STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33A081	A. Building B. Wing	11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Marys Hospital for Children	29 01 216 Street Bayside, NY 11360

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, interviews, and record review conducted during an abbreviated survey (NY00303294), the facility did not ensure that a resident was free from physical abuse. This was evident for 1 of 3 residents (Resident #1) reviewed for abuse. Specifically, on 10/04/22, a Registered Nurse (RN#1) reported to the Assistant Director of Nursing (ADNS) that a Certified Nursing Assistant (CAN#1) who was assigned to resident #1 on 10/03/22 was witnessed slapping resident's arm twice while the resident was reaching out to the nebulizer treatment. In addition, the RN#1 failed to remove the accuse C.N.A#1 from patient care and allowed the C.N.A#1 to continue to work until end of shift. Resident #1 was assessed with no injury sustained from the incident. The findings are: The facility Policy and Procedure titled Resident Abuse, Neglect, and Exploitation subtitled states that all residents are treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment, and care for personal needs. To ensure that residents are free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restrain not required to treat the resident's symptoms. Resident #1 was admitted to the facility with diagnoses including Generalized Epilepsy and Epileptic syndrome, Developmental Delays, Cortical Blindness, Tracheostomy and Gastrostomy Status. The Minimum Date Set (MDS) dated [DATE] documented that Resident #1 had a severely impaired cognition. Resident #1 also required a total assist of one person when performing Activity of Daily Livings. (ADLS). On 10/19/23 at 2:00 PM, the resident was observed in the day room performing school activity. The resident appeared confused, unable to make needs known to staff. It also appeared that the resident does not have awareness of their surroundings and did not respond when called by name. Staff were present at the time of this observation. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility completed investigation summary, dated 10/4/23 documented that, on 10/3/22 at approximately 8:30PM, the RN#1 witnessed the C.N.A #1 slapped resident #1's arm twice in a hard way. The investigation also documented that a physical assessment was immediately completed on resident #1 and found no visible injury. Staff were interviewed and statements collected from eyewitness. The facility concluded that there is caused to believe that an alleged resident abuse, crime, mistreatment, or neglect had occur. The incident was reported to the appropriate state agencies and the C.N.A #1 was terminated. No longer employed with the facility. A review of (RN) progress note dated 10/03/23 documented that resident # 1 was assessed for possible trauma to the hands. Resident is stable and no findings or any changes to baseline. A review of Nurse Practitioner (NP) progress note dated 10/03/23 documented that resident #1 was assessed with no sign of trauma, bruising and or abnormal findings. Resident was noted to be within their baseline. On 10/24/23 at 11:30 AM, an interview conducted with the C.N.A #1 who stated that on that, the resident likes to grab anything they see, and that was the reason why the resident was placed on one to one (1:1). The C.N.A #1 further stated that the resident was on one to one because the resident likes to attempt to reach to the tracheostomy and the gastrostomy tube. On 10/03/22, they stated that the RN#1 was about to start administering medications and the resident was trying to grab the tracheostomy tube as the RN #1 was preparing nebulizer treatment. The C.N.A #1 stated that they quickly grabbed the resident hands and said, don't do it The C.N.A #1 stated that they never slapped resident's hands, and that it was a gentle grappling. On 10/24/23 at 1:30PM, further interview conducted with the C.N.A#1 who stated that they believe that the RN#1 was rebelling on her because of a dispute they had on 10/03/22. The C.N.A#1 stated that they accused the RN#1 for leaving resident #1 in the pool of water on her diaper as the RN#1 was trying to flush the tube feeding and the resident got wet during the process. The C.N.A# acknowledged that they had a verbal argument with RN#1. The C.N.A #1 sated that the RN#1 did not say anything related to the abuse concerns before the end of the shift, and that they were surprised to hear that the Rn#1 reported her for an alleged abuse. They concluded by saying that they know when and how to report an allegation of abuse and also received abuse training two weeks prior to the incident. On 10/26/23 at 1:20 PM, an interview conducted the RN #1 who stated that they witnessed the C.N.A #1 slammed the resident #1 s right hand in a hard way while they were preparing medications for the resident. The RN#1 also stated that the resident was observed frozen for a few seconds after the slap, and the resident is nonverbal. The RN#1 stated that they did not interject or speak to the C.N.A#1 when they witness the slapping. They stated that the C.N.A#1 was a very unpleasant and unapproachable person, so they tried to avoid the C.N.A#1. The RN stated the incident occurred on 10/03/22 and they waited until the following day before they reported the incident to the nursing supervisor. The RN#1 stated they were not aware that that the incident of abuse supposed to be reported immediately. The RN #1 continues to say that they have completed an abuse training five months before the incident and they were fairly a new nurse at that time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/23 at 1:45PM, an interview conducted with the C.N.A #2 who stated that they were in the same room performing ADLS care for another resident. The C.NA #2 stated that they did not observe the C.NA #1 slapped resident however they heard the C.NA#1 saying in a loud voice stop touching a few times. The C.NA # 2 described the C.NA#1 as rude and nasty person to other staff member but they cannot really tell if they can abuse a resident. On 10/27/23 at 11.21AM, an interview conducted with the Director of Nursing (DON) who stated that all employees receive abuse trainings and when they were first hired and annually They stated that staff are knowledgeable on what to do if they witness resident abuse, and that they completed abuse training and they know what it takes to protect resident from abuse. The DON stated part of their trainings is to report abuse immediately, and to remove the accuse person from resident care before the investigation completed. Any form of abuse Neglect, and Exploitation are to be reported immediately and the DON will be the lead on investigating abuse and include all interdisciplinary team. The DON also stated that they found the RN#1 witness credible and they believe an abuse occurred and that was the reason why they terminated the C.N. A#1, however, the RN#1 also failed to report and remove the accuse C.N.A immediately. On 10/31/23 at 1:05 PM, an interview conducted with the Administrator who stated that stated that, it is the responsibility of the facility to make sure that each resident has the right to be free from abuse, neglect, and corporal punishment of any type by anyone. The administrator also stated that they did not aware of the incident until the following day at the end of shift. The incident should have been reported imminently. They further stated that the RN #1 also failed to remove the C.N.A # 1 immediately. 10 NYCRR 415.4(b)(1)(i)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33315 Based on observation, interviews, and record review conducted during an abbreviated survey (NY00303294), the facility did not ensure that an alleged violation of physical abuse was reported immediately, but not later than 2 hours if the alleged violation involves abuse to the New York State Department of Health (NYSDOH). Additionally, the facility did not report the alleged violation of abuse to local law enforcement (LLE). This was evident for 1 out of 3 residents (Resident #1) reviewed for abuse. Specifically, Resident #1 was slapped twice on their right hand by Certified Nursing Assistant (CNA) #1 on 10/03/22 at approximately 08:30 PM. Registered Nurse (RN) #1 witnessed the abuse on 10/03/22 and reported it to the Assistant Director of Nursing (ADON) on 10/04/22 at 08:30 AM. The facility reported the violation of abuse to NYSDOH on 10/04/22 at 08:42 AM. The facility did not report the abuse to local law enforcement. The findings are: The facility Policy and Procedure titled Resident Abuse, Neglect, and Exploitation subtitled Reporting last updated 10/2022, states that all employees and contractors providing patient care must report any allegation of abuse to the administrator and the Director of Nursing immediately, but not later than two hours after being informed of the allegation. The policy also states that incidents resulting in serious bodily injury, where there is reasonable suspicion to believe that the events causing the injury to constitute a crime and/or abuse against the resident, must be reported within 2 hours after forming the suspicion, and as applicable, the local police department., Resident #1 was admitted to the facility with diagnoses including Generalized Epilepsy and Epileptic syndrome, Developmental Delays, and Cortical Blindness The Minimum Date Set (MDS, a resident assessment tool) dated 09/19/22 documented that Resident #1 had a severely impaired cognition. A progress note, Registered Nurse Supervisor (RNS) #1, dated 10/04/22, documented that Resident #1 was assessed for possible trauma to the hands. Resident #1 was stable and there were no findings or any changes to baseline. The completed investigation summary dated 10/04/22 documented that on 10/03/22 at approximately 8:30 PM, RN #1 witnessed the CNA #1 slapped Resident #1's right arm twice in a hard way. A physical assessment was done and there was no visible injury. The investigation concluded that an alleged resident abuse had occurred. The incident was reported to the appropriate state agencies. The Intake Information notes documented that the incident occurred on 10/03/22 at 08:30 PM and the submission date 10/04/22 at 08:42:42 AM. The alleged violation of physical abuse was not submitted within 2 hours to NYSDOH. There is no documented evidence that the alleged violation was reported to local law enforcement. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/23 at 1:20 PM, RN #1 was interviewed and stated that they witnessed CNA #1 slapped Resident #1 on their right hand twice. RN #1 stated Resident #1's hand was slapped hard by CNA #1. RN #1 stated that Resident #1 froze for a few seconds after being slapped. RN #1 stated that Resident #1 was unable to respond verbally as the Resident is nonverbal. RN#1 stated that they reported the incident to the supervisor the following day (10/04/22 at 08:30 AM). RN #1 said that they received abuse training and was aware that the abuse must be reported. However, RN #1 stated that they were not aware that the abuse should have been reported immediately. RN #1 stated that they received in-service on abuse when they were first hired (five months ago) and that the in-service was brief and not detailed. On 10/27/23 at 11:21 AM, the Director of Nursing (DON) was interviewed and stated that the abuse allegation was credible. The DON stated that everyone goes through an abuse training from time to time and that all the staff are aware that they should report an allegation of abuse right away. The DON said that RN #1 was supposed to report the abuse to the nursing supervisor same day, instead, RN #1 reported the abuse at the end of their shift the following day (10/04/22) and that was not good. On 10/31/23 at 12:28 PM, the Administrator was interviewed and stated that the staff received mandatory training on abuse reporting upon hire and annually. The Administrator stated that they did not report the abuse to local law enforcement because they were not sure that the abuse had occurred. The Administrator said that the incident should have been reported immediately. 10 NYC RR 415.4(b)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, interviews, and record review conducted during an abbreviated survey (NY00303294), the facility did not ensure that an alleged violation of physical abuse was reported immediately, but not later than 2 hours of the alleged violation involves abuse to the New York State Department of Health (NYSDOH). This was evident for 1 of 3 residents reviewed for abuse (Resident #1). Specifically, the facility did not report the alleged allegation of abuse of resident #1 to the NYSDOH within 2 hours when the assigned Certified Nurse Assistant (C.N.A#1) was witnessed slapping resident's arm hard, twice while the resident was reaching out to the nebulizer treatment. The findings are: The facility Policy and Procedure titled Resident Abuse, Neglect, and Exploitation subtitled States Reporting last updated 10/2022 documented that the facility staff immediately reporting all alleged violations to the Administrator and to the DNS; and when necessary, to the police and the NYS DOH within specified timeframes. A review of the intake notes with complaint# (NY00303294) documented that the incident occurrence date as 10/03/2022 at 08:30 PM and the submission date 10/04/2022 at 08:42:42 AM. The alleged violation of physical abuse was not submitted within 2 hours to New York State Department of Health (NYSDOH Resident #1 was admitted to the facility with diagnoses including Generalized Epilepsy and Epileptic syndrome, Developmental Delays, Cortical Blindness, Tracheostomy and Gastrostomy Status. The Minimum Date Set (MDS) dated [DATE] documented that Resident #1 had a severely impaired cognition. Resident #1 also required a total assist of one person when performing Activity of Daily Livings. (ADLS). On 10/19/23 at 2:00 PM, the resident was observed in the day room performing school activity. The resident appeared confused, unable to make needs known to staff. It also appeared that the resident does not have awareness of their surroundings and did not respond when called by name. Staff were present at the time of this observation. A review of Registered Nurse (RN) progress note dated 10/3/22 documented that resident # 1 was assessed for possible trauma to the hands. Resident is stable and no findings or any changes to baseline. A review of medical progress note dated 10/3/22 documented that resident #1 was assessed, no sign of trauma, bruising and or abnormal findings. Resident was noted to be within their baseline. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility completed investigation summary, dated 10/4/22 documented that, on 10/3/22 at approximately 8:30PM, the RN#1 witnessed the C.N.A #1 slapped resident #1's right arm twice in a hard way. The investigation also documented that a physical assessment was immediately completed on resident #1 and found no visible injury. Staff were interviewed and statements collected from eyewitness. The facility concluded that there is caused to believe that an alleged resident abuse had occur. The incident was reported to the appropriate state agencies and the C.N.A #1 was terminated and no longer employed with the facility. On 10/26/23 at 1:20 PM, an interview conducted the RN #1 who stated that witnessed they C.NA#1 slapped resident #1 right hand while they were preparing medications for the resident. The RN #1 also stated that the slapping was hard to the extent that the resident became frozen for a few seconds after the slap. They stated that the resident is nonverbal. The RN# stated that they did not report the incident to the supervisor until the following day. The RN also stated that they had abuse training when they were first haired, like 5 months ago but it was brief and was not detailed. The RN stated that they were not aware that abuse need to be reported within the 2 hours. On 10/27/23 at 11.21AM, an interview conducted with the DON who stated that they found the abuse allegation credible because the RN#1 witnessed it. The DON stated that everyone goes through abuse training from time to time and they all know and should report allegation of abuse right away. The DON stated that they reviewed the C.N.A# 1's employee file and there was no prior history of abuse or discipline found. On 10/31/23 at 12:28 PM, an interview conducted with the Administrator who stated that all staff going through mandatory abuse training during hire and annually. They stated that staff who witness an abuse would report it to the charge nurse and/or supervisor. They stated it was the process of the facility to report allegations of abuse to the NYSDOH within required time frames. The investigation will start right away, and the interdisciplinary team will ensure the investigation completed on a timely manner. Administrator stated an investigation is comprised of a report of what had happened, staff statements, staff interviews, and resident interviews if possible. It should also include notification of the physician and family. An assessment is also completed to assess for injury. The resident will also be referred to social services and/or psychiatry or other disciplines as needed. The Administrator stated that the RN#1 failed to remove the C.N.A immediately but waited till the following morning at end of their shift. They concluded that that they believe an abuse occurred because the RN #1 witness it and her testimony was found credible. 10 NYCRR 415.4(b)(1)(i)

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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 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** 33315 Based on observation, interviews, and record review conducted during an abbreviated survey (NY00303294, the facility did not ensure that ensure a person-centered Comprehensive Care Plan (CCP) was developed and implemented to meet resident needs. This was evident for 1 (Resident #1) of 3 total sampled residents. Specifically, a CCP related to abuse prevention was not developed for Resident #1 following a substantiated abuse allegation. The finding is: The facility policy titled CCP last revised 10/2023 documented the CCP should be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the plan of care when there is a new problem that requires that discipline to intervene. The care plan will be revised to reflect the resident's current status, need, and achievements. Resident #1 was admitted to the facility with diagnoses including Generalized Epilepsy and Epileptic syndrome, Developmental Delays, Cortical Blindness, Tracheostomy and Gastrostomy Status. The Minimum Date Set (MDS) dated [DATE] documented that Resident #1 had a severely impaired cognition. Resident #1 also required a total assist of one person when performing Activity of Daily Livings. (ADLS). On 10/19/23 at 2:00 PM, the resident was observed in the day room performing school activity. The resident appeared confused, unable to make needs known to staff. It also appeared that the resident does not have awareness of their surroundings and did not respond when called by name. Staff were present at the time of this observation. A review of the facility completed investigation summary, dated 10/4/23 documented that, on 10/3/22 at approximately 8:30PM, the RN#1 witnessed the C.N.A #1 slapped resident #1's arm twice in a hard way. The investigation also documented that a physical assessment was immediately completed on resident #1 and found no visible injury. Staff were interviewed and statements collected from eyewitness. The facility concluded that there is caused to believe that an alleged resident abuse, crime, mistreatment, or neglect had occur. The incident was reported to the appropriate state agencies and the C.N.A #1 was terminated. No longer employed with the facility. A review of (RN) progress note dated 10/03/23 documented that resident # 1 was assessed for possible trauma to the hands. Resident is stable and no findings or any changes to baseline. A review of Nurse Practitioner (NP) progress note dated 10/03/23 documented that resident #1 was assessed with no sign of trauma, bruising and or abnormal findings. Resident was noted to be within their baseline. There was no documented evidence a CCP related to abuse treatment and prevention was developed and implemented following a Resident #1 s substantiated allegation of abuse on 10/04/22. (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 05/03/2023 at 1:30PM, the Director of Nursing (DON) stated the nursing department initiate abuse prevention CCPs upon admission, quarterly, significant changes and during annual assessments. They stated that the resident was known to be at risk for self-inflicted injury and that that is why they created a care plan for injury, and to provide supportive and safe environment for the resident. The DON stated that a CCP related to abuse prevention was not initiated for Resident #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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on record review and interviews conducted during an abbreviated survey (NY00302182, NY00303936), the facility failed to ensure that comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments. This was evident in 2 (Residents #2 and #3) of 3 residents reviewed for care planning. Specifically, Resident #2's and Resident #3's comprehensive care plan (CCP) for alteration in urinary elimination were not reviewed and revised at each quarterly assessment and after a change in resident condition. The findings are: The facility policy titled Comprehensive Care Plan that was last revised on 10/2023 documented the CCP should be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the plan of care when there is a new problem that requires that discipline to intervene. The care plan will be revised to reflect the resident's status, need, and achievements. The policy further documented that the care plan will be periodically reviewed and revised by the CCP team after each assessment, and the care plan will be updated on an on-going basis. Resident #2 was admitted to the facility with diagnoses of Congenital Malformation of Corpus Callosum, Congenital Deformity of Spine, and Epilepsy. The Minimum Data Set (MDS, a resident assessment tool) dated 10/17/22 documented that Resident #2 had severely impaired cognition. The MDS documented that Resident #2 was always incontinent of urinary bladder. A Nursing Note dated 09/11/22 at 6:14 PM documented that warm compress was applied by Licensed Practical Nurse #1 (LPN #1) to Resident #2's lower abdomen to encourage urination. A CCP for alteration in urinary elimination was initiated for Resident #2 on 09/20/14. Further review of the CCP revealed no documented evidence that it was reviewed and revised at each quarterly assessment or change in condition. Resident #3 was admitted to the facility with diagnoses of Congenital Laryngomalacia, Epilepsy, and Dysphagia. The MDS dated [DATE] documented that Resident #3 had severely impaired cognition. A CCP for alteration in urinary elimination for Resident #3 was initiated on 10/18/22. There was no documented evidence that the CCP was reviewed and revised at each quarterly assessment after 10/18/22. (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 on 10/31/23 at 2:30 PM, Registered Nurse Supervisor #1 (RNS #1) stated that the RN is responsible to initiate, review, and revise care plans. RNS #1 stated that CCPs are reviewed and revised quarterly, during annual assessments, and when there are significant changes. RNS #1 could not explain why the care plans were not reviewed and revised. During an interview on 10/31/23 at 2:55 PM, the Administrator stated that the CCP identified that Resident #2 and Resident #3 were at risk for urinary incontinence. The Administrator stated that with the new Electronic Medical Record (EMR), some of the CCP's were not revised. The Administrator stated that these care plans will be revised to reflect the resident's status, need, and achievements. 415.11(c)(2)(i-iii)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33315 Based on observation, record review, and interviews conducted during an abbreviated survey (NY00302182 and NY00303936), the facility did not ensure that residents were free from accidents. This was evident for 2 out of 3 residents (Resident #2 and #3) reviewed for accident. Specifically, 1.) Resident #2 was observed with redness to the right lower abdomen, by Certified Nursing Assistant (CNA) #3, on 09/11/22. The facility Investigation Summary dated 09/13/22 documented that Licensed Practical Nurse (LPN) #1 applied a hot compress to Resident #2's right lower abdomen to elicit elimination. LPN #1 left Resident #2's room and did not monitor the hot compress. As a result, Resident #2 sustained redness to the abdomen. Vitamin A & D Ointment was applied. Additionally, there was no Physician's Order for the use of the hot pack. 2.) Resident #3 was observed with a blister to the upper right thigh on 10/17/22 at 2:57 PM. The facility's Investigation Summary documented that Registered Nurse (RN) #5 placed a hot pack on Resident #3's right thigh on 10/17/22 at approximately 7:00 AM. There was documented evidence that the hot pack was monitored as per the facility's policy and Resident #3's plan of care. Additionally, a Physician's Order dated 09/15/22 documented instructions to apply a warm pack to Resident #3's suprapubic area if no void greater than 12 hours. The order did not indicate the duration and frequency. The findings are: The facility's Policy and Procedure titled, Heat and Cold Application dated 10/2022 documented the following: It is the policy of the facility that the application of heat or cold to treat a designated area be prescribed by the provider. The Heat Therapy is prescribed to promote comfort by stimulating the circulation to promote localization of purulent matter in tissues. The policy further documented that there will be a physician order for the use of hot pack and will be apply by the Registered Nurse (RN). Hot pack should be covered with a barrier. The hot pack should be removed, and the site assessed. The hot pack should be re-applied every 5minutes. After 20 minutes, terminate treatment and dry the skin. Do not leave patient unattended when pack is in use. Resident #2 was admitted to the facility with diagnoses that include Congenital Malformation of Corpus Callosum, Congenital Deformity of Spine, and Epilepsy. The Minimum Data Set (MDS, a resident assessment tool) dated 10/16/22 documented that Resident #2 had severely impaired cognition. A nursing note dated 09/11/22 at 6:14 PM documented that a warm compress wrapped in wipes was applied to Resident #2's lower abdomen to encouraged voiding. The warm compress caused redness to the lower right abdomen. A Progress Note, written by Registered Nurse (RN) #3, dated 09/11/22 documented that Resident #2 was assessed, and redness was observed to their lower abdomen. Nursing staff will continue to treat with Vitamin A and D Ointment as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33A081	A. Building B. Wing	11/10/2023

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St Marys Hospital for Children	29 01 216 Street Bayside, NY 11360

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan dated 09/12/22 documented that Resident #2 was observed with a pinkish, reddish, whitish, and blister-like area to the right lower abdomen. A Medical Progress Note (written by Nurse Practitioner) dated 09/12/22 documented that Resident #2 was examined and observed with erythema and peeling skin to the lower right side of their abdomen. Vitamin A and D Ointment to be applied as needed. An Investigation Summary dated 09/13/22 documented that Resident #2 was observed with redness to the right lower abdomen on 09/11/22 at 2:31 PM. The investigation also documented that LPN #1 placed a hot pack wrapped in a washcloth to Resident #2's right lower abdomen and left the room. The investigation also documented that on 09/12/22, there were no signs and symptoms of distress or pain observed. Further assessment revealed a pinkish white/scale like area and the doctor was notified. The investigation concluded that neglect had occurred. A Medical Note (written by Nurse Practitioner) dated 10/25/22 documented that the blistered area of Resident #2's skin is showing improvement and appears to be healing well. The plan includes Dermaphor Ointment to be applied. There was no Physician's Order for the hot compress that was applied to Resident #2's abdomen on 09/11/22. There was no documented evidence that the hot pack was removed, the site was assessed or that the hot pack was re-applied every 5 minutes as needed. There was no documented evidence that the hot pack treatment was terminated after 20 minutes. On 10/19/23 at 1:45 PM, an interview was conducted with CNA #3 who stated that they were assigned to Resident #2 on 09/11/22 on the morning shift (6:00 AM to 2:00 PM) and they observed a blister on Resident #2's lower abdomen and reported it to LPN #1. On 10/19/23 at 2:28 PM, an interview was conducted with the LPN #1 who was assigned to Resident #2 on 09/11/22 on the morning shift (7:00 AM to 2:00 PM). LPN #1 stated that Resident #2 did not void for over 12 hours and that they notified the Nurse Practitioner (NP) #1 who gave LPN #1 a verbal order to apply a hot pack to Resident #2's suprapubic area. LPN #1 could not recall what time they applied the hot pack to Resident #2. LPN #1 stated that the NP did not give them any instructions on how long the hot pack should remain in place, but that they monitored the hot pack every 5 to 10 munities. LPN #1 stated that it is a usual practice at the facility that if a resident does not void after 12 hours, the staff would place a warm compress to the suprapubic area to promote voiding. LPN #1 stated that CNA #3 reported that Resident #2 had redness to the skin, and they reported the redness immediately to the NP. On 10/20/23, at 10:00 AM, an interview was conducted with NP #1 who stated that they gave a one-time verbal order to LPN #1 on 09/11/22. NP #1 stated that it is the practice at the facility to use warm compress on a resident lower abdomen to aide urination. NP #1 stated that the practice is preferred over catheterization to avoid complications. NP #1 stated that there might have been an order prior to the new Electronic Medical Record (EMR) system, however, NP #1 stated that they reviewed the orders and found that there was no order for the hot pack. (continued on next page)

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	33A081	A. Building B. Wing	11/10/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/23 at 10.42 AM, an interview was conducted with Registered Nurse Supervisor (RNS) #3 who stated that a Physician's Order is required for the use of a hot pack. RNS #3 stated that this was the first time Resident #2 sustained a burn from the hot pack. RNS #3 stated that the hot pack should have been wrapped in a paper towel before placing the hot pack on the resident. RNS #3 stated that they assessed Resident #2 the following day (09/12/22) after the incident and Resident #2's lower abdomen was red, puffy, and had a small blister. RNS #3 said that the area was tender to touch, and that Resident #2 flinched when the area was touched. RNS #3 stated that the hot pack was removed from the unit. Resident #3 was admitted to the facility with diagnoses including Congenital Laryngomalacia, Epilepsy, and Dysphagia. The Minimum Data Set (MDS, a resident assessment tool) last quarterly assessments dated 06/20/22 documented that Resident #3 had a severely impaired cognition. A View Order Detail (Physician's Order) dated 09/15/22 documented instructions to apply a warm pack to suprapubic area if no void greater than 12 hours. The order did not indicate the frequency and the duration for the use of the warm pack. An Item Detail (Resident #3's Plan of Care) dated 09/15/22 documented apply warm pack to suprapubic areas if no void greater than 12 hours. The plan documented instructions that the warm pack should be removed after 30 seconds to observe an initial skin response to the therapy. The area should be assessed for tolerance of the warm compress. It is also documented that when the warm compress is in use, it should not be left unattended. The warm pack should have been replaced every 5 minutes as needed and the treatment should have been terminated after 20 minutes. There was no documented evidence that the instructions in the Resident #3's plan of care were followed. An Investigation Summary dated 10/17/22 documented that RN #5 placed a hot pack on Resident #3's upper right thigh at 7:00 AM to elicit elimination. The investigation documented that at 2:57 PM, Resident #3 was observed with a blister on the upper right thigh by CNA #2. The facility concluded that the blister was a result of the hot pack meeting Resident #3's skin. The investigation also concluded that abuse or mistreatment did not occur, and that the incident was an accident. An Item Detail - Plan of Care dated 10/17/22 documented that Resident #3 was observed with a blister to right upper thigh and Bacitracin was started. A Medical Progress Note (written by Nurse Practitioner #2) dated 10/17/22 documented that a Registered Nurse (RN) reported that Resident #3 was observed with a blister on the right thigh and that a hot pack was placed during the morning. Skin assessment revealed a 2x2 centimeter (cm) serous-filled blister at Resident #3 right anterior thigh. The assessment also documented that the blister was likely a second degree burn from the hot pack. The blistered was cleansed and drained and Bacitracin Ointment to apply. (continued on next page)

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	33A081	A. Building B. Wing	11/10/2023

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/01/23 at 02:27 PM, an interview was conducted with RN #3 who was assigned to Resident #3. RN #3 stated that they applied a hot pack to Resident #1 at around 7:00 AM on 10/17/22 and monitored the hot pack every 10 to 15 minutes. RN #3 stated that they applied and removed the hot pack within 10 to 20 minutes but does not recall what time they removed the hot pack. RN #3 stated that a Physician's Order is required for the use of a hot pack and that the hot pack should be wrapped in a towel before placing it on the resident. RN #5 stated that they wrapped the hot pack in a pillowcase and placed it on Resident #3. On 11/01/23 at 01:47 PM, an interview was conducted with CNA #4. who stated that they worked on 10/17/22 from 2:00 PM to 10:00 PM. CNA #4 stated that they observed a water bubble (blister) on the lower abdomen of Resident #3 and reported it to RN #3. CNA #4 stated that they do not recall the time, but that the hot pack was not on Resident #3's lower abdomen at the time the blister was observed. On 10/31/3 12:02 PM, an interview was conducted with NP #2 who stated that they examined Resident #3 on 10/17/22 and observed a blister on Resident #3's right thigh. NP #2 stated that they believed the warm pack caused the blister. NP #2 said that the hot pack was used to enhance urine output from Resident #3. NP #2 stated that they concluded that the burn appeared to be secondary burn. NP #2 stated that the nurses know how to apply and when to remove the hot pack. NP #2 also said that the hot pack gets cold within 10 minutes after the hot pack is broken. On 10/27/23 at 11:21 AM, an interview was conducted with the Director of Nursing (DON) who stated that Resident #3 had an order for a hot pack, but that Resident #2 did not have an order. The DON stated that the Physician's Order for Resident #3 did not indicate how long the hot pack should have remained in place. The DON stated that Resident #3 had a second degree burn as it was a blister. On 10/31/23 at 2:45 AM, an interview was conducted with the Administrator who is also a RN. The Administrator stated that it is the policy of the facility that the application of heat or cold to treat a designated area must be prescribed by the provider. The administrator stated that the hot pack should be covered with a barrier before applying. The Administrator further stated that they cannot explain why the protocol was not followed. The hot pack should be removed, and the site assessed. The hot pack should also be re-applied every 5minutes and removed after 20 minutes. 10 NYC RR 415.12(h)(1)(2)