STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335770	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N Y S Veterans Home IN N Y C	178 50 Linden Blvd Jamaica, NY 11434

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on observations, record reviews, and interviews, conducted during the Recertification survey from 05/09//2024 to 05/16/2024, the facility did not ensure that a resident received care consistent with professional standards of practice to prevent infection and promote healing. This was evident for 1 (Resident #139) reviewed for Pressure Ulcer Injury out of 38 sampled residents. Specifically, during wound care observation, Resident #139 did not receive the physician ordered pressure ulcer treatment. The findings are: The facility policy titled Pressure Ulcer Injury and Wound Prevention dated 4/2022 documented that the residents of the facility will have a pressure injury prevention and intervention program to identify risk factors, prevent pressure ulcer formation, when possible, and promote skin integrity, as well as implement interventions to heal existing pressure ulcer injury, prevent infection, and prevent new ulcer/ injuries from developing. Resident #139 had diagnoses of unhealed pressure ulcers and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #139 was severely cognitively impaired and at risk of developing pressure ulcers. A Physician's Order initiated 04/27/24 documented cleanse Resident #139's left and right great toes with Normal saline, pat dry, paint with Betadine 10% solution, and cover with non-woven gauze and secure with tape On 05/14/24 at 11:40 AM, Registered Nurse #8 was observed performing wound treatment for Resident #139 on Deep Tissue Pressure Ulcer injuries to both heels. NS, Betadine, Dry Gauze, foam and Keflex dressings were applied to the left and right heels. Registered Nurse #8 did not perform the physician ordered treatment to the left and right great toes. On 05/15/24 at 10:44 AM, Registered Nurse #8 was interviewed and, after reviewing the Physician's Order for Resident #139, stated that they forgot to perform the treatment ordered for the left and right great toes. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/24 at 10:11 AM The Director of Nursing was interviewed and stated they spoke with Registered Nurse #8 regarding not following physician wound treatment orders for Resident #139 and informed them that they should have reviewed the orders prior to performing the treatment. 10 NYCRR 415.12 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observations, record review, and interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure food was stored, prepared and served in accordance with professional standards for food service safety to prevent foodborne illness. This was evident during kitchen observation. Specifically, milk was stored above 41 degrees Fahrenheit and expired food was observed in the dry storage room in the kitchen. The findings are: The facility policy titled Food Service Sanitation Guidelines dated ,d+[DATE] documented if potentially hazardous food exceeded 41 degrees Fahrenheit for more than 2 hours, discard the food. On [DATE] at 09:50 AM, the kitchen was observed with the Dining Services Director. Refrigerator #3 was observed with milk and eggs on the shelf and the refrigerator thermometer read 51 degrees Fahrenheit. The dry storage room was observed with 6 5-pound bags of instant mashed potatoes with a expiration date of [DATE]. During an interview on [DATE] at 12:58 PM, Food Service Worker #1 stated they forgot to label the instant mashed potatoes with an expiration date. It is very important to put date and they forgot. 10 NYCRR 415.14 (h)

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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. 42101 Based on observations, record review, and interviews conducted during the Recertification Survey from 05/09/2024 to 05/16/2024, the facility did not ensure infection control practices were maintained. This was evident for 2 (Pine Unit and Maple Unit) of 6 floors. Specifically, 1) Certified Nursing Assistant #6 did not perform hand hygiene and did not sanitize the blood pressure cuff in between each resident use and 2) Certified Nursing Assistant #7 did not sanitize the blood pressure cuff in between resident use. The findings are: 1) On 05/09/2024 at 11:26 AM and 11:36 AM, Certified Nursing Assistant #6 was observed rolling the blood pressure machine to Resident #90 in the Pine Unit floor dayroom. Certified Nursing Assistant #6 did not perform hand hygiene and did not sanitize the blood pressure cuff before applying the cuff to Resident #90's right arm. After obtaining Resident #90's blood pressure reading, Certified Nursing Assistant #6 removed the cuff, did not perform hand hygiene, did not sanitize the cuff, and applied the blood pressure cuff to Resident #49's left arm. After obtaining Resident #49's blood pressure reading,Certified Nursing Assistant #6 did not perform hand hygiene, did not sanitize the blood pressure cuff, and proceeded to place the cuff on Resident #94's left arm. During an interview on 05/09/2024 at 2:38 PM, Certified Nursing Assistant #6 stated they were supposed to sanitize their hands and blood pressure cuff in between each resident use in accordance with infection control standards. During an interview on 05/09/2024 at 02:46 PM, Licensed Practical Nurse #3 was stated they reminded the Certified Nursing Assistants to sanitize the blood pressure cuff in between each resident use. Sanitizer wipes were available on the unit. 2) On 05/13/2024 at 04:23 PM, Certified Nursing Assistant #7 was observed rolling the blood pressure machine into Resident #139's room on the Maple Unit. Certified Nursing Assistant #7 did not perform hand hygiene, placed the blood pressure cuff on Resident #139's arm, obtained a blood pressure reading, removed the cuff, and rolled the blood pressure machine into Resident #164's room. Certified Nursing Assistant #7 did not sanitize the blood pressure cuff, did not perform hand hygiene, and placed the cuff on Resident #164's right arm to obtain a blood pressure reading. On 05/13/2024 at 04:39 PM, Certified Nursing Assistant #7 was interviewed and stated equipment shared between residents should be sanitized in between each resident use to promote infection control. Certified Nursing Assistant #7 stated they forgot to sanitize the blood pressure cuff in between use with Resident #139 and #164. On 05/13/2024 at 04:52 PM, Registered Nurse #2 was interviewed and stated they perform rounds every shift to observe staff interaction with residents. Equipment should be sanitized before and after resident use. (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 05/15/2024 at 10:01 AM, the Infection Control Preventionist they monitor that staff by arriving on the unit and watching the staff as they provide care. The Registered Nurse supervisor also monitors staff to ensure they are following infection control protocols. 10 NYCRR 415.19(b)(4)