department requested the availability of burgers for Resident # 36. We cannot serve meat during a dairy meal or dairy during a meat meal; however, we can provide meat to a resident at any time if they request. Chief Operating Officer #1 was interviewed on 5/23/2024 at 11:25 AM and stated the resident refuses to eat and has a poor appetite and the facility has to abide by kosher requirements. Chief Nursing Officer # 1 was interviewed on 5/23/2024 at 2:00 PM and stated nursing staff monitors the resident's weight and notifies the Dietician if the resident refuses to eat, offers alternate meals, and if the resident refuses the alternate meal then the nurse/Dietician should contact the kitchen to see if other options are available. If there are no other options then we see if the resident wants to order out. Chief Nursing Officer # 1 stated many residents here do not like the facility's food because of its kosher status. 10 NYCRR 415.14