STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335763	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Vincent Depaul Residence	900 Intervale Avenue Bronx, NY 10459

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00358734), the facility did not ensure the resident was immediately informed, consult with the resident's physician, and notify, consistent with their authority, the resident representative when there was need to alter treatment significantly. This was evident in 1 of 3 residents sampled (Resident #1). Specifically, on 08/07/2024, the Medical Doctor #1 ordered a urine test to rule out Urinary Tract Infection. On 08/11/2024, the positive urine test results were reported to the facility and the Medical Doctor was not informed. On 09/04/2024 at 1:55 PM, the Medical Doctor #2 reviewed the laboratory results and ordered antibiotic treatment for Urinary Tract Infection on 09/05/2024. Resident #1 's family was not notified about the positive urinary results on 08/11/2024 and on 09/05/2024, the family was not notified that antibiotic treatment was ordered,. The findings include: The facility Policy and Procedure entitled Notification of Changes Protocol, Policy, and Procedure, last reviewed/revised on 02/01/2022, documented it is the policy of the facility that changes in the resident's condition or treatment are immediately shared with the resident and/or the resident representative, and reported to the attending physician or delegate. The resident and /or resident representative will be educated about the treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Resident #1 was admitted to the facility on [DATE], with diagnoses that include Type 2 Diabetes Mellitus, Dementia, and Anxiety. The Minimum Data Set (a resident assessment tool) dated 10/21/2024, documented Resident #1 as severely cognitive impaired. A Medical Doctor's note dated 08/07/2024 at 5:12 PM, written by Medical Doctor #1 documented that a urinalysis (urine test) to rule out Urinary Tract Infection was ordered. A Physician Order dated 08/07/2024 at 5:14 PM, documented a Urine routine, Culture, and Sensitivity lab draw for Urinary Tract Infection. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The laboratory results dated [DATE], documented that urine was collected on 08/08/2024, and the result showed Escherichia coli greater than 100.000 Colony-Forming Unit/Milliliter Escherichia coli. Specimen was collected on 08/08/2024, reported on 08/11/2024 and Medical Doctor #2 reviewed on 09/04/2024 at 1:55 PM. A review of the nursing progress notes from 08/08/2024 to 9/05/2024, reveals no documented evidence that nursing staff notified the Medical Doctor about urinary laboratory results dated [DATE]. There was no documented evidence that Resident #1's representative was notified about urinary laboratory test results dated 08/11/2024. A Medical Doctor's note dated 09/05/2024 at 3:53 PM, written by Medical Doctor #2 documented Resident #1 was seen due to a Urinary Tract Infection. Urinalysis on 08/08/2024 showed greater than 100.000 Colony-Forming Unit/Milliliter Escherichia coli, sensitive to Nitrofurantoin. The order was placed for Macrobid 100 mg, one tab twice daily for seven days. A Physician Order dated 09/05/2024 documented Nitrofurantoin Monohyd/M -Cyst (Macrobid) 100 miligrams give 100 milligrams twice daily for Urinary Tract Infection. There was no documented evidence that the Medical Doctor notified Resident #1's representative that the Resident #1 was diagnosed with a Urinary Tract Infection and antibiotic treatment had been ordered on 09/05/2024. During an interview on 11/20/2024 at 11:00 AM, the Complainant stated they were told in August a urine test will be ordered to check for Urinary Tract Infection. The Complainant stated the facility did not notify them about the result of the urine test. The Complainant stated they don't know if the urine test was ordered. During a telephone interview on 11/24/2024 at 1:50 PM, Registered Nurse #1, who worked on 08/11/2024 during the 7:00 AM-3:00 PM shift, stated the Unit Manager was responsible for following up with labs and calling the Medical Doctor and the family and taking the orders if any. Registered Nurse #1 stated they were not aware of Resident #1's laboratory results that came on 08/11/2024. During an interview on 11/20/2024 at 2:10 PM, Registered Nurse Unit Manager #3, stated when there are abnormal laboratory test results the medical doctor should be notified immediately by the Registered Nurse or Registered Nurse Manager. Unit Manager #3 stated that when the medical doctor ordered new treatment, the charge nurse or nurse manager was supposed to notify the resident's representative. Unit Manager #3 stated that the Medical Doctor would be the best option to notify the resident's representative, but most of the time, they endorse nurses to inform the family. During an interview on 11/21/2024 at 11:41 AM, Medical Doctor #2 stated Resident #1's representative should have been called about abnormal results and ordered antibiotic treatment. Medical Doctor #2 stated that Medical Doctor #1, who was covering for them in August, did not feel it necessary to address the laboratory test dated 08/11/2024 because the resident was asymptomatic. Medical Doctor #2 stated that they were supposed to inform Resident #1's representative when they reviewed the laboratory result and ordered antibiotic treatment for Urinary Tract Infection on 09/05/2024, but they don't remember if they called, and they did not document it in the resident medical record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 10:57 AM, The Director of Nursing stated Medical Doctor #1 was covering on 08/07/2024 and saw Resident #1 for an episode of unresponsiveness on 08/06/2024. The Director of Nursing stated the resident's adult child knew about the episode on 08/06/2024 and that laboratory tests were ordered. The Director of Nursing stated it was not documented that the resident's child was notified that a urine test was ordered. The Director of Nursing stated that charge nurses or medical doctors are supposed to call the family about abnormal laboratory test results and treatment or care plans and document it in the resident medical records. The Director of Nursing stated it was not done after the laboratory reported that the urine test was abnormal on 08/11/2024. The Director of Nursing stated on 09/05/2024, the primary Medical Doctor #2 reviewed the laboratory results of a urine test and started antibiotic treatment because the family insisted, but Medical Doctor #2 did not document the progress note that the family insisted on. The Director of Nursing stated Resident #1' s Representative should have been notified about abnormal urine results on 08/11/2024 and that treatment of antibiotics that was ordered on 09/05/2024. 10 NYCRR 415.3(e) (2) (ii) (b)

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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 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** 39365 Based on record review and interviews conducted during an abbreviated survey (NY00358734), the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan. This was evident in 1 out of 3 residents sampled (Resident #1). Specifically, on 08/07/2024, the Medical Doctor #1 ordered a urine test to rule out Urinary Tract Infection. On 08/11/2024, a positive urine test results were reported to the facility for Escherichia coli (greater than 100.000 Colony-Forming Unit/Milliliter Escherichia coli). On 09/04/2024 at 1:55 PM, Medical Doctor #2 reviewed the urine test results, and ordered antibiotic treatment for Urinary Tract Infection which started on 09/05/2024, this resulted in 26 days delayed in treatment for Urinary Tract Infection. The findings are: The facility's Policy and Procedure entitled Urinary Tract Infection, effective date 03/27/2007, documented the purpose of the policy is to establish clear guidelines and procedures for the prevention, identification, and management of Urinary Tract infections among residents. This document also revealed the physician would order appropriate treatment for verified or suspected Urinary Tract Infections and/or urosepsis based on a pertinent assessment. Resident #1 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus, Dementia, and Anxiety. The Minimum Data Set (a resident assessment tool) dated 10/21/2024, documented Resident #1 as severely cognitive impaired. A Medical Doctor's note dated 08/07/2024 at 5:12 PM, written by Medical Doctor #1 documented that a urinalysis (urine test) to rule out Urinary Tract Infection was ordered. A Physician Order dated 08/07/2024 at 5:14 PM documented a Urine routine, Culture, and Sensitivity lab draw for Urinary Tract Infection. A laboratory results dated [DATE], documented that urine was collected on 08/08/2024, and the result showed Escherichia coli greater than 100.000 Colony-Forming Unit/Milliliter Escherichia coli. The urine specimen was collected on 08/08/2024, reported to the facility on [DATE] and Medical Doctor #2 reviewed the results on 09/04/2024 at 1:55 PM. A review of the nursing progress notes from 08/08/2024 to 9/04/2024 reveals no documented evidence that nursing staff followed up with urine test results. There was no documented evidence that the Medical Doctor evaluated Resident #1 after the laboratory sent urine test results on 08/11/2024. A Physician Order dated 09/05/2024, documented Macrobid (antibiotic) 100 milligram give twice daily for Urinary Tract Infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medical Doctor's note dated 09/05/2024 at 3:53 PM, written by Medical Doctor #2 documented Resident #1 was seen due to a Urinary Tract Infection. Urinalysis on 08/08/2024 showed greater than 100.000 Colony-Forming Unit/Milliliter Escherichia coli, sensitive to Nitrofurantoin. The order was placed for Macrobid 100 milligram, one tab twice daily for seven days. A Care Plan for Antibiotic Treatment dated 09/06/2024, related to Urinary Tract Infection as evidenced by Escherichia coli, resolved on 11/05/2024. Interventions included monitoring vital signs and administering antibiotic therapy as ordered. During an interview on 11/20/2024 at 11:00 AM, the Complainant stated they were told in August a urine test to check for Urinary Tract Infection will be done. The Complainant stated the facility did not notify them about the result of the urine test. The Complainant stated they don't know if the urine test was ordered. During a telephone interview on 11/24/2024 at 1:50 PM, Registered Nurse #1, who worked on 08/11/2024, stated the Unit Manager was responsible for following up with labs and calling the Medical Doctor and family and taking the orders if any. Registered Nurse #1 stated they were not aware of Resident #1's urine test results that came on 08/11/2024. During an interview on 11/21/2024 at 10:16 AM, Registered Nurse Unit Manager #1 stated when laboratory results were ready, the laboratory would send results to the computerized resident Electronic Medical Record, and the charge nurse was supposed to check and follow up with the result and notify the Medical Doctor immediately. The Registered Nurse Manager #1 also stated sometimes, the laboratory would call if the result were positive or critical. The Registered Nurse Manager #1 stated they were not aware of the urinalysis result on 08/11/2024. During a telephone interview on 12/10/2024 at 11:46 PM, Registered Nurse Unit Manager #2, who worked on the 08/11/2024, stated the laboratory would normally call them if there were abnormal labs. Registered Nurse Unit Manager #2 stated they did not receive a call from the laboratory and did not look at the computer. Registered Nurse Unit Manager #2 stated that both Registered Charge Nurses and Registered Nurse Unit Managers are responsible for checking the computer to see if there are results and to following up. Registered Nurse Unit Manager #2 stated they were supposed to check the labs on the computer, call the Medical Doctor, and notify the family about the laboratory results and what the Medical Doctor ordered. Registered Nurse Unit Manager #2 stated they and all nurses were in-serviced to follow-up with the labs. During an interview on 11/21/2024 at 11:41 AM, Medical Doctor #2 stated on 08/07/2024, Medical Doctor #1 was covering and evaluated Resident #1 for an episode of unresponsiveness on 08/06/2024. Medical Doctor #2 stated that Medical Doctor #1 ordered intravenous fluids, blood work, and a urinary analysis to rule out urinary tract infections. Medical Doctor #2 stated they were on vacation from 08/07/2024 to 08/23/2024 and saw laboratory results on 09/05/2024 were not addressed. Medical Doctor #2 stated they reviewed the laboratory results, and it qualified for antibiotic treatment. Medical Doctor #2 stated that the facility procedure is if the Medical Doctor orders the labs when the result comes, the nurses on the floor should notify the doctor of the result, and the doctor will give the appropriate order. Medical Doctor #2 stated it was not done until 09/05/2024. Medical Doctor #2 stated that they rely on the nurses to call with the results of the laboratory results for a fast response. Medical Doctor #2 stated that every Medical Doctor could check laboratory results on the computer, but the results are not always immediately posted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 10:57 AM, the Director of Nursing stated that when the laboratory results are ready, the medical doctors can see them online right away. The Director of Nursing stated that the charge nurse or manager on duty can also receive the result, call the doctor, and anticipate orders, if any. The Director of Nursing stated they didn't know why the charge nurse did not call the doctor about the result of positive Urine Tract Infection urine laboratory results on 08/11/2023. The Director of Nursing stated Medical Doctor #1 was covering on 08/07/2204 and saw Resident #1 for an episode of unresponsiveness on 08/06/2024. The Director of Nursing stated the laboratory results should be reviewed by Medical Doctor #1 as soon as possible. On 09/05/2024, primary Medical Doctor #2 reviewed laboratory results and started antibiotic treatment because the family insisted, but Medical Doctor #2 did not document the progress note that the family insisted on. 10 NYCRR 415.12