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	03/31/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that alleged violations involving neglect, was reported immediately, but not later that two (2) hours after the allegation is made, if the events that caused the allegation involved or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not result in serious bodily injury, to the administrator of the facility of the facility and to other officials (including to the State Agency and adult protective services where state law provides for judications in long term care facilities). This was evident for one (1) out of six (6) residents sampled (Resident #1) for respiratory care. Specifically, on [DATE] at 8:58 AM, facility staff neglected the resident by not responding to the resident alert alarm indicating that the resident oxygen levels were decreasing and failed to provide timely assessment of the resident resulting in the resident being unresponsive with gray skin. Cardiopulmonary resuscitation was initiated, and the resident was transferred to the hospital and was determined to have no brain activity. On [DATE], life support was terminated, and the resident expired. The incident occurred on [DATE] and the Administrator was notified on [DATE]. The New York State Department of Health was notified on [DATE], four (4) days after the event occurred.The findings are:The facility's policy and procedure, titled Reporting to State Agency and Other Entities/Individuals last reviewed 12/2025 states that all alleged/suspected violations of all substantiated incidents will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. The procedure documented should an alleged/suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, abuse, or qualified Department of Health reportable event be reported. The hospital Administrator, or his/her designee, will promptly notify the following persons or agencies of such incident: The State Survey Agency responsible for surveying/licensing the facility, the Office of Professions [if appropriate] and law enforcement officials [if appropriate]. Notices to the above agencies/individuals shall be made no later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury. All other events that cause suspicion that do not result in serious bodily injury shall be done within 24 hours. The report is to be made to the Department of Health using the electronic submission survey.The facility's policy and procedure, titled Pulse Oximetry created 01/2020, reviewed 12/2025 includes the escalation pathway for responding to alerts/alarms.Resident #1 was admitted to the facility with diagnoses that include spastic quadriplegic cerebral palsy (a neurological condition that causes increased muscle tone (spasticity) and stiffness, affecting all four limbs and the face), severe hypoxic ischemic encephalopathy (a critical brain injury in newborns caused by significant oxygen deprivation or restricted blood flow) chronic respiratory failure.The Minimum Data Set (a resident assessment tool) dated [DATE] identified that the resident was severely cognitively impaired. The resident was totally dependent on staff for all activities of daily living.A review of the facility's summary of investigation initiated on [DATE] revealed that the facility conducted a thorough investigation and concluded that no abuse, mistreatment, or neglect occurred rather there was a deviation from facility policy and procedure regarding responding to PSS Phone (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alarms.During an interview on [DATE] at 4:17 PM, the Director of Nursing stated they were notified of the Code Blue and the resident being transferred to the hospital. They were not aware that nursing staff did not respond to the alerts or assess the resident timely until they reviewed the alert system report and interviewed the staff. They stated they were unaware the incident should have been reported to New York State Department of Health and that it is the Administrator's responsibility to report incidents to the Department of Health.During an interview on [DATE] at 5:16 PM, the Administrator stated they were in the facility on [DATE] and was not notified of the Code Blue. They stated the Chief Medical Officer notified them on [DATE] about the incident and the Code Blue. The Administrator stated during an administrative meeting on [DATE] they were made aware of the incident involving the Registered Nurses and Respiratory Therapist not responding promptly to the Vocera alarm. The Administrator stated in the meeting they informed the Director of Nursing that the incident was reportable to the New York State Department of Health, and they proceeded with the submission. The Administrator stated they are now included in the Code Blue debriefing. The Administrator stated they instructed the Assistant Directors of Nursing, the Nursing Supervisors and Respiratory Director to report all incidents to the Administrator directly.10 New York Codes, Rules, and Regulations 415.4(b)(2).

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who required respiratory care, including tracheostomy (a surgically created opening called a stoma in the front of the neck leading into the windpipe (trachea) to help a person breathe) care, received services consistent with professional standards of practice and the comprehensive person-centered care plan. This deficient practice was evidenced by the facility's nursing and respiratory therapy staff's failure to respond to critical oxygen saturation alarms for one (1) of six (6) residents (Resident #1) sampled for respiratory care. Specifically, on [DATE] at 8:58 AM, the resident's oxygen saturation dropped to 84%. A mobile alert was transmitted sequentially to Registered Nurses #1, #2, #3, and Respiratory Therapist #1. From 8:58 AM - 9:23 AM, the assigned staff failed to respond to the alarm or perform a clinical assessment of the resident. The alarm cycle continued for 25 minutes without intervention. At 9:23 AM, a second alert was triggered when saturation levels reached 52%, Registered Nurse #4 (not assigned to the resident) responded after hearing the alarm while near the room. Registered Nurse #4 discovered Resident #1 unresponsive with gray skin. A Code Blue was activated, and although a pulse was briefly restored via cardiopulmonary resuscitation, the resident was transferred to the hospital and determined to have no brain activity. On [DATE], life support was terminated, and the resident expired. This failure resulted in actual harm and Immediate Jeopardy to Resident #1, who expired following a period of unresponsiveness and brain death, and placed 105 residents connected to the vital signs and respiratory alert systems at risk.The findings are:The facility's policy and procedure, titled Pulse Oximetry created on 01/2020, reviewed 12/2025 to include the escalation pathway. Clinical alerts will be delivered to nursing staff via Vocera devices (handheld communication devices) as per oxygen and pulse rate parameters ordered by medical providers. The primary nurse will receive the first notification/alert. The secondary notification is sent to the Nurse Buddy if not acknowledged by the Primary Nurse. The third escalation point is the clinician designated as the backup depending on the alarm type if not acknowledged by the Nurse Buddy. Charge nurse (third nurse) will receive both alerts (SpO2 and pulse). Respiratory therapists will only receive SpO2 (oxygen saturation).Resident #1 was admitted to the facility with diagnoses that include spastic quadriplegic cerebral palsy (a neurological condition that causes increased muscle tone (spasticity) and stiffness, affecting all four limbs and the face), severe hypoxic ischemic encephalopathy (a critical brain injury in newborns caused by significant oxygen deprivation or restricted blood flow) chronic respiratory failure.The Minimum Data Set (a resident assessment tool) dated [DATE] identified that the resident was severely cognitively impaired. The resident was totally dependent on staff for all activities of daily living.A review of the Care Plan titled, Respiration Alteration, initiated on [DATE], identified the resident with tracheostomy and pulse oximeter noted in place with oxygen saturation level parameters set for an alert below 92%.A physician's order dated [DATE] ordered mechanical ventilation, continuous positive airway pressure to tracheostomy collar 12:00 AM to 8:00 AM and humidified trach collar oxygen 8:00 AM to 12:00 AM. It is also documented to maintain oxygen saturation above 92%.A review of the facility's investigation form dated [DATE] revealed that the facility conducted an investigation into the incident and concluded that staff failed to respond to alarms. The report documented that there was a failure of staff to appropriately acknowledge and review alerts. It also concluded that there was a failure by nursing and respiratory therapy staff to maintain accessibility to required communication devices and failure to escalate when they were occupied or unable to respond to the alert. The report specified Registered Nurse #1, Registered Nurse #2, Registered Nurse #3 and Respiratory Therapist #1 as having failed to respond to the alert and assess the resident.A review of the facility's video surveillance footage revealed that on [DATE] at 9:22 AM, Registered Nurse #4 entered Resident #1's room.A review of the facility's staffing sheet dated [DATE] for Unit 4C reported a census of 25 residents and documented five (5) registered (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	nurses from 7:00 AM to 7:30 PM. Registered Nurse #1 worked until 3:30 PM and was relieved by another nurse. Staffing sheet revealed there were five (5) registered nurses and seven (7) certified nursing assistants on the unit at the time of the incident and one (1) respiratory therapist scheduled for that shift.A review of the Call Point Detailed Activity Report dated [DATE] revealed the time each nurse and the respiratory therapist received an alert on their Patient Safe Solutions (mobile phone). The report revealed that at 8:58 AM, Resident #1's oxygen saturation levels dropped to 84% and an alert was sent to Registered Nurse #1, at 8:59 AM an alert was sent to Registered Nurse #2, and at 9:01 AM an alert was sent simultaneously to Registered Nurse #3 (unit charge nurse) and Respiratory Therapist #1. The report indicated that Registered Nurse #1 pressed Accepted on their device at 9:04 AM, again when it alerted at 9:17 AM, and again when it alerted at 9:18 AM, all for decreased oxygen saturation levels. A review of nursing notes on [DATE] did not include documentation from Registered Nurses #1, #2, or #3 indicating that they responded to the alerts or assessed the resident in response to the decreased oxygen saturation levels. During a telephone interview on [DATE] at 11:00 AM, Registered Nurse #1 stated they were the primary registered nurse assigned to the care of Resident #1 on that day. They acknowledged that on [DATE] at 8:58 AM, they received an alert on their Patient Safe Solutions phone from Resident #1's pulse oximeter. Registered Nurse #1 stated at that time they were unable to accept or escalate the alert because they were assisting another resident. Registered Nurse #1 stated they expected the other assigned staff (Registered Nurse #2, Registered Nurse #3, or Respiratory Therapist #1) to respond to the alert since they could not. Registered Nurse #1 stated they recalled accepting the alert once but did not go to the room to assess the resident. Registered Nurse #1 stated that they were unaware activating the accept would end the alerts. Registered Nurse #1 stated they did receive training when they were hired but could not recall a more recent in-service on the alert system.A review of in-service records revealed that nursing and respiratory staff were trained on [DATE] on Vocera Edge Alerts and Alarms systems. Registered Nurse #1 was hired on [DATE] and received training upon hire. Registered Nurse #2 was hired on [DATE] and received training on [DATE]. Registered Nurse #3 was hired on [DATE] and received training on [DATE]. Respiratory Therapist #1 was hired on [DATE] and received training upon hire.During an interview on [DATE] at 1:00 PM, Registered Nurse #2 (buddy nurse) stated they could not recall hearing the alert. They stated they can recall administering medications, and the schedule was hectic that day. They stated that they were unaware Resident #1 was in distress until they heard the rapid response, and they went to assist. Registered Nurse #2 stated they were in-serviced on using the alert phone on orientation and recently after the incident on [DATE].During an interview on [DATE] at 12:37 PM, Registered Nurse #3 (charge nurse) stated that they did receive the alert and did not respond timely. They stated that they expected a response from the primary nurse (Registered Nurse #1) or buddy nurse (Registered Nurse #2). Registered Nurse #3 stated they and the buddy nurse went to the resident's room when rapid response was announced. They stated that they received an in-service on the pulse oximetry policy and training to use the Patient Safe Solutions (phone). Registered Nurse #3 stated they met with the Human Resources Director, the Director of Nursing, and their union representative on [DATE] to discuss the incident and received a written warning. They stated that they were taken off duty until [DATE] and were required to complete in-service prior to assignment.During an interview on [DATE] at 12:03 PM, Registered Nurse #4 stated they were not assigned to Resident #1 but while passing their room, they heard an alarm and went into the room to check Resident #1. Resident #1 was sitting in a chair, skin appeared gray, and they were unresponsive. Registered Nurse #4 stated they activated rapid response and Registered Nurse #5 responded. Both nurses returned Resident #1 to bed and Registered Nurse #5 started chest compressions. Registered Nurse #5 stated Code Blue (part of rapid response activity) was activated at 9:23 AM and the team arrived. They stated emergency medical service was called and responded at 9:44 AM. They stated Resident #1 regained a pulse, was connected to the respirator, and transferred to the hospital.During a telephone interview on [DATE] at 12:36 PM, Respiratory Therapist #1 stated (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	they worked per-diem at the facility since 02/2025. Respiratory Therapist #1 stated they were trained on the Patient Safe Solution system (mobile devices to send alerts) during orientation. Respiratory Therapist #1 stated they worked on [DATE] in the morning and at 8:15 AM they did rounds and Resident #1 was on continuous positive airway pressure overnight and tracheostomy collar during the daytime. Respiratory Therapist #1 stated they assessed, suctioned, and placed the tracheostomy collar on Resident #1. Respiratory Therapist #1 stated that when they were finished, certified nursing assistants came in the room to provide morning care to Resident #1. Respiratory Therapist #1 stated Resident #1's oxygen saturation was 96% and they were comfortable. Respiratory Therapist #1 stated they were in the room when Resident #1 was taken out of bed to the wheelchair. Respiratory Therapist #1 received the alert on the mobile device but was busy with other residents and expected the other staff to respond. Respiratory Therapist #1 stated when they heard the rapid response overhead, they went to the room and Resident #1 was in their wheelchair. Respiratory Therapist #1 stated they used the Ambu bag (artificial manual breathing unit) on Resident #1 and checked their tracheostomy. Respiratory Therapist #1 remained at the bedside during the Code Blue and placed Resident #1 on the ventilator with pressure control settings that were ordered. Respiratory Therapist #1 stated they met with their manager and Director of Human Resources on [DATE]. They were instructed to see their manager on [DATE] when they return to work.During an interview on [DATE] at 3:20 PM, the Nurse Educator stated, if the primary nurse does not answer the alarm, it escalates to the buddy nurse, and if no response, it escalates to the charge nurse and the respiratory therapist. They stated that the settings for the Vocera Edge Alerts and Alarms Training system are View, Accept, Escalate. The Nurse Educator stated if nothing is done (not accepted), the system will escalate and alarm again in 75 seconds. The Nurse Educator stated, on [DATE] at 8:58 AM, the alarm went off and Registered Nurse #1 got an alert alarm in 15 seconds, no response in 75 seconds so the alert went to Registered Nurse #2 (buddy nurse). No response, and the alert went to Registered Nurse #3 (charge nurse) and Respiratory Therapist #1. If escalate is pushed, the alert goes to the buddy nurse immediately. The Vocera system alarm is audible in the room and close by in the hallway. The Nurse Educator stated the Vocera (hands free wearable communication device) system was launched in 2020, and nursing and respiratory staff were trained. There was a re-education in 2024, and training launched [DATE] after the incident. The Nurse Educator stated that the facility did not offer annual in-service for the Vocera Alert and Alarm.During an interview on [DATE] at 11:35 AM, the Chief Medical Officer explained that residents with respiratory and cardiac issues are equipped with pulse oximeters linked to the Vocera monitoring system, which alerts staff when vital signs fall outside of set parameters. Specifically, Resident #1 had a physician's order for alarms to activate when oxygen saturation levels exceeded 92% or dropped below 84%. The Chief Medical Officer noted that when these levels were not within range, the Vocera system triggered alarms both at Resident #1's bedside and on the mobile devices of nursing and respiratory staff. However, a delay in responding to these alerts led to a postponement in assessing Resident #1, which could have resulted in the critical intervention for a Code Blue situation.During an interview on [DATE], at 4:17 PM, the Director of Nursing recounted the incident from [DATE], when they were on their way to the facility and received a call from the Nurse Educator about a Code Blue involving Resident #1. The Nurse Educator reported that Resident #1 had regained their heart rate and was subsequently transported to the hospital. Upon arriving at the facility, the Director of Nursing checked the Vocera (hands free wearable communication device) alerts and found that Registered Nurse #1 had accepted the alarms three (3) times, which halted the notifications to Registered Nurse #2, the charge nurse (Registered Nurse #3), and Respiratory Therapist #1. The alarms later cycled again, and a review of hallway video footage showed that Registered Nurse #1 did not assist Resident #1. When the Director of Nursing interviewed Registered Nurse #1 on [DATE], they claimed they were attending to another resident and had only acknowledged the alarms on their Patient Safe Solution device. Registered Nurse #2, who was administering medications at the time, assumed that Registered Nurse #1 had responded when the (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	alarms ceased. Similarly, Registered Nurse #3 (charge nurse) also did not respond after the alarms stopped. Following these interviews, the Director of Nursing and the Director of Human Resources met with Registered Nurses #2 and #3 and provided them with written counseling for their lack of response to the alarms. Both nurses received three (3) days of administrative leave and were required to complete mandatory Vocera Edge training upon their return. Additionally, all nursing and respiratory staff were scheduled for Vocera in-service training from [DATE] to [DATE]. The Director of Nursing emphasized the need for increased diligence in reviewing and instructing staff on the pulse oximetry policy, along with additional education through mock codes throughout the year.During an interview on [DATE] at 5:16 PM, the Administrator reported that they were present at the facility on [DATE] but were not informed about the Code Blue incident until they were notified by the Chief Medical Officer on [DATE]. The Administrator learned about the delayed response of the registered nurses and respiratory therapist to the Vocera alarm during an administrative meeting on [DATE]. They advised the Director of Nursing that the incident needed to be reported to the New York State Department of Health, and the necessary submission was made. The Administrator also mentioned that they are now part of the Code Blue debriefing process and have directed the assistant directors of nursing, nursing supervisors, and the respiratory director to report all incidents directly to them.During an interview on [DATE] at 4:00 PM, Director of Quality stated they reviewed the Quality Assurance Performance Improvement Plan with the committee members and conduct quarterly meetings. They stated areas for improvement are evaluated by using the Plan Do Study Act performance improvement model and a fish bone Root Cause analysis is further used to analyze the deficient practice. The Director of Quality stated they currently conduct monthly audits for compliance with following physician orders to set respirator and pulse oximeter parameters. They stated based on the incident on [DATE], they are planning audits to monitor the two (2) steps in the process of response and action to alarms/alerts. First step, review the alert system report for time alarm initiated and time it took clinician to respond. Second step, check for escalation and accepted. In addition, observe when clinicians are at residents' bedside.Based on the corrective actions taken by the facility there was sufficient evidence that the facility corrected the identified non-compliance and was in substantial compliance for this specific regulatory requirement on [DATE], prior to surveyor's onsite visit on [DATE].10 New York Codes, Rules and Regulations 415.12(k)(4,6)Corrective actions taken by the facility as of [DATE]Review of the camera footage (8:43 AM to 10:02 AM), Patient Safe Solution phone verification notifications, pulse oximetry policy.Re-education to involved staff on the pulse oximetry alarm response, notification handling and escalation expectations.Voice alarm presentation sent via email to all assistant nurse managers/assistant directors of nursing to review during evening huddle [DATE] and morning huddle [DATE].Enforce that Vocera device functionality was reviewed, and staff were instructed to ensure devices always remain accessible and operational.IT/MIS checked and confirmed monitoring equipment to be functioning properly.Disciplinary action to the staff involved - three (3) registered nurses and one (1) respiratory therapist.A root cause analysis was discussed on [DATE] and formally initiated on [DATE].Review and revision of pulse oximetry policyLeadership oversightAn audit for alert response time audit to be implemented.