STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335702	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwell Health Stern Family Center for Rehab	300 Community Drive Manhasset, NY 11030

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review and interviews during the Recertification Survey initiated on 2/6/2025 and completed on 2/12/2025, the facility did not ensure that each resident's Advanced Directive wishes were formulated and clearly communicated. This was identified for one (Resident #374) of five residents reviewed for Advanced Directives. Specifically, Resident #374 completed a Medical Orders for Life-Sustaining Treatment (MOLST) form while in the hospital on 1/19/2025 indicating Do Not Attempt Resuscitation. Upon readmission to the facility, there was no Physician order placed for Do Not Resuscitate. In addition, the Social Work assessment dated [DATE] documented the resident was a Full Code (indicating resuscitation should be provided). The finding is: The facility's policy titled Advanced Directives, dated 6/2024 documented that upon admission, nursing staff will ask the resident if they have a Do Not Resuscitate order (from the community or hospital). If yes, the resident is asked if they would like to continue. If the resident wishes to continue, the Physician is contacted and an order for Do Not Resuscitate is obtained. During the psychosocial assessment of the resident upon admission, the social worker will ask the resident about all Advanced Directives in place. The social worker will also assist a resident with any changes in Advanced Directives. Advanced Directives and related education are documented on the Advanced Directives care plan in the electronic health record. Resident #374 was admitted with diagnoses including Septicemia (infection), Anxiety Disorder, and Depression. The 1/18/2025 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. There were no Advanced Directives documented in the Minimum Data Set assessment. The Social Work Admission assessment dated [DATE] documented the resident response to Advanced Directive- Willing to fill out while here. There was no documented follow-up from social work regarding Resident #374's advanced directives between 1/14/2025 (admission) and 1/18/2025 (discharge to hospital). The Medical History and Physical dated 1/14/2025 and completed on 1/16/2025 documented under Advanced Directives: The resident wanted Cardiopulmonary Resuscitation at present. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was transferred to the hospital due to Hypoxia (inadequate oxygen supply to body tissues) and shortness of breath on 1/18/2025 and returned to the facility on [DATE]. A Medical Orders for Life-Sustaining Treatment (MOLST) form dated 1/19/2025 completed at the hospital documented that Resident #374 gave verbal consent for Do Not Attempt Resuscitation. The document was signed by a Registered Nurse and a Physician from the hospital. The Nursing Admission assessment dated [DATE] (completed by Registered Nurse #2) documented the resident's response to Advanced Directives as Yes; a Do Not Resuscitate Advance Directive was completed. The direction in the assessment documented that if the response to the Advance Directive is Yes, then notify the provider to obtain a Do Not Resuscitate order. A review of the medical record revealed Resident #374 did not have a Physician's order for Do Not Resuscitate. The Social Work Admission assessment dated [DATE], completed by Social Worker #1, documented under Advanced Directives, Education Provided, Full Code. The Medical History and Physical dated 1/24/2025 and completed on 1/27/2025, documented the resident verbalized they would like their Advanced Directives to be Do Not Resuscitate/Do Not Intubate. A review of the medical record revealed no comprehensive care plan for Advanced Directives. The Admission Minimum Data Set assessment dated [DATE] documented: No Advanced Directives. During an interview on 2/7/2025 at 3:41 PM, Registered Nurse #2 stated they completed Resident #374's nursing admission assessment on 1/24/2025 and selected a Yes response to indicate that the resident had Advance Directive and wished for a Do Not Resuscitate order. Registered Nurse #2 stated they did not contact the Physician to obtain the Do Not Resuscitate order because they thought the system would automatically prompt the Physician to write the order based on the response entered in the nursing admission assessment. Registered Nurse #2 stated the resident's paper chart had a Medical Orders for Life-Sustaining Treatment (MOLST) form that was completed in the hospital and indicated the resident wished to be a Do Not Resuscitate, however, Medical Orders for Life-Sustaining Treatment (MOLST) form was not uploaded onto the electronic medical record. Registered Nurse #2 reviewed the current Physician orders and stated there was no order for Do Not Resuscitate. A Physician's order dated 2/7/2025 at 4:24 PM documented Advance Directives: Do Not Intubate. A Physician's order dated 2/7/2025 at 4:25 PM documented Advance Directives: Do Not Resuscitate. During an interview on 2/8/2025 at 7:44 AM, Social Worker #1 stated they did not know why they documented a full code status for Resident #374 in the Social Work assessment on 1/25/2025. Social Worker #1 stated they could not remember if they spoke to the resident or the resident representative regarding the resident's Advance Directive wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2025 at 8:15 AM, the Administrator stated the software in the electronic medical record prompts the admission nurse to contact the Physician to get a Do Not Resuscitate order based on the resident's response entered. Registered Nurse #2 did not contact the Physician and did not obtain orders for Resident #374 for Do Not Resuscitate. It was Registered Nurse #2's responsibility. During an interview on 2/10/2025 at 9:22 AM, Social Work Director #1 stated when Social Worker #1 completed the admission assessment on 1/25/2025 the Medical Orders for Life-Sustaining Treatment (MOLST) form was not uploaded into the electronic medical record and there was no Physician's order for Do Not Resuscitate, therefore the Social Worker documented the resident's Advance Directive as full code. During an interview on 2/10/2025 at 10:03 AM, the Director of Nursing Services stated the resident's Medical Orders for Life-Sustaining Treatment (MOLST) form indicated the resident wished for Do Not Resuscitate as their Advance Directives; a physician's order should have been obtained and a Comprehensive Care Plan should have been in place for Do Not Resuscitate Advance Directive. The Physician who did the History and Physical on 1/24/2025 was unavailable for the interview. During an interview on 2/10/2025 at 1:25 PM, the Medical Director stated if a resident is admitted with a Medical Orders for Life-Sustaining Treatment (MOLST) form indicating an Advanced Directive of Do Not Resuscitate, the admitting nurse should ask the resident if they want to continue the same Advance Directives. If the resident says Yes, the nurse is supposed to call the Physician for an order for Do Not Resuscitate. In addition, the Physician should have also confirmed that there was an order in place. 10NYCRR 415.3(e)(1)(ii)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews during the Recertification Survey initiated on 2/6/2025 and completed on 2/12/2025, the facility did not ensure that at the time each resident was admitted , the facility had physician orders for the resident's immediate care. This was identified for one (Resident #427) of two residents reviewed for Urinary Catheter. Specifically, Resident #427 was readmitted to the facility on [DATE] and was utilizing an external urinary catheter at bedtime. The Physician's order was not obtained for the use of the external catheter until 2/11/2025. The finding is: Resident #427 was admitted with diagnoses that included a Right Femur Fracture, Osteoporosis, and Malnutrition. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The Minimum Data Set documented the resident was occasionally incontinent of urine and bowel and did not utilize an external catheter. A Comprehensive Care Plan titled Risk for Alteration in Bowel and Bladder Function dated 1/30/2025 documented the resident was continent of bladder and bowel. Interventions included but were not limited to the resident requiring maximum assistance of one person for toilet use. The resident preferred the use of an external catheter at bedtime. The external urinary catheter would be used at night when the resident is in bed and removed when the resident is out of bed. A review of Resident #427's current physician orders revealed there was no documented evidence that a physician's order was obtained for the use of an external urinary catheter until 2/11/2025. During an interview on 2/11/2025 at 11:45 AM, the Director of Nursing Service stated a physician's order should be obtained for residents who utilize an external catheter. The Director of Nursing Services stated the facility's policy was not clear regarding the roles of Certified Nursing Assistants and Licensed Nurses related to the use of the external urinary catheter. During an interview on 2/12/2025 at 10:44 AM, Registered Nurse #12, the unit manager, stated Resident #427 had been using an external catheter since they were admitted to the facility and a Physician's order should have been obtained by the admission nurse. Registered Nurse #12 stated they contacted Resident #427's attending physician on 2/11/2025 and obtained an order for the external catheter. During an interview on 2/12/2025 at 11:04 AM, Physician #1, the attending physician, stated nursing staff should have notified them and obtained an order for an external urinary catheter for Resident #427 upon admission. Physician #1 stated they were not aware Resident #427 requested the use of an external urinary catheter until 2/11/2025. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a re-interview on 2/12/2025 at 12:13 PM, the Director of Nursing Service stated Resident #427's physician should have been notified to obtain an order for the use of the external urinary catheter. The Director of Nursing Services stated they expected Certified Nursing Assistants to apply the external catheter and the Licensed Nurses were responsible for ensuring that correct suction settings were in place. The Director of Nursing Services stated that the current policy must be reviewed and revised to reflect the need to obtain a Physician's order and to clearly indicate the nursing staff's roles involving the care. 10 NYCRR 415.11

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews during the Recertification Survey initiated on 2/6/2025 and completed on 2/12/2025, the facility did not ensure the Minimum Data Set assessment was completed to accurately reflect each resident's status. This was identified for one (Resident #222) of two residents reviewed for hospitalization . Specifically, Resident #222's Discharge Minimum Data Set assessment dated [DATE] did not correctly reflect Resident #222's discharge location. The finding is: The facility's policy titled Minimum Data Set (MDS) Assessment last revised on 9/2024 documented that the Minimum Data Set is utilized by all disciplines responsible for the care of the resident. Each individual completing a portion of the assessment electronically signs and certifies the accuracy of that portion of the assessment. Resident #222 was admitted with diagnoses including Dysphagia and Hypertension. The Discharge Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had intact cognition. The Minimum Data Set assessment Section A documented the resident had a planned discharge and return was not anticipated. The discharge date was 11/22/2024 and the discharge status as short-term general hospital (acute hospital, Inpatient Prospective Payment System). The Interdisciplinary Team Discharge Patient Instructions dated 11/22/2024 documented that Resident #222 was discharged to home on 11/22/2024 at 11:00 AM. A nursing progress note dated 11/22/2024 documented that the resident left the facility to home with a family member. During an interview on 2/7/2025 at 2:35 PM, the Lead Minimum Data Set Specialist stated they were responsible for completing the Minimum Data Set assessment section related to discharge location and ensuring the information was accurate. The Lead Minimum Data Set Specialist stated Resident #222 was not discharged to the hospital on 11/22/2024 but went home with a Certified Home Health service in place. The Lead Minimum Data Set Specialist stated the current Minimum Data Set book did not accurately reflect the discharge location. The Discharge Minimum Data Set assessment should have documented the discharge location as home under care of organized home health service organization. During an interview on 2/11/2025 at 11:49 AM, the Director of Nursing Services stated all Minimum Data Set assessments should be completed accurately. The Discharge Minimum Data Set assessment dated [DATE] should have accurately reflected Resident #222's discharge location to home and not the hospital. 10 NYCRR 415.11(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** 49245 Based on observation, record review, and interviews during the Recertification initiated on 2/06/2025 and completed on 2/12/2025, the facility did not ensure that a comprehensive person-centered care plan was developed and implemented for each resident that includes measurable objectives and timeframes to meet medical and nursing needs. This was identified for one (Resident #130) of four residents reviewed for Skin Conditions. Specifically, Resident #130 had a Physician Order to apply Mupirocin (an antibiotic) ointment to the left large toe for an infection. There was no documented evidence that a care was developed to address Resident #130's left large toe infection. The finding is: The facility's policy titled, Resident Care Plan, last reviewed and revised on 2/2024 documented that the facility's interdisciplinary team uses a collaborative and coordinated approach to identify, integrate, and prioritize the resident's strengths, needs and personal and cultural preferences in the assessment, reassessment, and development of goals of care. The team formulates a comprehensive care plan specifying actions or interventions to meet/define care. The facility is accountable for ensuring that care plans are followed. Care plans must be individualized to ensure that residents achieve the highest practicable level of function. Resident #130 was admitted with diagnoses including Type 2 Diabetes Mellitus, Pulmonary Hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart), and Urinary Tract Infection. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #130 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #130 was at risk for developing pressure ulcers and used pressure-reducing devices for chair and bed, and application of dressing to feet. The nursing progress note dated 1/10/2025 documented a sample for culture was obtained from the abscess on the left big toenail, and was sent to the laboratory. A Physician's Order dated 1/13/2025 documented Mupirocin 2 percent topical ointment applied by topical route three times per day to the left first toe for an infection. Resident #130 was observed in their room on 2/6/2025 at 2:54 PM with a dressing on the left great toe and the second left toe. A review of Resident #130's medical record revealed that Resident #130 did not have any Comprehensive Care Plan (CCP) for the left toe infection or foot care. During an interview on 2/10/2025 at 8:45 AM, Registered Nurse #8, Unit Manager, stated Resident #130 had a wound on the left great toe with treatment in place. Registered Nurse #8 stated they did not know why Resident #130 had no care plan for the left great toe infection. Registered Nurse #8 stated that a care plan should have been developed when the order for Mupirocin ointment was obtained. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/11/2025 at 6:45 AM, Registered Nurse #5 stated the resident had an abscess on the left great toe and on 1/10/2025, they (Registered Nurse #5) obtained an order for the wound culture from the left great toe abscess. Registered Nurse #5 stated they did not initiate a care plan because the culture results were not available. During an interview on 2/11/2025 at 9:15 AM, Registered Nurse #6 stated on 1/13/2025 they received the order for Mupirocin 2 percent ointment to be applied to Resident #130's infected left great toe; however, they forgot to initiate a care plan. During an interview on 2/11/2025 at 1:00 PM, the Director of Nursing Services stated the Nurses should have started a care plan for Resident #130's left large toe infection. 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. 48827 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/06/2025 and completed on 2/12/2025, 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 #109) of one resident reviewed for Edema. Specifically, Resident #109, had a physician's order to use the ace wrap (elastic bandage) for both lower legs daily for Edema (swelling caused by fluid buildup in the tissues). The resident refused to use the physician-ordered ace wrap and utilized their own compression socks instead. The Comprehensive Care Plan was not updated to include the resident's refusal of the physician-ordered ace wrap and the use of the resident's personal compression socks. The finding is: The facility's policy titled Resident Care Plan, last reviewed 2/2024 documented that the appropriate interventions and goals are documented and reviewed to determine if the anticipated results for the resident are achieved. The facility is accountable for ensuring that care plans are being followed. The facility's policy titled Support (Compression) Stockings, last reviewed 2/2024 documented a physician's order is required before applying any Compression Stockings and the intervention should be documented on the resident's care plan. Resident #109 was admitted with diagnoses including Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Hypertension. The Minimum Data Set assessment documented a Brief Interview for Mental Status Assessment score of 14, indicating the resident was cognitively intact. A physician's order dated 1/29/2025 and renewed on 2/08/2025 documented to apply the Ace wraps to the bilateral legs on the day shift, and remove the ace wraps on the evening shift. A Comprehensive Care Plan titled Alteration in Cardiac System effective 1/17/2025 was not updated to include the use of the ace wrap as per the physician's orders. Additionally, the care plan was not updated to reflect the resident was using their own compression socks instead of the physician-ordered ace wraps. The Treatment Administration Record for January 2025 documented that ace wraps were applied as per the physician's order on 1/30/2025 and the resident refused the treatment on 1/31/2025. The Treatment Administration Record for February 2025 documented that Resident #109 refused the ace wraps every day from 2/01/2025 through 2/11/2025. The treatment was discontinued on 2/11/2025. During an interview on 2/11/2025 at 9:34 AM, Registered Nurse Manager #9 stated Resident #109's care plan was not updated to include the use of the ace wraps as per the physician's orders. The staff should have notified the physician if the resident refused the treatment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 2/11/2025 at 9:50 AM, Resident #109 was observed wearing compression socks on both legs. Resident #109 stated they use their own compression socks because their socks work better. The Certified Nursing assistants put the compression socks on each morning and remove them at bedtime. During a reinterview on 2/11/2025 at 9:53 AM, Registered Nurse Manager #9 stated the Certified Nursing Assistants should have told the nurses the resident uses their own compression socks and the physician orders and the care plan should have been updated. During an interview on 2/11/2025 at 1:51 PM, Registered Nurse #10 stated Resident #109 has been refusing the Ace wrap bandages. The resident told them they didn't like the ace wraps and would use their own compression socks. Registered Nurse #10 stated they notified the covering physician that the resident refused to use the ace wraps and preferred to use their own compression socks. The covering physician agreed that the resident could use their own compression socks. Registered Nurse #10 stated they did not document the communication with the physician and did not update the physician's orders. Registered Nurse #10 stated they should have revised the care plan to include use of the compression socks. During an interview on 2/12/2025 at 9:12 AM, the Director of Nursing Services stated the physician's orders and care plan should have been updated to reflect the resident's refusal and their use of the compression socks. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/06/2025 and completed on 2/12/2025, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (Resident #131) of three residents reviewed for Position and Mobility. Specifically, Resident #131 with a diagnosis of Diabetes Mellitus, utilized an Ankle Foot Orthosis (AFO) Brace (a brace that supports the foot) for their right dropped foot, without a Physician's order. The Ankle Foot Orthosis was brought from home by Resident #131. There was no documented evidence that a plan of care was developed for using the Ankle Foot Orthosis and that skin assessment was conducted according to the facility's policy related to the use of the Ankle Foot Orthosis. The finding is: The facility's policy titled Braces, reviewed in December 2022 documented that all braces require a physician's order. Hygiene inspections are done every shift. Inspection includes observing for redness, irritation, or swelling. The facility's policy titled Resident Care Plan reviewed in February 2024 documented to respect the rights of its patients and residents to participate in the development of their person-centered plan of care including, the right to receive services and/or items included in the plan of care. The care plan contains resident problems, needs, and strengths, with reasonable and measurable goals set. Resident #131 was admitted with diagnoses that include Type 2 Diabetes Mellitus and Spinal Stenosis. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident had intact cognition. There was no documentation on the Minimum Data Set for using a splint or brace. The Medical History and Physical report dated 1/23/2025 documented the resident has a history of foot drop. The Nursing Admission assessment dated [DATE] did not indicate the use of the Ankle Foot Orthosis (AFO) Brace or a history of a right foot drop. The Physical Therapy Evaluation and Plan of Treatment dated 1/24/2025 documented under the resident's history: the resident used a right Ankle Foot Orthosis (AFO) Brace. There was no documentation of an assessment and recommendations for continued use of the Ankle Foot Orthosis (AFO) Brace. There was also no documented evidence that the nursing staff was educated regarding the use the Ankle Foot Orthosis. The Occupational Therapy Evaluation and Plan of Treatment dated 1/24/2025 documented under the resident's history: the resident used a right Ankle Foot Orthosis (AFO) Brace. There was no documentation of the assessment and recommendations for continued use of the Ankle Foot Orthosis (AFO) Brace. There was also no documented evidence that the nursing staff was educated regarding the use the Ankle Foot Orthosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan titled Rehabilitation dated 1/24/2025 did not include the use of the Ankle Foot Orthosis (AFO) Brace. There was no physician's order for the use of the Ankle Foot Orthosis (AFO) Brace. During an observation and interview on 2/11/2025 at 8:51 AM, Resident #131 was sitting up in bed, fully dressed, and had the Ankle Foot Orthosis (AFO) Brace on that connected to the front of their sneaker. Resident #131 stated they bought three different Ankle Foot Orthosis (AFO) Brace themselves because they have a right foot drop. They put the Ankle Foot Orthosis (AFO) Brace on themselves each day. One of the braces is attached to their sneaker, another one is for when they are not wearing a shoe, and the third one they can wear and put their shoe over the brace. The community doctor told them if the Ankle Foot Orthosis (AFO) Brace works, they should continue to use the brace. Resident #131 stated they brought all three Ankle Foot Orthosis (AFO) Braces to the facility. They put on the Ankle Foot Orthosis (AFO) Brace daily and in the morning and take it off when they get ready for bed. During an interview on 2/11/2025 at 8:53 AM, Registered Nurse Manager #11 stated they were aware Resident #131 used the Ankle Foot Orthosis (AFO) Brace on their right foot that they brought from home. There should have been a physician's order and a Care Plan for the use of the Ankle Foot Orthosis (AFO) Brace. There should be specific instructions for the Ankle Foot Orthosis (AFO) Brace use and to monitor the skin as well. Registered Nurse Manager #11 stated the residents are allowed to use a brace brought from home; however, the resident should have been assessed to ensure they knew how to put the brace on and off correctly. During an interview on 2/11/2025 at 9:23 AM, Occupational Therapist #1 stated they were aware Resident #131 wears the Ankle Foot Orthosis (AFO) Brace and there should be an order and a care plan in place for the use of the Ankle Foot Orthosis (AFO) Brace. Occupational Therapist #1 stated they documented the use of the Ankle Foot Orthosis (AFO) Brace in their notes; however, they did not assess the use of the Ankle Foot Orthosis (AFO) Brace or educate the nursing staff regarding the brace use. During an interview on 02/11/2025 at 9:26 AM, Physical Therapist #1 stated they were aware Resident #131 wears the Ankle Foot Orthosis (AFO) Brace and there should be an order and a care plan in place for the use of the Ankle Foot Orthosis (AFO) Brace. Physical Therapist #1 stated they documented the use of the Ankle Foot Orthosis (AFO) Brace in their notes; however, they did not assess the use of the Ankle Foot Orthosis (AFO) Brace or educate the nursing staff regarding using the brace correctly. During an interview on 2/11/2025 at 9:16 AM, the Director of Nursing Services stated there should be an physician's order and a care plan for the use of the Ankle Foot Orthosis (AFO) Brace. The nursing staff should monitor for the skin integrity under the brace, and document each shift. The resident should have been assessed to ensure they were correctly using the Ankle Foot Orthosis (AFO) Brace. 10 NYCRR 415.12

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	335702	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwell Health Stern Family Center for Rehab	300 Community Drive Manhasset, NY 11030

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34798 Based on observation, interviews, and record review during the Recertification Survey initiated on 2/6/2025 and completed on 2/12/2025, the facility did not ensure that each licensed nurse had the specific competencies, and skill sets necessary to care for residents' needs and to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for one (Resident #375) of five residents observed during Medication Administration. Specifically, on 2/7/2025 during the breakfast meal, Registered Nurse #1 handed the resident a souffle cup of oral medication tablets and left the room before the resident consumed the medications. Registered Nurse #1 then returned to the resident's room interrupted the resident's meal and administered a Lovenox (blood thinner) injection into the resident's abdomen. The finding is: The facility's policy titled Medication Administration, dated 2/2024, documented under the heading: Medication Administration During Meal-nurse may bring the medication cart to the dining room and administer medications, which must be given with food. Under no circumstances are drops/ointments of any kind or injections to be given during meals. Resident #375 was admitted with diagnoses including Fracture of the Left Pubic Ramus (pelvis fracture), Sacral fracture (the triangular bone at the base of the spine), and Hypertension. The Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. During the medication pass observation for Resident #375 on 2/7/2025 at 8:22 AM, Registered Nurse #1 prepared the following medications outside the resident's room: Famotidine 20 milligram oral tablet for Gastroesophageal Reflux Disease (GERD); Acetaminophen 325 milligrams oral tablet (two tablets) for pain; Lisinopril 20 milligrams oral tablet (for blood pressure); Vitamin D3-25 microgram oral tablet (for a supplement). Enoxaparin (Lovenox) 40 milligram/0.4 milliliter subcutaneous (tissue layer between the skin and the muscle) injection (for blood clot prevention). There was no documentation in the physician's orders that these medications should be administered with food. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #1 entered Resident #375's room. The resident was in bed and the overbed table was in place over the resident's midsection with the resident's breakfast tray on top of the table with the food dome removed and other food items opened. The nurse handed the souffle cup to the resident, and before the resident completed taking the oral tablets, the nurse left the room to get an alcohol pad for the injection to be given. The nurse returned to the room with an alcohol pad after the resident consumed the oral medications. Registered Nurse #1 then administered the Lovenox injection into the resident's abdomen. During an interview on 2/7/2025 at 8:30 AM, Registered Nurse #1 stated the resident did not request to get their medications during breakfast. Registered Nurse #1 stated they should not have left the room before the resident had completed taking the oral medications, and they were not aware of a facility policy about not administering medications or injections during meals. During an interview on 2/10/2025 at 9:12 AM, Nurse Educator #1 stated Registered Nurse #1 should not have left the room while the resident was taking the medications. The nurses should wait for the resident to complete the meal and should not administer injections during a meal. During an interview on 2/10/2025 at 9:59 AM, the Director of Nursing Services stated Registered Nurse #1 should have waited and let the resident take the medications before leaving the room to get the alcohol pad. Registered Nurse #1 should have waited until the breakfast meal was completed to administer the medications, and certainly should not have given an injection if the resident was having breakfast. 10 NYCRR 415.26(c)(1)(iv)

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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** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/6/2025 and completed on 2/12/2025, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for two (Resident #525 and Resident #32) of three residents reviewed for Transmission Based Precautions. Specifically, Resident #525 was positive for COVID-19 (a contagious disease caused by the Coronavirus) infection and had a Physician's Order for Contact/Isolation Precautions; however, the signage posted outside Resident #525's door indicated Enhanced Barrier Precautions (EBP). Resident #32 was positive for COVID-19 infection and had a Physician's Order for Contact/Isolation Precaution; however, the signage posted outside Resident #32's door did not direct staff to use eye protection as specified in the facility's policy as part of the appropriate Personal Protective Equipment to be used for positive COVID-19 infection. The finding is: The facility's policy titled Coronavirus 2019 (COVID-19) Management Guideline last revised on 7/23/2024 documented that the healthcare provider who enters the room of a resident with suspected or confirmed positive COVID-19 infection should adhere to standard precautions and use a NIOSH (National Institute for Occupational Safety and Health) approved particulate respirator with N95 (a Non-oil particulate for use in the work environment with 95 percent efficiency) mask, a gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Resident #525 was admitted with diagnoses of COVID-19 infection, Pneumonia, and Hypertension. The Minimum Data Set assessment was not yet completed for Resident #525 as the resident was recently admitted to the facility. The Nursing Admission assessment dated [DATE] documented that Resident #525 was alert, and oriented to person, place, and time. A Comprehensive Care Plan (CCP) titled, Isolation COVID-19, Droplet and Contact Precaution, dated 2/3/2025 documented interventions that included Contact Droplet Precautions, private room/signage outside the room, and strict handwashing for staff and residents. A physician's order dated 2/3/2025 documented Precautions: Isolation-Standard Droplet and Contact. A physician's order dated 2/3/2025 documented Robafen (cough medication)100 milligrams per 5 milliliters oral liquid, give 5 milliliters by oral route every 6 hours as needed for cough. During an observation on 2/6/2025 at 10:13 AM, a precaution sign outside Resident #525's door indicated the resident was on Enhanced Barrier Precautions (EBP). The sign read: everyone must clean their hands, including before entering and when leaving the room. The sign instructed to use gloves and gown for high-contact resident care activities including dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting. An additional sign was posted outside Resident #525's room that indicated the use of an N95 mask instructing the team members that it is clinically necessary to enter a COVID-19 isolation room with an N95 mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 was admitted with diagnoses of Osteomyelitis (bone infection) of the vertebrae, Atrial Fibrillation, and COVID-19 infection. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #32 had intact cognition. A Comprehensive Care Plan (CCP) dated 2/4/2025 titled Isolation Care Plan documented interventions that included Contact/Droplet Precautions, private room/signage outside the door, and strict handwashing for staff and residents. A physician's order dated 2/4/2025 documented Standard Droplet and Contact Precautions. A physician's order dated 2/4/2025 documented Mucinex (medication that loosens mucus and clears congestion) 600 milligrams tablet, extended-release one tablet twice daily for 14 days. During an observation on 2/6/2025 at 10:13 AM, a precautions sign outside Resident #32's room indicated Contact/Droplet Precautions: everyone must perform hand hygiene before and after entering Resident #32's room. The sign also instructed to use Personal Protective Equipment (PPE) including wearing a gown and gloves before entering Resident #32's room. The signage did not include the use of eye protection (goggles or face shield) before entering Resident #32's room. An additional sign was posted outside Resident #525's room that indicated the use of an N95 mask instructing the team members that it is clinically necessary to enter a COVID-19 isolation room with an N95 mask. During an interview on 2/6/2024 at 10:15 AM, the Unit Secretary stated that they are responsible for putting the isolation precaution signage at the door for any isolation precaution room after they get instructions from the Nurses to place the signage. The Unit Secretary stated that the wrong precaution signage was placed on Resident #525's door because the signage for Enhanced Barrier Precautions (EBP) and Contact/Droplet Precautions are the same color and it was an oversight. During an interview on 2/6/2025 at 11:45 AM, the Infection Preventionist stated staff must wear gowns, gloves, surgical masks, an N95 mask, and eye protection when entering resident rooms with positive COVID-19 infection, and residents placed on Contact/Droplet precautions for other infections. The Infection Preventionist stated they did not know that the wrong signage was posted outside Resident #525's door. The Infection Preventionist stated that the signage on Resident #32's door did not indicate the use of eye shield protection and should have. During an interview on 2/7/2025 at 10:20 AM, the Medical Director stated that eye protection was a requirement as part of the Personal Protective Equipment (PPE) for all staff entering a positive COVID-19 resident's room. The Medical Director stated that Resident #32's signage should have included the use of eye protection. The Medical Director stated that Droplet Precaution is used for residents who tested positive for Influenza (Flu) and in those cases eye protection is not necessarily required unless the resident is coughing or producing copious (a large quantity) amounts of secretion, then staff should wear eye protection when providing care. During a subsequent interview on 2/7/2025 at 10:22 AM, the Infection Preventionist stated the Droplet Precaution signage was meant to be used for residents with positive Influenza (Flu), and in that case, eye protection was not required unless the resident exhibited symptoms of Flu such as coughing. The Infection Preventionist stated that staff must wear eye protection when entering a resident's room who was positive for COVID-19 infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/2025 at 10:20 AM, the Director of Nursing Services stated all positive COVID-19 residents should have the Contact/Droplet precautions signage posted outside the door. The Director of Nursing Services stated that Resident#525 should have had a Contact/Droplet precaution signage instead of the Enhanced Barrier Precaution signage because of a positive COVID-19 infection. The Director of Nursing Services stated the precautions signage for Resident #32 should have included the use of eye protection as Resident #32 had confirmed positive COVID-19 infection. 10 NYCRR 415.19(a) (1-3)