

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/27/2023
NAME OF PROVIDER OR SUPPLIER  Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673</b></p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00329990, NY00329232) the facility did not ensure pharmaceutical services that assure timely acquiring, receiving, and administering medications met the needs of 2 of 3 residents (Resident #2 and #5) reviewed for medication administration. Specifically, Resident #2 was prescribed Dronabinol (an appetite stimulant) 2.5 milligram, 2 capsules twice a day. Resident #2 missed 46 doses when the medication was unavailable. Resident #5 was prescribed Bupropion 300 milligram tablet by mouth daily for depression and 8 doses of the medication was not administered. There was no documentation for reasons why doses were missed.</p> <p>The findings are:</p> <p>The Policy and Procedure titled Medication Administration, undated, documented medications shall be administered in a safe and timely manner and as prescribed to assist the resident to meet their highest practicable mental and psychological wellbeing. If a medication is not available, the nurse must contact the Nursing Supervisor and the pharmacy. If a replacement cannot be obtained in a timely manner the physician must be notified and a progress note written with the Physician instructions for the medications.</p> <p>1. Resident #2 was admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition, atrial fibrillation, and adult failure to thrive.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] documented the resident had moderately impaired cognition and was on a therapeutic diet.</p> <p>A physician order dated 9/5/23 documented to administer Dronabinol 2.5 milligram capsule, 2 capsules twice a day.</p> <p>A nurse note dated 10/21/2023 at 1:18 PM, written by licensed practical nurse (Licensed Practical Nurse) #3 documented the pharmacy notified the facility that Dronabinol 2.5 mg was out of stock and the prescription would be automatically filled when it was back in stock.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Medication Administration Record documented Dronabinol was not administered on the following dates: 9/6/2023 -both doses, 10/15/2023- both doses, 10/16/2023- both doses, 10/22/2023- AM dose, 10/25/2023-PM dose, 10/26/2023- both doses, 10/27/2023- AM dose, 11/4/2023-PM dose, 11/5/2023- both doses, 11/6/2023- both doses, 11/8/2023-AM dose, 11/13/2023-PM dose, 11/14/2023- both doses, 11/15/2023- both doses, 11/16/2023- both doses, 11/17/2023- both doses, 11/18/2023-AM dose, 11/19/2023- both doses, 11/20/2023- both doses, 11/21/2023- both doses, 11/22/2023- both doses, 11/23/2023- both doses, 11/24/2023-both doses, 11/25/20232-both doses, 11/26/2023-both doses, 11/27/2023-PM dose, 11/28/2023-AM dose.</p> <p>There was no documentation in the MAR as to the reason the medication was not given, and review of the nursing progress notes did not document a reason for not giving or if the physician was notified for any of the missed doses.</p> <p>Review of the controlled medication utilization records revealed medication was received as follows:</p> <ul style="list-style-type: none"> <li>-on 9/7/23 60 capsules were received with the last one administered on 9/21/23 at 5 PM.</li> <li>-on 9/21/23 90 capsules were received with the last one administered on 10/15/23 at 5 PM.</li> <li>-on 10/16/23 20 capsules were received with the first one given on 10/17 at 9 AM (none given 10/16/23) and the last one administered on 10/21/23 at 5 PM.</li> <li>- on 10/21/23 12 capsules were received with the first one given on 10/22 at 5 PM (none given 10/22 AM dose) and the last one administered on 10/25/23 at 9 AM.</li> <li>-on 10/26/23 12 capsules were received with the first one given on 10/27 at 5 PM (none given 10/25 PM or 10/26 AM and PM or 10/27 AM) and the last one administered on 10/30/23 at 9 AM.</li> <li>-on 10/31/23 12 capsules were received with the first one given on 10/31 at 5 PM ( none given 10/30 PM or 10/31 AM) and the last one administered on 11/04/23 at 9 AM.</li> <li>- on 11/6/23 12 capsules were received with the first one given on 11/7 at 9 AM ( none given 11/04 PM or 11/05 and 11/06 AM and PM) and the last one administered on 11/09/23 at 5 PM.</li> <li>-on 11/9/23 12 capsules were received with the first one given on 11/10 at 9 AM and the last one administered on 11/12/23 at 5 PM.</li> </ul> <p>There were no further deliveries of Dronabinol documented and there was no documented evidence the physician or pharmacy were notified the resident was not receiving the prescribed medication.</p> <p>A medical progress note written by the nurse practitioner, dated 11/29/2023, documented the resident was seen for COVID-19 follow up and to renew the Dronabinol for appetite. The nurse practitioner was informed by nursing that the Dronabinol had not been given for 15 days, and the resident was eating better. Physician order dated 11/29/2023 documented the Dronabinol was discontinued.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/20/2023 at 2:00 PM Licensed Practical Nurse #1 stated when a medication was not given to a resident, or held, the nurse was supposed to notify the Nurse Practitioner and write a note. Licensed Practical Nurse #1 stated they notified the Nurse Practitioner but did not write a note.</p> <p>During an interview on 12/20/2023 at 2:33 PM, Licensed Practical Nurse#2 stated if a medication was not given, she would call the nurse practitioner, and document in the Medication Administration Record that it was held or not administered.</p> <p>During an interview on 12/20/2023 at 2: PM, Registered Nurse #3 stated that they did not have the Dronabinol in the facility to give the resident and all of the nurses as well as the pharmacy were aware. Registered Nurse #3 stated Licensed Practical Nurse #3 documented a note on 10/21/2023 stating that the Pharmacy basically told them to stop calling and the medication was on back order. Registered Nurse #3 stated they documented not administered on the MAR since the medication was not available.</p> <p>During an interview on 12/21/23 at 9:23AM the Nurse Practitioner they were aware the resident ran out of Dronabinol but was not concerned as the resident's weight was stable.</p> <p>During an interview on 12/21/23 at 12 PM, the pharmacist stated they informed the facility when a medication was on backorder, and it was the facility's responsibility to notify the provider to change the dose or discontinue the medication.</p> <p>2.Resident # 5 was admitted to the facility on [DATE] with diagnoses including depression, obstructive uropathy (urinary flow problem) and benign prostatic hyperplasia (enlarged prostate). The admission Minimum Data Set (MDS) dated [DATE] documented the resident had intact cognition and felt down, depressed, or hopeless for several days over the last 2 weeks. The resident had a diagnosis of depression and was taking an antidepressant.</p> <p>A physician order dated 11/7/23 documented to administer Bupropion 300 milligram tablet by mouth daily at 9 AM.</p> <p>Review of the Medication Administration Record dated 11/7/23 to 12/20/23 revealed the resident was not administer Bupropion on 12/1, 12/4, 12/6, 12/11, 12/12, 12/14, 12/18, and 12/19/23. On 12/6 and 12/19/23, there was a notation that they were waiting for pharmacy to deliver.</p> <p>During an interview on 12/19/23 at 10AM, Resident #5 stated they did not always get their Bupropion and the nurses told them the medication went to another unit.</p> <p>During an interview on 12/19/2023 at 2:33 PM, Licensed Practical Nurse #2 stated if a medication was not given, they called the Nurse Practitioner and document in the MAR that the medication was held or not administered and the reason.</p> <p>10NYCRR 415.18(a)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673</b></p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00329990, NY00329232), the facility did not ensure that residents are free of significant medication errors. This was evident for 2 of 3 residents (Resident #2 and #5) reviewed for medication administration. Specifically, Resident #2 was prescribed Dronabinol (an appetite stimulant) 2.5 milligram, 2 capsules twice a day. Resident #2 missed 46 doses when the medication was unavailable. Resident #5 was prescribed Bupropion 300 milligram tablet by mouth daily for depression and 8 doses of the medication was not administered. There was no documentation for reasons why doses were missed.</p> <p>The findings are:</p> <p>The Policy and Procedure titled Medication Administration, undated, documented medications shall be administered in a safe and timely manner and as prescribed to assist the resident to meet their highest practicable mental and psychological wellbeing. If a medication is not available, the nurse must contact the Nursing Supervisor and the pharmacy. If a replacement cannot be obtained in a timely manner the physician must be notified and a progress note written with the Physician instructions for the medications.</p> <p>1. Resident #2 was admitted to the facility on [DATE] with diagnoses including severe protein-calorie malnutrition, atrial fibrillation, and adult failure to thrive.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] documented the resident had moderately impaired cognition and was on a therapeutic diet.</p> <p>A physician order dated 9/5/23 documented to administer Dronabinol 2.5 milligram capsule, 2 capsules twice a day.</p> <p>A nurse note dated 10/21/2023 at 1:18 PM, written by licensed practical nurse (Licensed Practical Nurse) #3 documented the pharmacy notified the facility that Dronabinol 2.5 mg was out of stock and the prescription would be automatically filled when it was back in stock.</p> <p>Review of the Medication Administration Record (MAR) documented Dronabinol was not administered on the following dates: 9/6/2023 -both doses, 10/15/2023- both doses, 10/16/2023- both doses, 10/22/2023- AM dose, 10/25/2023-PM dose, 10/26/2023- both doses, 10/27/2023- AM dose, 11/4/2023-PM dose, 11/5/2023- both doses, 11/6/2023- both doses, 11/8/2023-AM dose, 11/13/2023-PM dose, 11/14/2023- both doses, 11/15/2023- both doses, 11/16/2023- both doses, 11/17/2023- both doses, 11/18/2023-AM dose, 11/19/2023- both doses, 11/20/2023- both doses, 11/21/2023- both doses, 11/22/2023- both doses, 11/23/2023- both doses, 11/24/2023-both doses, 11/25/20232-both doses, 11/26/2023-both doses, 11/27/2023-PM dose, 11/28/2023-AM dose.</p> <p>There was no documentation in the Medication Administration Record as to the reason the medication was not given, and review of the nursing progress notes did not document a reason for not giving or if the physician was notified for any of the missed doses.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the controlled medication utilization records revealed medication was received as follows:</p> <p>on 9/7/23 60 capsules were received with the last one administered on 9/21/23 at 5 PM; -on 9/21/23 90 capsules were received with the last one administered on 10/15/23 at 5 PM; on 10/16/23 20 capsules were received with the first one given on 10/17 at 9 AM (none given 10/16/23) and the last one administered on 10/21/23 at 5 PM; on 10/21/23 12 capsules were received with the first one given on 10/22 at 5 PM (none given 10/22 AM dose) and the last one administered on 10/25/23 at 9 AM; -on 10/26/23 12 capsules were received with the first one given on 10/27 at 5 PM (none given 10/25 PM or 10/26 AM and PM or 10/27 AM) and the last one administered on 10/30/23 at 9 AM; on 10/31/23 12 capsules were received with the first one given on 10/31 at 5 PM ( none given 10/30 PM or 10/31 AM) and the last one administered on 11/04/23 at 9 AM; on 11/6/23 12 capsules were received with the first one given on 11/7 at 9 AM ( none given 11/04 PM or 11/05 and 11/06 AM and PM) and the last one administered on 11/09/23 at 5 PM; on 11/9/23 12 capsules were received with the first one given on 11/10 at 9 AM and the last one administered on 11/12/23 at 5 PM.</p> <p>There were no further deliveries of Dronabinol documented and there was no documented evidence the physician or pharmacy were notified the resident was not receiving the prescribed medication.</p> <p>A medical progress note written by the nurse practitioner, dated 11/29/2023, documented the resident was seen for COVID-19 follow up and to renew the Dronabinol for appetite. The nurse practitioner was informed by nursing that the Dronabinol had not been given for 15 days, and the resident was eating better. Physician order dated 11/29/2023 documented the Dronabinol was discontinued.</p> <p>During an interview on 12/20/2023 at 2:00 PM Licensed Practical Nurse #1 stated when a medication was not given to a resident, or held, the nurse was supposed to notify the Nurse Practitioner and write a note. Licensed Practical Nurse #1 stated they notified the Nurse Practitioner but did not write a note.</p> <p>During an interview conducted with the Licensed Practical Nurse#2 on 12/20/2023 at 2:33 PM, the Licensed Practical Nurse#2 stated if a medication was not given, she would call the nurse practitioner, and document in the Medication Administration Record that it was held or not administered.</p> <p>During an interview conducted with the Registered Nurse #3 on 12/20/2023 at 2: PM, the Registered Nurse #3 stated that they did not have the Dronabinol in the facility to give the resident and all of the nurses as well as the pharmacy were aware. The Registered Nurse #3 stated Licensed Practical Nurse #3 documented a note on 10/21/2023 stating that the Pharmacy basically told them to stop calling and the medication was on back order. The Registered Nurse #3 stated they documented not administered on the MAR since the medication was not available.</p> <p>During an interview conducted with the Nurse Practitioner on 12/21/2023 at 9:23AM, the Nurse Practitioner they were aware the resident ran out of Dronabinol but was not concerned as the resident's weight was stable.</p> <p>During an interview conducted with the Pharmacist on 12/21/2023 at 12 PM, the Pharmacist stated they informed the facility when a medication was on backorder, and it was the facility's responsibility to notify the provider to change the dose or discontinue the medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident # 5 was admitted to the facility on [DATE] with diagnoses including depression, obstructive uropathy (urinary flow problem) and benign prostatic hyperplasia (enlarged prostate). The admission Minimum Data Set (MDS) dated [DATE] documented the resident had intact cognition and felt down, depressed, or hopeless for several days over the last 2 weeks. The resident had a diagnosis of depression and was taking an antidepressant.</p> <p>A physician order dated 11/07/2023 documented to administer Bupropion 300 milligram tablet by mouth daily at 9 AM.</p> <p>Review of the Medication Administration Record dated 11/7/23 to 12/20/23 revealed the resident was not administer Bupropion on 12/1, 12/4, 12/6, 12/11, 12/12, 12/14, 12/18, and 12/19/23. On 12/6 and 12/19/23, there was a notation that they were waiting for pharmacy to deliver.</p> <p>During an interview on 12/19/23 at 10AM, Resident #5 stated they did not always get their Bupropion and the nurses told them the medication went to another unit.</p> <p>During an interview on 12/19/2023 at 2:33 PM, Licensed Practical Nurse #2 stated if a medication was not given, they called the Nurse Practitioner and document in the MAR that the medication was held or not administered and the reason.</p> <p>During an interview on 12/21/23 at 10:30AM the Nurse Practitioner stated she was aware that the resident did not have doses of Bupropion and they reordered the medication, but it was not received.</p> <p>10NYCRR 415.12(m)(2)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>49372</p> <p>Based on observation, record review and interviews during an abbreviated survey (NY00329232, NY00329990 and NY00326047), the facility did not ensure a resident's actual food, dietary needs and choices were met for 1 out of 5 residents (Resident #5) reviewed for food and meals. Specifically, Resident #5, did not receive double portions as per his dietary recommendations, physician order, and meal ticket.</p> <p>The findings are:</p> <p>Resident #5 had diagnoses including benign prostatic hyperplasia, obstructive uropathy (the flow of urine is blocked), and depression.</p> <p>The Admission Minimum Data Set (MDS-resident assessment tool) dated 11/13/23 documented the resident's cognition was intact and the resident was on a therapeutic diet.</p> <p>The Comprehensive care plan for nutrition dated 11/7/23 documented the resident was on a regular, no concentrated sweets, thin liquids and double portions diet. Interventions included adhering to the resident's foods preferences.</p> <p>A physician order dated 11/10/23 documented the resident's diet as double portions, no concentrated sweets, and regular consistency.</p> <p>A nutrition progress note dated 11/15/23 documented the resident was receiving protein entree times two at all meals.</p> <p>During a meal observation, in the dining room, on 12/19/2023 at 12:12 PM, the resident received 1 turkey and cheddar melt sandwich and consumed the entire sandwich. Review of meal ticket on the tray revealed Residnet #5 was supposed to receive 2 sandwiches.</p> <p>During a meal observation on 12/21/2023 at 12:10 PM, Resident #5 received 1 grilled turkey and swiss melt sandwich. Review of the meal ticket on their tray revealed the resident was supposed to receive 2 sandwiches.</p> <p>During an interview with the Food Service Director on 12/21/2023 at 10:24 am, stated The line supervisor makes sure all the scoop sizes are correct for portion control and consistencies before the line starts. If a resident was to receive a double portion, they should receive 2 whole sandwiches for double portions.</p> <p>During an interview on 12/21/2023 at 12:15 PM with the Registered Nurse Unit Manager (RUNM #1), stated when trays are delivered to the unit, the nurse and nurse's aide will assist residnets who need set up to be sure all items are opened for the resident. Residents will usually let the staff know if they needed any additional items or if they did not receive an item.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/21/2023 at 1:15 PM, the line supervisor stated the resident should have received 2 sandwiches on their lunch tray.</p> <p>10NYCRR 415.14</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44673</p> <p>Based on observation and interview conducted during an abbreviated survey (NY00326047) the facility did not ensure proper storage of refrigerated food in accordance with professional standards for food safety. Specifically, food items in the walking refrigerator were unlabeled and undated.</p> <p>The findings are:</p> <p>The policy and procedure titled cold food storage and shelf life dated 1/20/15 documented foods must be labeled with date made or date received. The item then must be properly stored and refrigerated. Food must be discarded after three days.</p> <p>During a tour of the facility kitchen on 12/21/23 at 10:30am, the walk-in refrigerator had a pan with meat marinated in a brown liquid covered with a plastic wrap with no label and no date. In addition, a small plastic container about 4.7 inches wide with a lid had a green paste with no label or date.</p> <p>During an interview on 12/21/2023 at 10:40 PM with the Food Service Director, they stated the containers should be dated and labeled. When not labeled the staff would not know what is in the container and for how long it has been in the refrigerator.</p> <p>During an interview on 12/27/23 at 11:00AM, the Assistant Food Service Director stated, food must be labelled to protect the residents from getting sick. Without the labels staff would not know how long the food has been in the refrigerator. Moving forward all the containers will have dates and labels.</p> <p>10NYCRR 415.14(h)</p>		