STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335141	A. Building B. Wing	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerge Nursing and Rehabilitation at Glen Cove	2 Medical Plaza Glen Cove, NY 11542

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 34798 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00307267) initiated on 9/18/2023 and completed on 9/25/2023, the facility did not ensure each resident was provided care that meets professional standards of practice. This was identified for one (Resident #191) of two residents reviewed for Urinary Catheter. Specifically, Resident #191's Foley catheter was removed on 12/1/2022 for a void trial (assesses the ability of the bladder to empty). The resident was not monitored and assessed timely after the Foley catheter was removed to determine the trial void outcome. The finding is: The facility's policy titled Voiding Trial, effective 12/1/2020, documented the nurse will obtain a physician's order to discontinue the Foley catheter and start a voiding trial; parameters for re-insertion of Foley catheter will be designated by a physician if needed; monitor output every shift for 24 hours; monitor residual output via bladder scan for 24 hours. If greater than 300 milliliters (ml) is noted, then perform straight catheterization (a tube used to empty urine from bladder intermittently) and notify the physician. Resident #191 was admitted with diagnoses including Cancer, Obstructive Uropathy, and Parkinson's Disease. The 10/13/2022 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderately impaired cognition. The MDS documented the resident had an indwelling urinary catheter. A physician's order dated 11/1/2022 documented Foley Catheter Size 16 French for diagnosis of Retention of Urine. A urology consult dated 11/3/2022 documented to start a void trial on 12/1/2022 at 6 AM; an office visit was scheduled for 12/1/2022 in the afternoon. A nursing progress note dated 11/3/2022 documented the resident went to a Urology appointment on 11/3/2022 and returned to the facility alert and oriented, with no complaint of discomfort or nausea. As per the consult resident's Foley catheter was changed. Recommendations included starting a void trial on 12/1/2022 at 6 AM and the office visit was scheduled on the same day on 12/1/2022 in the afternoon. The Physician Assistant (PA) was notified. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 11/3/2022 documented to remove the Foley Catheter and to start a void trial, start date 12/1/2022 at 12:00 AM. A physician's order dated 12/1/2022, entered at 3:23 PM, documented to obtain a Bladder Scan every 8 hours for 72 hours, at 6:00 AM, 2:00 PM, and 10:00 PM for 3 days. There were no parameters documented in the order for re-catheterization. A nursing progress note dated 12/1/2022 at 8:08 AM documented, the resident was alert and verbally responsive. To start voiding trials this morning. The Foley catheter drained 600 cubic centimeters (cc) of dark amber urine. The Foley catheter was removed at 4:45 AM. No hematuria (blood in the urine) and no complaint of pain or discomfort. Continue to monitor urine output. Endorsed to day nurse. There were no further nursing progress notes until 12/2/2022 at 3:17 AM. A review of the Treatment Administration Record (TAR) for December 2022 documented no entry for the Bladder Scan on 12/1/2022 until 10:00 PM. The nurse's initials were entered; however, no urine volume was documented. The 24-hour report for 12/1/2022, 7:00 AM-3:00 PM shift, documented status-post Foley [removal], bladder scan every shift, urine noted this shift. There was no documentation if the Bladder Scan was performed; the amount of urine voided; or if the resident was assessed after the resident's Foley catheter was removed. The 24-hour report for 12/1/2022, 3:00 PM-11:00 PM shift, documented a Bladder Scan was completed with 230 ml (residual amount of urine in the bladder). There was no documentation of an assessment of the resident and no corresponding nurses progress notes. A medical progress note written by PA #1 dated 12/1/2022 at 12:53 PM documented the resident had the Foley catheter removed for a pending urology appointment; unfortunately, the appointment was moved from 12/1/2022 to 12/8/2022. The resident stated that they (resident) would like to leave the Foley catheter out; a bladder scan every shift (every 8 hours) was ordered. A nursing progress note dated 12/2/2022 at 3:17 AM documented the resident was in bed with a call bell within reach. The resident complained of a pain level of 6 out of 10 on the pain scale (zero being the lowest pain level and 10 being the highest level on the pain scale) in the pelvic areas. The void trial was in progress status post Foley catheter removal. The bladder was scanned at 3 AM and showed 576 cc of urine in the bladder. The pelvic and lower abdomen regions were hard to touch and distended. The resident was told to try to urinate on their own. The resident was unable to urinate. Straight catheter insertion was explained and the resident was agreeable. A straight catheter was inserted and 700 cc of yellow urine with sediment was obtained. The catheter was removed and the resident verbalized feeling relieved after the procedure. A medical progress note dated 12/2/2022 at 9:28 AM written by PA #1 documented the staff reported that the resident needed to be straight catheterized last night. They (PA #1) spoke with the resident, and the resident understood that if they (resident) needed a straight catheter again, a Foley catheter would be placed. The resident denied any other issues or concerns but was frustrated that they may need the Foley catheter again. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 12/2/2022 at 5:32 PM documented resident continued on void trial, and has a directive to re-insert the Foley catheter if the resident retains greater than 500 milliliters (ml) of urine as the resident had been straight catheterized one time during this void trial. The resident was drinking fluids as instructed. The urology appointment was scheduled for 12/8/2022. PA #1 was interviewed on 9/20/2023 at 11:40 AM and stated the void trial for Resident #191 was started on 12/1/2022 so that the Urologist could assess the resident at the scheduled appointment later in the day. PA #1 stated the facility found out that the appointment was changed to 12/8/2022 after the resident's Foley catheter was removed. The resident did not go to the Urologist on 12/1/2022 as previously scheduled. PA #1 could not recall why the resident's urology appointment was changed or who had notified PA #1 of the appointment change. Registered Nurse (RN) #4, the 11:00 PM-7:00 AM RN Supervisor who wrote a progress note on 12/1/2022 at 8:08 AM, was interviewed on 9/21/2023 at 8:13 AM. RN #4 stated they did not remember if they (RN #4) or another nurse removed Resident # 191's Foley catheter on 12/1/2022 at 4:45 AM. RN #4 stated there should have been documentation in the progress notes or the TAR regarding the bladder scan being performed during the 7:00 AM- 3:00 PM shift. RN #4 further stated the documentation should also include how the resident tolerated the removal of the Foley catheter and the amount of urine output obtained after the Foley catheter was removed. The Director of Nursing Services (DNS) was interviewed on 9/21/2023 at 11:39 AM and stated after the Foley catheter was discontinued for Resident #191, the physician's orders for the void trial and bladder scan should have included parameters including when to re-catheterize the resident based on urinary output or bladder scan results. PA #1 was re-interviewed on 9/22/2023 at 8:33 AM and stated they do not put the orders in the Electronic Medical Record (EMR). PA #1 stated they always understood as a standard of practice, nurses know they have to monitor and re-insert the catheter if the bladder scan result is 500 ml or greater urine residual in the bladder. RN #6, the unit Supervisor who entered the bladder scan order in the EMR on 12/1/2022, was interviewed on 9/22/2023 at 11:15 AM. RN #6 stated the doctor or a medical practitioner is supposed to define what the parameters are for re-insertion of the Foley catheter in the bladder scan order, because the parameters are tailored per the resident. RN #6 stated that Resident #191's physician's order did not include any parameters. RN #6 stated the directive to reinsert the Foley catcher would have to come from the PA or the doctor. RN #6 stated there is a treat in place order that nurses understand that the resident should be straight catheterized when the bladder scan shows 300 ml of urine in the bladder; however, there was a verbal directive from the PA to catheterize Resident #191 when the bladder scan showed 500 ml of residual urine. There was no documented physician's order that indicated to re-catheterize the resident if the bladder scan showed 500 ml or more of residual urine in the bladder. The DNS was re-interviewed on 9/22/2023 at 2:30 PM and stated urine output is hard to measure if a resident is incontinent, but there should have been a bladder scan done on the 7:00 AM-3:00 PM shift. The DNS also stated if the directive was to catheterize the resident when the bladder scan showed 500 ml of residual urine in the bladder, there should have been a written physician's order. The DNS stated they were not sure if an assessment of the resident during a void trial is part of the facility protocol. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) #8, who conducted the bladder scan during the 3:00 PM-11:00 PM shift on 12/1/2022, was interviewed on 9/25/2023 at 12:10 PM. LPN #8 stated when a resident is on void trial, they (LPN #8) would evaluate the resident for pain and distension in addition to completing the bladder scan. LPN #8 stated they could not recall if they evaluated Resident #191 after they performed the bladder scan. 10 NYCRR 415.12(d)(1)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34798 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00317548), initiated on 9/18/2023 and completed on 9/25/2023, the facility did not ensure pain management was provided to each resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was identified for one (Resident #190) of three residents reviewed for pain management. Specifically, Resident #190 had a Physician prescribed as needed (PRN) pain medication, Tramadol. The facility staff administered the pain medication; however, did not consistently assess the resident's pain level prior to and after the medication administration to monitor the effectiveness of the pain medication. Additionally, all facility staff were not knowledgeable regarding the process of entering the PRN pain management evaluation protocol into the Medication Administration Record (MAR). The finding is: The facility's policy titled Pain Management, dated April 2018, documented to monitor resident response to pain management interventions; a 0-10 numeric pain scale may be utilized when defining the intensity of pain when the resident is able to verbalize the level of pain; nurses must evaluate the effectiveness of medications; and nurses must document in the electronic medical record the medication and effectiveness. Residents should be fully observed and monitored for pain and as much relevant information as possible should be obtained. Resident #190 was admitted with diagnoses including Paraplegia, Thoracic Spinal Cord Injury, and Chronic Pain Syndrome. The 5/12/2023 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS documented that the resident had frequent pain with a level of 6 out of a 10-pain scale, with zero being no pain and 10 as the worst pain. A physician's order dated 5/5/2023 documented Pain Scale Rating-Monitor and Record Pain Scale Every Shift. A physician's order dated 5/5/2023 documented to administer Tramadol (a narcotic pain reliever) 50 milligram (mg) tablet, give one tablet by oral route every 6 hours as needed (PRN) for a diagnosis of unspecified pain. A physician's order dated 5/5/2023 documented to administer Tylenol 325 mg tablet, give 2 tablets (650 mg) every 6 hours as needed for a diagnosis of unspecified pain. A Comprehensive Care Plan (CCP) titled Pain, effective 5/6/2023, documented an intervention to monitor the effectiveness of medication. A physician's order dated 5/16/2023 documented to administer Ibuprofen 200 mg tablet, give three tablets (600 mg) by oral route as needed for a diagnosis of unspecified pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2023 MAR revealed Resident #190 received the Tramadol PRN on May 6, 7, 9, 11, 12, 14, 15, 17, 19, 21, 23, 24, 25, and 26; received the Tylenol on May 16, 26, and 29; and received the Ibuprofen on May 16, 17, 18, 19, 27, and 30. There was no documentation in the monitoring section of the MAR indicating an evaluation of the effectiveness of these PRN pain medications. The resident also received one-time physician orders for Tramadol 50 mg from the Emergency (E) box on May 27, 28, and 29, and the May 2023 MAR revealed that the resident received these one-time doses with no evaluation of the effectiveness of the pain medication. The Physical Medicine and Rehabilitation (PM&R) progress note dated 5/30/2023 documented Resident #190 was seen today (5/30/2023) and has a primary diagnosis of Thoracic (T) Spinal Cord Injury. The resident had T3-Lumbar (L) 3 Posterior Spinal Instrumentation and Fusion (PSIF) and intraoperatively (during surgery) had motor loss (weakness) of bilateral lower extremities. Today, the resident admitted to back pain that can reach severe levels and the pain radiates into bilateral lower extremities. The resident rated their pain at a 9 out of 10 on the pain scale. The resident reported that Tramadol was not helping and they would like a stronger medication for the pain. The Physician recommended to discontinue the Tramadol and start Oxycodone 5 mg every 6 hours as needed. The Physician recommended to continue the use of Tylenol and Ibuprofen as ordered. A physician's order dated 5/30/2023 documented to administer Oxycodone 5 mg tablet, give one tablet every 6 hours as needed for chronic pain syndrome. A nursing progress note written by Licensed Practical Nurse (LPN) #5 on 5/30/2023 at 4:16 PM documented the resident was in pain and Ibuprofen was given. The Physician Assistant (PA) saw the resident and ordered a Lidocaine patch to the lower back daily. The resident's family wanted the resident to be sent to the hospital. The doctor (PM&R) was in the facility and was able to see the resident immediately. A new order for Oxycodone 5 mg every 6 hours was received and a STAT (Immediate) dose was given at 11:00 AM. At 11:45 AM LPN #5 returned to the resident's room and the resident stated they were feeling better. A review of the 24-hour report dated 5/30/2023 for the 7:00 AM-3:00 PM shift documented Oxycodone was administered with positive effects. A review of the MAR for May 2023 revealed that the resident was administered Oxycodone on 5/30/2023 at 8:33 PM; however, there was no documentation regarding the monitoring of the effectiveness of the medication. A review of the 24-hour report dated 5/30/2023 for the 3:00 PM-11:00 PM shift documented Oxycodone was given with positive effects. A review of the MAR for 5/30/2023 during the 11:00 PM-7:00 AM shift revealed that the resident reported a pain level of 10 out of 10. Oxycodone was administered on 5/31/2023 at 3:16 AM. There was no documentation for the 11:00 PM-7:00 AM shift on the 24-hour report; there was no monitoring of the effectiveness of the pain medication in the MAR; and there were no follow-up progress notes related to the effectiveness of the pain medication in the Electronic Medical Record (EMR). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #5, who administered the STAT dose of Oxycodone on 5/30/2023 and gave PRN pain medications, was interviewed on 9/19/2023 at 2:57 PM. LPN #5 stated when a PRN pain medication is administered, the computer system generates a pop-up that includes the facility protocol to monitor the effectiveness of the medication. LPN #5 stated the monitoring protocol is not triggered when a one-time STAT dose of pain medication is administered. LPN #5 stated it is basic nursing to follow up to monitor the effectiveness of pain medication after pain medication is administered. LPN #5 stated on 5/30/2023 the note indicated that LPN #5 administered the Oxycodone at 11:00 AM and returned to Resident #190's room at 11:45 AM. Resident #190 told them (LPN #5) that they (Resident #190) were feeling better. Pharmacist #1 and the Pharmacy Director were interviewed concurrently on 9/20/2023 at 12:09 PM. They both stated the pharmacy received a prescription for Resident #190 for Tramadol on 5/9/2023. The pharmacy provided a total of 20 Tramadol tablets. Pharmacist #1 and the Pharmacy Director both stated that there were no other prescriptions received for Tramadol after the 20 tablets were administered. LPN #6, who administered the Oxycodone on 5/30/2023 at 8:33 PM, was interviewed on 9/20/2023 at 3:13 PM. LPN #6 stated they frequently turned and positioned Resident #190 and monitored the resident's pain; however LPN #6 did not document the resident's pain on a pain scale of 0-10. Registered Nurse (RN #4), Registered Nurse (RN) #4, the 11:00 PM-7:00 AM nursing Supervisor was interviewed on 9/21/2023 at 8:20 AM and stated on 5/31/2023 Resident #190 complained of pain measuring 10 out of 10 and they (RN #4) administered Oxycodone at 3:16 AM. RN #4 stated the Oxycodone order did not include the monitoring protocol. RN #4 stated the nurses who enter any PRN pain medication order need to be inserviced on how to accurately enter the pain medication order into the EMR; therefore, initiating the pain assessment section on the MAR. RN #4 stated there should have been follow up documented after the PRN pain medication was given and the following shift should have followed up. RN #5, who entered the PRN Tramadol order dated 5/5/2023, was interviewed on 9/21/2023 at 12:54 PM. RN #5 stated after administering a PRN pain medication the nurses are expected to follow up with the resident regarding the effectiveness of the pain medication. RN #5 stated the EMR does not allow us to add in parameters for follow-up (before and after) for PRN pain medications. RN #2, the Inservice Coordinator, was interviewed on 9/22/2023 at 10:31 AM and stated when a pain medication is given, the nurse is supposed to assess the pain level and then check back in 30 minutes to assess the resident's pain level using the pain scale. RN #2 stated it is not always expected that the pain level be obtained initially--it depends on the situation; for instance if the resident has a headache, just give Tylenol. RN #2 stated the pain assessment should be on the MAR in the monitoring section. RN #6, the unit supervisor, was interviewed on 9/22/2023 at 11:15 AM. RN #6 stated there is a way to put the protocol for pain monitoring in the EMR. RN #6 stated the nurse (RN #5) who said there was no way to enter the protocol was wrong. RN #6 stated as far as an assessment, the pain level cannot be quantified with positive effects or feeling better statements. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services (DNS) was interviewed on 9/22/2023 at 2:30 PM and stated it is acceptable to document positive effect after administering a pain medication, it means it is therapeutic (provided pain relief) and the resident is comfortable. The DNS stated the protocol for before and after pain medication evaluation can be documented in the EMR and inservice education for the nurses is needed. The DNS stated there should have been follow up after the PRN pain medications were administered. RN #2 was re-interviewed on 9/25/2023 at 11:15 AM and stated the inservice education does not include the topic of documenting the pain assessment before and after administration of pain medication in the EMR or how to properly enter the physician's order into the EMR to initiate the pre and post pain assessment protocol on the MAR. 10 NYCRR 415.12

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 9/18/2023 and completed on 9/25/2023, the facility did not ensure drugs and biologicals were labeled in accordance with currently accepted professional principles. This was identified for 1) one (Resident #78) of five residents observed during medication administration; and 2) one (Resident #32) of one resident reviewed for choices. Specifically, 1) during the medication administration task Resident #78's Lexapro (antidepressant medication) blister pack label did not match the current physician's order nor had a change in order sticker as per the facility's policy; and 2) Resident 32 was observed with a Physician prescribed inhaler medication in their room unattended by the facility staff. The findings are: 1) The facility's policy titled Medications and Medication Labels, effective 1/2023, documented if the prescriber's directions for use change or the label is inaccurate, the nurse may place a direction change, change of order-check chart, or similar label on the container indicating there is a change in direction for use. If directions for use change, the provider pharmacy is informed prior to the next refill of the prescription so the new container will show an accurate label. Resident #78 was admitted with diagnoses including Depression, Seizure Disorder, and Metabolic Encephalopathy. The 7/28/2023 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS documented that the resident received antidepressant medications. A physician's order dated 7/29/2023, and renewed on 9/16/2023, documented Escitalopram (Lexapro) 5 milligram (mg) tablet, give one tablet once daily at 9 AM for Depression. On 9/19/2023 at 8:35 AM Resident #78's medication administration was observed performed by Licensed Practical Nurse (LPN #4). The Escitalopram blister pack used by LPN #4 had a label that did not match the physician's order and reflected Escitalopram 5 mg tablet, give 1.5 tablets by mouth daily (a total of 7.5 mg). There was no change in direction sticker on the blister pack. For each dose in the blister pack there was a 5 mg whole tablet and a half tablet (2.5 mg). LPN #4 discarded the half tablet (2.5 mg) and provided the 5 mg tablet to the resident. When LPN #4 was questioned about the discrepancy with the order and the label, LPN #4 stated they (LPN #4) called the pharmacy and was directed by the pharmacist to remove the half tablet because insurance did not allow the pharmacy to send a new blister pack while there was still enough medication left to fulfill the physician's order. LPN #4 stated they did not have the change in direction stickers and had asked a supervisor, but the supervisor did not know where the stickers were. Pharmacist #1 was interviewed on 9/19/2023 at 3:15 PM and stated usually if the new order of a medication can be fulfilled with the supply on hand at the facility, then insurance will not cover new orders and the nurses are directed to use the supply that is already available in the facility. Insurance wants the supply finished. Pharmacist #1 stated a change in direction sticker should have been placed on the blister pack by the nurse when the new order was obtained. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy Director was interviewed on 9/20/2023 at 11:15 AM and stated when the order for Escitalopram was changed from 7.5 mg to 5 mg daily on 7/29/2023 the pharmacy received the new order; however, the data entry technician failed to process the new order appropriately and refilled the old order for 7.5 mg instead of the 5 mg Escitalopram. The Director of Nursing Services (DNS) was interviewed on 9/20/2023 at 9:36 AM and stated if there is a medication order change, the nurses are supposed to place a direction change sticker on the blister pack. 40696 2) The facility Storage of Medication policy dated 4/18/2022 documented that all medications including treatment items are stored in a locked cabinet or room inaccessible to residents and visitors. Medication is accessible only to licensed nursing personnel. Resident #32 was admitted to the facility with the diagnoses of Chronic Obstructive Pulmonary Disease, Respiratory Failure and Heart Failure. The 5-day Minimum Data Set (MDS) assessment dated [DATE] documented Resident #32 had a Brief Interview for Mental Status assessment score of 13, indicating intact cognition. The physician's order dated 9/3/2023 documented to administer Spiriva Respimat (a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs) 2.5 micrograms (mcg) /actuation solution for inhalation. Inhale 2 puffs (5 mcg) by inhalation route once daily at the same time each day every day at 9:00 AM. The September 2023 Medication Administration Record documented Licensed Practical Nurse (LPN) #2 administered Spiriva Respimat on 9/19/2023 and the medication was administered by LPN #1 on 9/21/2023. The Respiratory Dysfunction care plan dated 7/27/2023 documented that Resident #32 was at risk for respiratory distress related to Chronic Obstructive Pulmonary Disease and Asthma. The interventions included to administer medications and to monitor for signs and symptoms of respiratory distress. Resident #32 was observed seated in a wheelchair in their room with a Spiriva inhaler on the overbed table on 9/19/2023 at 10:07 AM. Resident #32 stated that they (Resident #32) self-administer the medication and takes two puffs once a day. Review of Resident #32's medical records revealed that there was no assessment or care plan for self-administration. Licensed Practical Nurse (LPN) #1 was interviewed on 9/21/2023 at 1:10 PM. LPN #1 stated that they (LPN #1) were regularly assigned to Resident #32 during the day shift. LPN #1 stated that Resident #32 does not self-administer the Spiriva inhaler and the medication should be in the medication cart, and not in Resident #32's room. LPN #1 looked through the medication cart and stated that the Spiriva inhaler was not in the medication cart. LPN #1 was then observed to enter Resident #32's room and exit the resident's room with the Spiriva inhaler. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335141	A. Building B. Wing	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerge Nursing and Rehabilitation at Glen Cove	2 Medical Plaza Glen Cove, NY 11542

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 was interviewed on 9/22/2023 at 11:50 AM. LPN #2 stated that on 9/19/2023, LPN #2 opened the Spiriva inhaler and gave the inhaler to Resident #32. LPN #2 was then called by another staff member and stepped out of the room to assist with another resident. LPN #2 stated they left Resident #32 with the inhaler. The Director of Nursing Services (DNS) was interviewed on 9/22/2023 at 2:29 PM. The DNS stated that the nurses are expected to administer the inhaler, clean it, and place it back into the medication cart. The DNS stated that the nurses should not have left the Spiriva inhaler in Resident #32's room. 10 NYCRR 415.18 (d) and 415.18(e)(1-4)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34798 Based on observation, record review, and interviews during the Recertification Survey, initiated on 9/18/2023 and completed on 9/25/2023, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #193) of two residents reviewed for Pressure Ulcers. Specifically, on 9/21/2023 Licensed Practical Nurse (LPN) #3 was assisted by Registered Nurse (RN) #2 with the wound care treatment for Resident #193. RN #2 was observed placing the resident back onto the soiled barrier after the resident's unstageable coccyx (tailbone) pressure ulcer was cleansed therefore, allowing the pressure ulcer to come in contact with the soiled barrier. The wound was not re-cleansed before the treatment was applied. The finding is: The facility's policy titled Infection Control, effective 2/2022, documented the organization uses a coordinated process to reduce the risks of endemic and epidemic nosocomial infections in residents and health care workers. The primary purposes of this facility's infection control policies and procedures are to establish guidelines to follow to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Establish guidelines to follow in implementing Standard Precautions for the handling of blood, body fluids, secretions, excretions, mucous membranes and nonintact skin. Resident #193 was admitted with diagnoses including Seizure Disorder, Intracranial Hemorrhage, and Hemiplegia. The 9/11/2023 Admission Minimum Data Set (MDS) assessment documented no Brief Interview for Mental Status (BIMS) score as the resident rarely or never makes self understood. The MDS documented that the resident had an unstageable pressure ulcer. A Comprehensive Care Plan (CCP) titled Presence of Coccyx Pressure Ulcer, effective 9/1/2023, documented the resident was seen by the wound care physician on 9/13/2023. The wound was identified as unstageable pressure ulcer measuring 7 centimeters (cm) x 6.5 cm x 0.5 cm, with 99% slough (dead tissue), 1 % granulating (healthy growing) tissue. The interventions included to monitor for signs and symptoms of infection such as increased redness, warmth, drainage, foul odor, etc. A physician's order dated 9/13/2023 documented to apply Santyl (enzymatic debridement agent) 250 unit/gram topical ointment, apply by topical route to coccyx; cleanse wound with wound cleanser followed by Santyl and Calcium Alginate (an absorbent dressing), and silicone-bordered dressing every day and when needed, for diagnosis of pressure ulcer, unstageable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/21/2023 at 10:42 AM Resident #193's wound care treatment was observed, performed by Licensed Practical Nurse (LPN#3) and assisted by Registered Nurse (RN #2, the Infection Preventionist and Inservice Coordinator. The resident had an air mattress that auto-turned and positioned the resident, and RN #2 positioned the resident on the resident's right side, exposing the coccyx/sacral area. RN #2 held the resident in that position while the wound treatment was being performed. LPN #3 placed a clean barrier on the mattress directly under the wound area. LPN #3 removed the old dressing. There was a moderate to large amount of slough and serosanguinous (blood tinged) drainage on the dressing. The wound contained mostly slough. LPN #3 cleansed the wound with spray wound cleanser, which drained out of the wound and onto the barrier. The soiled barrier was not removed. After the wound was cleansed, while LPN #3 was performing hand hygiene, RN #2 allowed the resident to lie on their back in a supine position, allowing the cleansed wound to come in contact with the soiled barrier. The surveyor brought the observation to the attention of RN #2; however, the wound was not re-cleansed and the wound treatment continued to completion. RN #2 was interviewed on 9/21/2023 at 11:43 AM and stated the resident was heavy and the mattress was auto-turning. RN #2 stated the resident only went back a little bit but allowing the resident to go back on the soiled barrier was not an acceptable procedure. RN #2 stated from their vantage point, RN #2 could not see where the wound was, but did not think that allowing the cleansed wound to come in contact with the soiled barrier created an infection potential. RN #3, the wound care nurse, was interviewed on 9/21/2023 at 2:00 PM and stated the wound definitely should not have come in contact with the dirty barrier. RN #3 stated they (RN #3) would have removed the barrier after cleaning the wound. The Director of Nursing Services (DNS) was interviewed on 9/22/2023 at 2:30 PM and stated the wound should have been re-cleansed after it came in contact with the soiled drape. 10 NYCRR 415.19(a)(1-3)