Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335784	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schervier Pavilion	22 Van Duzer Place Warwick, NY 10990

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 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** 47626 Based on observation, record review, and interview during the recertification survey conducted 10/22/24 to 10/29/24, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs for 2 of 5 residents (Residents #14 and #52) reviewed for unnecessary medication and 1 of 1 resident (resident #44) reviewed for Respiratory therapy. Specifically, 1) Resident #14 did not have a care plan in place for anticoagulant and diuretic use. 2) Resident #52 did not have a plan of care in place for long term antibiotic use. 3) Resident #44 did not have a care plan in place for respiratory care and the use of oxygen. Findings include: The facility policy, Comprehensive Person-Centered Care Planning Process dated 1/26/2017, documented the facility would develops and maintain a person-centered comprehensive care plan for each resident. 1) Resident #14 had diagnoses including cerebral infarction, hemiplegia, and heart failure. A review of the Significant Change Minimum Data Set (an assessment tool) dated 8/16/24 documented the resident had moderately impaired cognition and was dependent with activities of daily living. The assessment documented the resident received anticoagulants and diuretics. A review of the current physician orders documented, Eliquis 2.5 milligrams 1 tab 2 times a day dated 7/16/24, and Lasix 20 milligrams 1 tab in the evening dated 7/30/24. A review of the medical record noted no care plan for the use of diuretic or anticoagulants. During an interview on 10/29/24 11:16 AM, the Quality Assurance Performance Improvement Coordinator stated the nurse managers were responsible for creating the comprehensive care plan. The resident did not have a care plan related the use of a diuretic or the use of an anticoagulant. These care plans should have been created. 2) Resident #52 had diagnoses including heart failure, psychosis, and osteoarthritis (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 Quarterly Minimum Data Set (an assessment tool) dated 10/3/2024 documented the resident's cognition was intact. The resident required supervision with eating, and partial to moderate assistance with all other activities of daily living. The assessment documented the use of antibiotics. Physician orders dated 1/24/24 documented Amoxicillin 500 milligrams 2 times a day for bacteremia/endocarditis indefinite. A Physician note dated 7/27/24 documented continued long-term use of amoxicillin for infective endocarditis per infectious disease doctor. A review of the resident's medical record revealed no care plan for antibiotic use. During an interview on 10/29/24 11:16 AM, the Quality Assurance Performance Improvement Coordinator, stated the nurse managers were responsible for creating comprehensive care plan. Resident #52 did not have a care plan created for antibiotic use and should have. During an interview on 10/29/24 at 10:25 AM, the Registered Nurse Manager stated they were responsible for ensuring that care plans were developed for residents receiving medication such as antibiotics, diuretics, and anticoagulants. They stated It was important to create a care plan with interventions, so everyone knew what to monitoring for. 50766 3) Resident #44 had diagnoses including metabolic encephalopathy, heart failure, and chronic atrial fibrillation. The Significant change Minimum Data Set, dated dated dated [DATE] documented Resident #44 had intact cognition and was on intermittent oxygen therapy. The physician's order dated 09/17/24 documented oxygen 2 liters via nasal cannula as needed. The physician's order dated 10/16/24 documented palliative care - oxygen administration for comfort. A comprehensive care plan related to oxygen administration and care was not observed in Resident #44's electronic medical record. During an interview on 10/28/24 at 12:46 PM with the Director of Nursing, they stated that an oxygen care plan for Resident #44 was not in place and nursing staff were responsible for adding care plan. 10 NYCRR 415.11(c)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observations, record review and interviews conducted during the Recertification survey from 10/22/2024 through 10/29/2024, the facility did not ensure 2 of 4 residents (Residents #3 and #39) reviewed for pressure ulcers, received care and services to promote healing. Specifically, 1) Resident #3 had a facility acquired Stage 2 pressure ulcer, and 2) Resident #39's pressure ulcer was not consistently and adequately assessed with clear description of size, location, and characteristics. Findings include: Policy and Procedure titled Prevention of Pressure Ulcer dated 9/2017 documented the purpose to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. 1) Resident #3 had diagnoses including Muscular Dystrophy, Type 2 Diabetes, and Chronic Obstructive Pulmonary Disease. A review of the Quarterly Minimum Data Set (an assessment tool) dated 8/26/24 documented the resident's cognition was intact. The resident required supervision for eating and was dependent on staff for all other activities of daily living; and had a Stage 2 pressure ulcer that was not present on admission. A review of the facility Matrix, received on 10/22/24, documented Resident #3 had a new Pressure Ulcer that was not present on admission. A review of the Care Plan dated 6/6/20 titled risk for developing pressure ulcer and was updated 10/24/24 (during survey) documented a history of healed and open areas. A review of the physician orders dated 08/22/24 documented Calcium Alginate right gluteal fold every evening. A review of the medical note dated 9/22/24 documented Right Gluteal wound 0.2 x 0.3 centimeters. Weekly skin assessments dated 8/24/24, 8/31/24, 9/7/24, 9/21/24, 9/27/24, 10/5/24, 10/15/24 and 10/15/24 documented the resident had no new skin condition, prior area treated per physician order. Documentation did not include location and staging, size measurements, exudate, pain and wound bed completed at least weekly. A review of the facility wound tracking record dated 9/10/24 documented Resident #3 with a wound on the right gluteus with onset of 8/23/24 , a recurring pressure ulcer measurement of 0.3 x 0.4 centimeter, no exudate. Treatment: calcium alginate-silver external pad. Interventions documented as Air Mattress, offload buttocks, Vitamin C 500 mg daily, Zinc daily, Vitamin B 12 Intramuscularly monthly, vitamin D3 daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility wound tracking record dated 10/4/24 documented Resident #3 with a wound on the right gluteal with onset of 8/23/24, a recurring 0.2 x 0.3 centimeter. Treatment: calcium alginate-silver external pad. Interventions documented as Air Mattress, off load buttock, vitamin supplements. A facility wound tracking record dated 10/8/24 did not include Resident #3. No wound tracking records were provided for the weeks of 9/17/24, 9/24/24 or 10/1/24, 10/11/24, 10/18/24, or 10/25/24. During an interview and observation on 10/23/24 at 09:41 AM, Resident #3 was in bed on an air mattress and positioned on their back. They stated they had a wound on their buttock. During an interview with Registered Nurse Staff #3 on 10/25/24 at 09:22 AM stated, the resident has a small Stage 2 ulcer on the buttock and required dressing changes. During an interview on 10/25/24 at 09:45 AM, Certified Nurse Aide #2 stated the resident had a Stage 2 pressure ulcer on their bottom. During an observation on 10/25/24 at 10:39 AM the resident was positioned on their left side, the dressing of Calcium alginate-silver external pad was changed to the right ischium and a Stage 2 pressure ulcer was observed. During an interview on 10/28/24 12:25 PM Registered Nurse Manager #11 stated the resident's pressure ulcer had opened and closed multiple times and was tracked on weekly. Upon reviewing the resident's medical record, they stated they did not have documentation of the resident's pressure ulcer. During an interview on 10/28/24 at 2:30 PM, the Director of Nursing stated the Nurse Educator was responsible for the weekly wound rounds and documenting on the wound tracking sheet. The Director of Nursing stated they were aware they were behind on the documentation and was planning on speaking to the Nurse Educator, but they were on vacation. During an interview on 10/29/24 at 12:21 PM, the Medical Director stated they were unaware wound rounds were not being done or documented weekly. 40686 2) Resident #39 had diagnoses of osteomyelitis and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #39 was moderately cognitively impaired with a Stage 4 pressure ulcer that was present upon admission to the facility. The Comprehensive Care Plan related to Stage 4 sacral/right buttock ulcer dated 8/13/2024 documented notify Medical Director if the wound did not show improvement within 14 days. The Physician's Orders as of 10/28/2024 documented Resident #39 was ordered Fibracol External Pad wound dressing to the sacrum every night with Allevyn cover. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Notes reviewed from 10/1/2024 through 10/22/2024 documented on 10/9/2024, Resident #39 had wound change to left buttock 1 cm .5 cm by 1 cm depth with slough. On 10/10/2024 an area was 2 centimeters by 1 centimeter wide. Nursing Note dated 10/18/2024 documented Resident #39 had 3 cm deep left buttock wound with brown drainage. On 10/19/2024, Resident #39 had brown foul-smelling drainage and the Medical Director was called. Weekly Skin Assessments from 10/1/2024 through 10/22/2024 did not document Resident #39's wound characteristics, size, and shape. On 10/29/2024 at 12:22 PM, Registered Nurse #7 was interviewed and stated Resident #39 was admitted to the facility with a diagnosis of osteomyelitis and a gaping sacral wound from extensive exposure to a heating pad in the community. Resident #39 completed a round of antibiotic therapy for the osteomyelitis and the wound began improving; however, treatment orders recently changed and Resident #39's wound began presenting with brown drainage. Resident #39 complained of pain after the new treatment orders were implemented, the Medical Director was informed, and the treatment order was changed again. Resident #39's wound began responding to the current treatment and a wound vacuum will be placed at the site to promote healing. Registered Nurse #7 stated that, as the Nurse Manager for the unit, they were responsible for assessing the size, shape, and other characteristics of resident wounds and could verbally provide that information. Registered Nurse #7 stated that they began working for the facility approximately 5 months ago and was adjusting to the electronic medical record of the facility and wound care documentation procedures. Registered Nurse #7 stated they ensured any change, whether healing or worsening, was communicated to the Medical Director. On 10/29/2024 at 02:07 PM, the Quality Assurance Committee Leader was interviewed and stated the Staff Educator was also the facility's Wound Care Coordinator and was responsible for using wound care assessments to track the progression of resident wounds. The issues with wound care assessment completion made it difficult for the Wound Care Coordinator to gather the information necessary to track wound progression. On 10/25/2024 at 6:29 PM and 10/29/2024 at 1:30 PM, the Director of Nursing was interviewed and stated the Wound Care Coordinator was currently on vacation. The Director of Nursing stated they identified that wound care assessment documentation and tracking was inadequate, incomplete, and inconsistent. The Nursing Department plans to present this as a performance improvement project at the next quality assurance performance improvement meeting. Nurse Managers were responsible for completing a comprehensive weekly skin assessment of any resident with a pressure ulcer, skin impairment, and/or wound care. 10 NYCRR 415.12(e)(1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record reviews conducted during the recertification survey from 10/22/2024 to 10/29/2024, the facility did not ensure the attending physician documented in the resident's medical record that the identified drug regimen review irregularity was reviewed, and any action taken to address it. This was evident for 1 (Resident #39) of 5 residents reviewed for unnecessary medication. Specifically, there was no documented evidence the Medical Director reviewed and responded to Resident #39's Drug Regimen Reviews dated 8/13/2024 and 9/3/2024. The findings are: The facility policy titled Drug Regimen Review dated 5/2022 documented the attending physician will review the consultant pharmacist findings and recommendations, accepting or rejecting the findings, then sign off the review in the medical record. Resident #39 was admitted [DATE] with diagnoses of osteomyelitis and dementia. Physician Orders as of 10/26/2028 documented Resident #39 was ordered olanzapine 5 milligrams daily for dementia with behavior on 8/13/2024, and bumex 2 milligrams daily for edema on 9/10/2024. The Pharmacist Drug Regimen Review dated 8/14/2024 documented recommendations to document the clinical benefit versus risk of using multiple antipsychotics (olanzapine and quetiapine) for Resident #39. The Pharmacist Drug Regimen Review dated 9/3/2024 documented recommendations to evaluate Resident #39's order for furosemide 40 mg twice daily due to recent lab results out of normal range. There was no documented evidence the Medical Director documented their response and rationale related to Resident #39's Drug Regimen Reviews dated 8/14/2024 and 9/3/2024. On 10/25/2024 at 06:29 PM, the Director of Nursing was interviewed and stated the Medical Director had been overwhelmed since taking over the position as Medical Director and Attending Physician for all residents in the facility in 7/2024. The Medical Director reported to Administration that they were behind on completing monthly renewals and Drug Regimen Reviews for residents. The Medical Director promised to catch up with reviewing and responding to Drug Regimen Review recommendations by the Pharmacist. The Director of Quality Assurance had a conversation with the Medical Director regarding their responsibility and requirements to respond to the Drug Regimen Reviews for all residents in a timely manner. The Director of Nursing stated they noticed issues with the Medical Director being able to keep up with the documentation requirements for the position in August 2024. On 10/29/2024 at 02:07 PM, the Director of Quality Assurance was interviewed and stated the Medical Director has been delayed in their ability to respond to Drug Regimen Review recommendations due to their adjustment to using the facility's electronic medical record. The Medical Director received training on the electronic medical record and required documentation and performance has improved. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/2024 at 12:38 PM, the Medical Director was interviewed and stated they were overwhelmed with taking on the responsibilities of Medical Director and becoming the Attending Physician for all residents in the facility in 7/2024. They recently became aware of their responsibilities and the importance of the Drug Regimen Review recommendations and response requirements. The Pharmacist did send emails containing the Drug Regimen Review recommendations and a conversation did occur between the Medical Director and Director of Nursing regarding the documentation requirements of the Medical Director. The Medical Director stated the facility had a lot of admissions and discharges that were time consuming, and the Medical Director requested assistance from Administration with the responsibilities of being the Attending Physician. 10 NYCRR 415.18(c)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50766 Based on observation and interviews conducted during the recertification survey from [DATE] to [DATE], the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, 1. the walk-in refrigerator contained expired food products and a product that was to labeled to remain frozen, 2. the walk-in freezer contained unlabeled food products and one item with freezer burn, and 3. the dry storage pantry contained an expired and undated food product. The Facility policy Food and Supply Storage, revised ,d+[DATE], stated foods past the use-by,sell-by, best-by, enjoy-by , date should be discarded. Commercially produced foods may be held frozen util the manufacturer's expiration date, or for 3 months if no expiration date on the package. Once the packaging: around the food has been opened, food must be used within 3 months. The findings are: During an initial tour of the kitchen on [DATE] at 12:19 PM accompanied by Food Service Supervisor, observations included: 1) The walk-in refrigerator had two boxes of Eggo pancakes labeled keep frozen were no longer frozen and being stored in refrigerator. One bottle of Grey Poupon mustard had an expiration date of [DATE]. One 5-pound container of Galbani ricotta had an expiration date of [DATE]. Three 4-pound cans Tuna Fish had an expiration date of [DATE]. One 66.6 ounce can Empress tuna did not have an expiration date on can. 2) The walk-in freezer had one 3-pound bag of chicken pieces did not have a date opened or expiration date. One bag of biscuits had a [DATE] expiration date. A 20-pound bag of ground beef patties did not have a date opened or expiration date. One bag of breakfast sausage did not have a date opened or expiration date. Freezer burn was observed on breakfast sausage product. Five bags of chicken breast were not labeled, did not have a date opened or expiration date. Three bags of chicken legs were not labeled, did not have a date opened or expiration date. One bag of chicken patties were not labeled, did not have a date opened or expiration date. 3) The dry storage area had a container with approximately 25 individual packets of Citavo Brand decaffeinated coffee with an expiration date of [DATE]. During follow up tour of kitchen and interview with Director of Food Services on [DATE] at 11:56 AM, they stated they were made aware by Food Service Supervisor of expired and unlabeled products observed during initial tour of kitchen on [DATE]. They stated that staff were trying not to have as many boxes in the freezer and staff unloaded the frozen product and discarded boxes which contained expiration dates. They stated that the individual bags of frozen items should have been labeled with opening dates and expiration dates and expired food products should have been discarded. 10NYCRR 415.14(h)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 40686 Based on interview and record reviews conducted during the recertification survey from 10/22/2024 to 10/29/2024, the facility did not ensure medical director was responsible for the coordination of medical care in the facility. This was evident during review of Pressure Ulcer Care and Unnecessary Medication. Specifically, the Medical Director stated they were overwhelmed and not provided with requested assistance to address the responsibilities and requirements of their position in the facility. The findings are: Please refer to F686 and F796. On 10/25/2024 at 06:29 PM, the Director of Nursing was interviewed and stated the Medical Director has been overwhelmed since taking over the position as Medical Director and Attending Physician for all residents in the facility in 7/2024. The Medical Director reported to Administration that they were behind on completing monthly renewals and Drug Regimen Reviews for residents. The Medical Director promised to catch up with reviewing and responding to Drug Regimen Review recommendations by the Pharmacist. The Director of Quality Assurance had a conversation with the Medical Director regarding their responsibility and requirements to respond to the Drug Regimen Reviews for all residents in a timely manner. The Director of Nursing stated they noticed issues with the Medical Director being able to keep up with the documentation requirements for the position in August 2024. On 10/29/2024 at 02:07 PM, the Director of Quality Assurance was interviewed and stated the Medical Director has been delayed in their ability to respond to Drug Regimen Review recommendations due to their adjustment to using the facility's electronic medical record. The Medical Director received training on the electronic medical record and required documentation and performance has improved. On 10/29/2024 at 12:38 PM, the Medical Director was interviewed and stated they were overwhelmed with taking on the responsibilities of Medical Director and becoming the Attending Physician for all residents in the facility in 7/2024. The Medical Director stated the facility had a lot of admissions and discharges that were time consuming, and the Medical Director requested assistance from Administration with the responsibilities of being the Attending Physician. On 10/29/2024 at 02:08 PM, the Administrator was interviewed and stated the facility was aware the Medical Director was overwhelmed with the responsibilities and requirements of their position. The Administrator stated the previous Medical Director had a Nurse practitioner that assisted in covering the resident care in the facility. The current Medical Director did not have any other Attending Physician or Nurse Practitioner to assist them with overseeing resident care. The Administrator stated the facility was in talks with other physicians to obtain assistance for the Medical Director. 10 NYCRR 415.15(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50766 Based on observations, record review, and interviews conducted during the Recertification survey between 10/22/2024 and 10/29/24, the facility did not ensure infection control practices and procedures were maintained. This was evident 2 of 2 units during review of enhanced barrier precautions and 2 of 19 residents total sampled residents. Specifically, 1) Resident #44's oxygen tubing was observed soiled and not dated or changed in accordance with professional standards of practice, 2) Resident #58 was observed with their Foley catheter (tube to drain urine from the bladder) tubing and wound vacuum (treatment that uses suction to heal wounds) tubing touching the floor, and 3) 2 of the 5 residents observed for pressure ulcer/injury (Residents #3 and Resident #58) had a Stage 2 pressure ulcers and enhanced barrier precautions were not in place. The findings are: 1) The facility's policy and procedure titled Oxygen Administration revised 03/2014, documented: All oxygen tubing must be changed and dated once per week. After completion of the oxygen set-up or adjustment, the following information should be recorded in the resident's medical record: the date and time the procedure was performed, the name and title of the individual who performed the procedure. Resident #44 diagnoses included metabolic encephalopathy, heart failure, and chronic atrial fibrillation. The Significant change Minimum Data Set, dated dated dated [DATE] documented Resident #44 had intact cognition and was on intermittent oxygen therapy. A comprehensive care plan updated 9/11/24 did not document oxygen administration and equipment care for oxygen usage. The Physician's order dated 09/17/24 documented oxygen 2 liters via nasal cannula as needed. A review of the progress notes and treatment administration record for Resident #44 did not include documentation of nasal cannula tubing change since 9/17/24. During observations on 10/22/24 at 1:50 PM, 10/23/24 at 10:50 AM, and 10/25/24 at 09:13 AM, Resident # 44 was receiving oxygen at 2 liters/minute via nasal cannula. There was no date observed on oxygen tubing and the tubing was soiled with a brownish substance mid-length. During an interview on 10/25/24 at 9:27 AM, Resident #44 stated they were not sure if tubing was changed and could not recall if they saw the tubing being changed in the past week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/24 at 11:23 AM, Registered Nurse Unit Manager #11 stated that Resident #44 had a physician order for oxygen 2 liters via nasal cannula as needed as of 9/17/24. They stated they were not sure of facility policy for frequency of changing the nasal cannula for residents on oxygen therapy. They stated it could be daily or every 3 days and that they would look into it. They stated that nursing staff were responsible for changing nasal cannula tubing and should document the completion of the task in electronic medical record. They were not sure if the documentation should be placed in the treatment administration record or in progress notes. The Unit Manager Maple Unit was not aware when the nasal cannula was last changed for Resident #44 or if the task was completed by day shift or night shift. They stated they thought it was the responsibility of the night shift. They stated they were responsible for supervising nursing staff, including the completion of tasks. During an interview on 10/25/24 at 11:31 AM, Licensed Practical Nurse #6 stated they were not aware of schedule for changing nasal cannula tubing on oxygen concentrators. They stated they had recently received in-service training on oxygen administration therapy. They believe night shift was responsible for the task. They stated they had not changed tubing or humidification water bottles for Resident #44 recently. During an interview on 10/28/24 at 12:46 PM, the Director of Nursing stated weekly changing of oxygen nasal cannula tubing was the policy of facility. They stated when the order was placed for oxygen, the order should include the liter amount, administration route (nasal cannula, etc.) and tubing and filter to be changed weekly and as needed. They stated the night shift was responsible for weekly cannula tubing change and the nurse changing the tubing or filter was responsible for documenting completion of the task on the treatment administration section of the electronic medical record. They stated that the order and oxygen care plan for Resident #44 was not in place. 40686 2) Resident #58 had diagnoses of stage 4 left hip pressure ulcer, benign prostatic hyperplasia, history of sepsis, and history of urinary tract infection. Physician Orders as of 10/25/2024 documented Resident #58 had a Foley catheter and wound vacuum placed on their left hip. On 10/25/2024 at 11:10 AM, Resident #58 was observed in the 2nd Floor Lounge with a bag containing their wound vacuum machine hanging from the left handlebar on the back of their wheelchair. Tubing was observed running from the wound vacuum into the top of Resident #58's pants on their left side. Certified Nurse Aide #8 wheeled Resident #58 out of the lounge and down the hall towards the nursing station. Resident #58's wound vacuum tubing fell to the ground while the resident was being wheeled in the hallway and dragged on the ground underneath the resident's wheelchair for several feet. Certified Nurse Aide #8 noticed the wound vacuum tubing was dragging on the ground and picked up the tubing with their bare hands, coiled the tubing, and placed the tubing in the wound vacuum bag on the back of Resident #58's wheelchair. Certified Nurse Aide #8 did not perform hand hygiene and did not sanitize the wound vacuum tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schervier Pavilion	22 Van Duzer Place Warwick, NY 10990

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/2024 at 3:20 PM, Certified Nurse Aide #8 was interviewed and stated they received infection control training and education. Certified Nurse Aide #8 stated they picked up Resident #58's wound vacuum tubing from the floor with their bare hands when wheeling the resident down the hallway. Certified Nurse Aide #8 stated they knew this was not the proper procedure in accordance with infection control practices and should have sanitized their hands prior to handling the tubing and sanitized the tubing after picking it up from the floor. On 10/29/2024 at 10:31 AM, Resident #58 was observed sitting in their wheelchair across from the Briar Hall Nursing Station. Resident #58 had a Foley catheter dignity bag hanging from the crossbar of their wheelchair under their seat. The Foley catheter tubing leading from the drainage bag to the bottom of Resident #58's right pant leg was observed touching the floor. On 10/29/2024 at 11:33 AM, Certified Nurse Aide #9 was interviewed and stated they were assigned to Resident #58. Certified Nurse Aide #9 observed Resident #58 during the interview and stated Resident #58 had a Foley catheter and the tubing should not be touching the floor. Certified Nurse Aide #9 then picked up Resident #58's Foley catheter tubing with their bare hands and attached it to a plastic clip under their wheelchair near the drainage bag. Certified Nurse Aide #9 stated Resident #58's wheelchair was lower to the ground and the plastic clip to keep tubing from dragging on the floor was not very strong which put Resident #58's Foley catheter tubing at greater risk of falling onto the floor. Resident #58's catheter tubing should not be in the floor in accordance with infection control and to prevent risk of infections such as urinary tract infections. Leg bags were available for residents with Foley catheters but were only used to promote resident dignity if they planned to go out on pass with family. On 10/29/2024 at 11:58 AM, Registered Nurse Manager #7 was interviewed and stated Foley catheter leg bags were not used unless a resident was going out on pass with family because handling the tubing to transfer between a regular drainage bag and leg bag created a greater risk of infection. Resident #58 had a wheelchair lower to the ground and Foley catheter drainage bag and tubing were lower to the ground than they were for other residents. Wound vacuum tubing and Foley catheter tubing should not be on the floor to promote infection control. 47626 3) Resident # 3 had diagnoses including Muscular Dystrophy, Diabetes, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set (an assessment tool) dated 8/26/24 documented the resident's cognition was intact. The resident required supervision for eating and was dependent on staff with all other activities of daily living. The resident had a Stage 2 pressure ulcer that was not present on admission. A review of the Resident Certified Nurse Aide care card had no documentation of enhanced barrier precautions. A review of the medical record had no Care Plan for enhanced barrier precautions. A review of the Physician orders had no documentation for enhanced barrier precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Schervier Pavilion		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Van Duzer Place Warwick, NY 10990	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/24/24 at 8:20 AM, the resident was in bed having morning care performed by 2 Certified Nurse Aides; neither aide was wearing an isolation gown during care. During an interview on 10/25/24 at 09:22 AM, Registered Nurse #3 stated the Resident #3 had a small Stage 2 pressure ulcer on their buttock and the resident was supposed to be on enhanced barrier precautions. During an interview on 10/25/24 at 9:30, Certified Nurse Aide #1 stated the resident was on precautions because they had a wound. There should have been a sign and a holder on the door for the Personal Protective Equipment. They stated they did not know why it was not there. During an interview on 10/25/24 at 9:45 AM, Certified Nurse Aide #2 stated the resident had a Stage 2 pressure ulcer on her right ischium and the resident was on enhanced barrier precautions. They stated they did know why there was no signage above the bed. They stated they were aware that if a resident had an indwelling catheter, they needed to wear a gown but did not know until yesterday that they needed to wear a gown for residents with wounds. During an interview on 10/28/24 at 10:09 AM, the Registered Nurse Quality Assurance Performance and Improvement Coordinator stated the staff were educated on enhanced barrier precautions multiple times. They stated it was the responsibly of the Unit Manager to ensure the signs were up, and the Personal Protective Equipment was available in the resident room. During an interview on 10/28/24 at 12:25 PM, the Registered Nurse Unit Manager #11 stated the resident had a pressure ulcer. They stated Enhanced Barrier Precautions were initiated for residents with indwelling catheters or open wounds. The staff should have been wearing isolation gown and gloves when giving care. The supply of Personal Protective Equipment should be available at the bedside. There should be a physician order and a care plan for enhanced barrier precautions. The Nurse Manager was responsible for putting up the sign and putting the resident on precautions. 10 NYCRR 415.19

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50766 Based on record review and interviews during a recertification survey from 10/22/24 to 10/29/24, the facility did not ensure they had an Infection Preventionist (IP) who was responsible for the facility's Infection Control Program. Specifically, the facility failed to ensure that the Infection Preventionist worked at least part-time in the facility. Findings include: The Facility Infection Prevention and Control Program Policy Reviewed 8/2024, documented the authority for the Infection Prevention and Control Program has been delegated by the Administrator to the System Director of Infection Prevention and Control. The daily infection prevention and control duties will be fulfilled by an Infection Preventionist. During an interview with the facility Administrator on 10/24/24 at 10:57 AM, they stated the Systems Director for Infection Prevention did not spend 50 percent of their time working in the facility. The Administrator stated that the Infection Preventionist spent very little time in the facility. The Administrator stated that another staff member, the Quality Assurance Registered Nurse, provided day-to-day infection surveillance for the facility and was in the process of obtaining Infection Preventionist certification. During an interview with the Quality Assurance Coordinator Registered Nurse on 10/25/24 at 4:00 PM, they stated they were currently taking the Infection Preventionist Certification Training and had not completed it. They stated they provided day-to-day infection prevention/surveillance for the facility and the Systems Director for Infection Prevention provided oversight, mostly remotely, including the monthly Quality Assurance meetings. During an interview with Systems Director for Infection Prevention on 10/28/24 at 3:11 PM, they stated they did not spend 50 percent of their time working at the facility. They stated they provided oversight of facility infection control program including 24 hour, 7 days a week availability by telephone or video conference. They stated that the facility Quality Assurance Registered Nurse was in the process of obtaining Infection Preventionist Certification and presently provided the day-to-day infection prevention/surveillance for the facility. They stated they attended monthly Quality Assurance meetings, mostly remotely, and concerns related to Infection Control were reviewed via email or telephone discussion. 10NYCRR 415.19