STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335156	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation and Nursing Center	275 W Merrick Road Freeport, NY 11520

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024, the facility did not provide a homelike environment and maintenance services to maintain a comfortable interior for three (Unit 1 North, Unit 1 South, and Unit 2 South) of four units observed during the environmental task. Specifically, Rooms 217 (Unit 2 South) 117 (Unit 1 South), 115, and 111 (Unit 1 North) had unrepaired water damage in the walls. Resident #60's room (Unit 1 North) was observed with holes in the wall due to the removal of the soap dispenser from the wall and the area was left unrepaired. The finding is: The facility's Quality of Life: Homelike Environment policy dated 4/2024 documented to provide residents with a comfortable and homelike environment. The facility staff and management shall maximize the characteristics of the facility that reflect a homelike setting including an inviting decor. The Resident Council Meeting minutes dated 2/21/2024 documented that a resident expressed that water is coming out from the walls in their rooms. The minutes documented that the Administrator stated that the plumber was scheduled to come to the facility on [DATE] and that the plumber had come in the past to fix the problem. A plumbing estimate dated 2/22/2024 documented leaking sanitary piping repairs were provided including opening of the sheetrock wall under the basin in room [ROOM NUMBER]; removal and replacement of leaking galvanized sanitary piping in the wall; installation of pipe, fittings, gaskets couplings hangers, and hardware, testing of repairs and removal of debris was completed. The estimate also documented that the contractor excluded all carpentry, sheetrock, spackling, painting tile, and flooring repairs. An initial facility tour on 4/7/2024 from 9:25 AM to 11:00 AM revealed the following: 1a) On Unit 2 South room [ROOM NUMBER] was observed on 4/7/2024 at 9:29 AM. On the wall outside of room [ROOM NUMBER], the wallpaper was peeling with some brown spots and exposed spackle. Inside room [ROOM NUMBER], the sink was observed on the left-hand side of the room entry. Above the sink, the wall was covered with a bubbled spackled area that crumbled upon touch. Under the sink, there were holes in the wall surrounding the pipes. The footboard on the right-hand side of the bathroom door was detached from the wall. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b) During an observation on Unit 1 South on 4/7/2024 at 10:18 AM, room [ROOM NUMBER] was observed with peeling paint on the left wall by the room entrance. The sheetrock above the sink was crumbling. The wall below the room sink and the wall adjacent to the sink that leads to the bathroom were observed with ripped-up sheetrock and several water-damaged spots. 1c) On Unit 1 North following rooms were observed on 4/7/2024: -At 10:22 AM, room [ROOM NUMBER] was observed with a large, water damage that extended from the power outlet to behind the wardrobe set against the wall. There were also areas of exposed and crumbling sheetrock along that wall and under the room sink. -At 10:28 AM, room [ROOM NUMBER] was observed with ripped sheetrock and several large areas of water damage on the wall on the right side of the alcove leading to the bathroom entry. 1d) Resident #60 was admitted to the facility with the diagnoses of Parkinson's Disease, Coronary Artery Disease, and Hyperlipidemia. The Quarterly Minimum Data set assessment dated [DATE] documented Resident #60 had a brief interview for mental status assessment score of 14, indicating intact cognition. During an observation on 4/7/2024 at 10:30 AM Resident #60 was observed seated in a wheelchair in their room on Unit 1 North. Resident #60 stated they have heard complaints about leaking problems from other residents in the facility. Resident #60 stated there was significant water damage in room [ROOM NUMBER] that looked bad and they felt sorry for the residents who live in that room in that condition. Resident #60 stated that the maintenance staff did not finish projects and pointed to the two holes in the wall at the entrance wall above the sink. Resident #60 stated approximately 3 months ago the maintenance worker moved the soap dispenser to the right on the wall but left the unrepaired holes. Resident #60 stated they have requested for the holes to get patched up several times and the maintenance worker told Resident #60 that they would return to repair but never did. A review of facility work orders from 1/1/2024 to 4/10/2024 revealed no work orders for rooms 111, 115, 117, and Resident #60's room to address damaged walls. The facility work order report generated on 4/11/2024 documented work order number 1625 for the damaged walls in room [ROOM NUMBER] was opened by the Administrator on 2/21/2024 at 4:37 PM. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/2024 at 10:48 AM the Director of Maintenance toured rooms 111, 115, 117, 217, and Resident #60's room with the surveyor. The Director of Maintenance stated that the bubbling in the wall in room [ROOM NUMBER] could be related to water seeping from the outdoor facing wall. The Director of Maintenance stated that the walls are made of concrete and the water can get into the walls without a waterproof barrier. The Director of Maintenance stated that the torn sheetrock could be the result of banging a wheelchair or seat against the wall. The Director of Maintenance stated that they were not made aware of the damaged walls in room [ROOM NUMBER] and did not know if there were any work orders placed for repairs. The Director of Maintenance stated that in room [ROOM NUMBER], the wall from the room entry is shared with the communal shower room. There could have been some water damage from the shower room. The Director of Maintenance stated that they were not aware of the condition of the walls in room [ROOM NUMBER] and did not know if there were any work orders placed for repairs. The Director of Maintenance stated that room [ROOM NUMBER] was affected by the broken main drainpipe in room [ROOM NUMBER] since 2/21/2024. The walls were damaged due to water leaking into rooms [ROOM NUMBER] from room [ROOM NUMBER]. The Director of Maintenance stated a plumber repaired the affected pipes but could not recall the exact date. The Director of Maintenance and the Assistant Director of Housekeeping repaired the damaged walls in rooms [ROOM NUMBERS] in early March 2024. The Director of Maintenance stated that they used the waterproof sheetrock in room [ROOM NUMBER] but did not extend the sheetrock to the entire wall because they needed more materials. The Director of Maintenance stated the wallpaper outside of room [ROOM NUMBER] was not repaired because they had to get the wall sampled for mold before they closed it up. The Director of Maintenance stated that they do not recall when they sent a sample to the vendor for mold testing. The Director of Maintenance stated that the soap dispenser anchors came loose in Resident #60's room and the soap dispenser was reattached in a different location. The Director of Maintenance stated that the Assistant Director of Housekeeping did the repairs and that the holes should have been patched up after the soap dispenser was re-attached to the wall. The facility did not provide documented evidence of mold testing for the wall outside of room [ROOM NUMBER]. Licensed Practical Nurse #2 was interviewed on 4/11/2024 at 11:38 AM and stated that they have been the supervisor for the first floor for the last six months and were not aware of the damages on the walls in Resident #60's room and in room [ROOM NUMBER], or 115. Licensed Practical Nurse #2 stated If they were made aware of the damages they would have placed a work order for the maintenance to repair the damage in the rooms. Certified Nurse Aide #7 was interviewed on 4/11/2024 at 11:34 AM and stated they have worked with Resident #60 for the last three months and the holes from the soap dispenser were always there. Certified Nurse Aide #7 stated they did not put in a request or report the issue to anyone. The Director of Nursing Services was interviewed on 4/11/2024 at 12:30 PM and stated nursing staff are expected to report any maintenance issues to the Nursing Supervisor who in turn should place a work order. The housekeepers and Maintenance staff are also expected to make note of any disrepair in the residents' rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 4/11/2024 at 12:39 PM and stated they were aware that the facility needed improvement with the aesthetic of the building. The Administrator stated that they intended to hire additional staff to do maintenance work. The Administrator stated that they started working at the facility on 5/8/2023 and after they caught up with adjusting to the facility, they felt that the resident rooms needed work. The Administrator stated the Director of Maintenance needs to have the work orders organized and track when repairs are needed. The Administrator stated that they also intended to implement routine environmental checks so that the maintenance staff could identify environmental concerns and repair them as needed. 10 NYCRR 415.5(h)(2)

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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. 34798 Based on record review and interviews during the Recertification Survey and Extended Survey (NY 00321584), the facility did not ensure that it reported each injury of unknown origin to the New York State Department of Health within 24 hours as required. This was identified for one (Resident #35) of four residents reviewed for Discharge. Specifically, on 8/5/2023 Resident #35 was identified by facility staff with discoloration and swelling to the right arm; an x-ray on 8/6/2023 confirmed an acute oblique fracture of the distal radius (a fracture that is on an angle of one of the bones in the forearm that connects to the wrist). The incident was not reported to the New York State Department of Health until 8/7/2023. The finding is: The facility's policy titled, Resident Accident/Incident Report last revised 4/2018, documented it is the responsibility of the Director of Nursing Services/Administrator to notify the New York State Department of Health within five working days of the occurrence when an accident/incident involves alleged abuse. Resident #35 was admitted with diagnoses including Seizure Disorder, Respiratory Failure, and Anoxic Brain Damage (brain damage due to cessation of blood supply to brain tissue). The 6/29/2023 Quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score because the resident was documented as comatose (deep unconsciousness). A nursing progress note, written by the former Assistant Director of Nursing/Risk Manager, dated 8/5/2023 at 2:21 PM documented resident was noted with mild swelling and discoloration to the right hand and wrist. A Physician was notified and an order was given to obtain a right wrist hand x-ray and Doppler. An x-ray report dated 8/6/2023 documented an acute oblique fracture of the distal radius. A nursing progress note dated 8/6/2023 documented that the resident was sent to the hospital for further evaluation as per the physician's order. A nursing progress note dated 8/7/2023 documented the resident returned from the hospital with the right wrist soft cast. A review of the Accident and Incident report dated 8/7/2023 documented, on 8/5/2023 at approximately 2:00 PM the resident was observed with mild swelling and an area of discoloration to the right hand/wrist measuring 10 centimeters by 6 centimeters. An investigation was immediately initiated and statements from staff were collected. As per staff reports there was no discoloration observed prior to 8/5/2023. The report concluded that although the cause of this investigation is undetermined at this time, the resident's care plan was followed by staff, it is reasonable to conclude that there is no cause to believe any alleged abuse, neglect, or mistreatment regarding this resident occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident was reported to the New York State Department of Health on 8/7/2023 at 9:55 AM by the Director of Nursing Services. The current Assistant Director of Nursing/Risk Manager was interviewed on 4/10/2024 at 11:15 AM and stated the former Risk Manager, who had completed the investigation related to the injury of an unknown origin for Resident #35, is no longer employed at the facility. The current Assistant Director of Nursing/Risk Manager stated the Director of Nursing Services was responsible for reporting all reportable incidents to the New York State Department of Health. The Director of Nursing Services was interviewed on 4/10/2024 at 12:12 PM and stated they knew that an injury of unknown origin should be reported within 24 hours. The incident related to Resident #35 was identified on the weekend (8/5/2023) and they (Director of Nursing Services) did not find out about the incident until Monday (8/7/2023) during the morning report. The Director of Nursing Services stated they then reported the incident of injury of unknown origin to the New York State Department of Health, which should have been completed within 24 hours. 10NYCRR 415.4 (b)(2)

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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** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024, the facility did not ensure that a comprehensive person-centered care plan was developed or implemented for each resident to meet a resident's medical and nursing needs. This was identified for one (Resident #47) of one resident reviewed for Limited Range of Motion. Specifically, Resident #47 had a physician's order for a hand roll to be worn on the right hand at all times due to limited mobility. Resident #47 was observed multiple times without the hand roll as per the physician's order. The finding is: The facility's policy and procedure titled, Comprehensive Care Plan last revised on 3/2016, documented that all residents will have an individualized interdisciplinary care plan developed by the interdisciplinary care plan team on admission, annually, and upon identification of significant change in condition. Resident #47 was admitted with diagnoses of Acute Respiratory Failure, Chronic Inflammatory Demyelinating Polyneuritis (a neurological disorder that involves progressive weakness and reduced senses in the arms and legs), and Type II Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #47 had moderate cognitive impairment. A Comprehensive Care Plan (CCP) for skin integrity dated 2/9/2024 documented interventions including to check the area under braces and positioning devices during care and to implement Range of Motion as per the physician's order. A physician's order dated 2/14/2024 documented a hand roll to be worn on the right hand at all times and removed for skin checks and hygiene. The Certified Nursing Assistant Accountability Record (Resident care instructions provided to the Certified Nursing Assistants) dated 4/8/2024 documented that a hand roll must be worn on the right hand at all times and to be removed for skin check and hygiene. Resident #47 was observed on 4/7/2024 at 9:00 AM lying in their bed. The resident was not wearing a hand roll on their right hand as per the physician's order. Resident #47 was observed on 4/8/2024 at 6:46 AM. Resident #47 was in bed and was not wearing a hand roll on the right hand. Certified Nursing Assistant #2 was interviewed on 4/8/2024 at 10:46 AM and stated that they are not the regularly assigned aide for Resident #47 and were assigned to care for the resident on 4/8/2024. Certified Nursing Assistant #2 stated they did not know that Resident #47 needed a hand roll because they were not familiar with the resident's care needs. Certified Nursing Assistant #2 stated they did not check the Certified Nursing Assistant Accountability Record before caring for Resident #47. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47 was observed on 4/9/2024 at 10:36 AM. Resident #47 lying in their bed and was not wearing a hand roll on their right hand. A hand roll was observed on top of the nightstand. Certified Nursing Assistant #3 was interviewed on 4/9/2024 at 10:50 AM and stated they normally applied the hand roll after the resident received the morning care and was ready for their physical therapy. At times Resident #47 refused to use the hand rolls. Certified Nursing Assistant #3 stated they reported the refusal to the nurse in charge; however, could not recall when. The Assistant Occupational Therapist was interviewed on 4/9/2024 at 1:25 PM and stated Resident #47 participated in rehabilitation therapy and was normally wearing a hand roll on the right hand. There were times when Resident #47 requested to take the hand roll off. The Assistant Occupational Therapist stated that Resident #47 could take off the hand roll with their left hand. Registered Nurse #4, the Unit Supervisor, was interviewed on 4/9/2024 at 2:08 PM and stated the Certified Nursing Assistants are responsible for applying the hand roll for Resident #47 and the nurses on the unit are responsible for making sure that the hand roll is applied as per the physician's order. Registered Nurse #4 stated they were not aware that Resident #47 was refusing the hand roll use. The Director of Rehabilitation Services was interviewed on 4/10/2024 at 9:39 AM and stated that they were not aware of Resident #47's refusal of the hand roll. The Director of Rehabilitation Services stated that the nurses on the unit should have reported the refusals to the Unit Supervisor who would then report to the Rehabilitation Therapy Department. The Occupational therapist would then evaluate the need for the device or an alternative device for Resident # 47. The Director of Nursing Services was interviewed on 4/10/2024 at 2:58 PM and stated Resident #47 should be wearing the hand roll to prevent further contractures. The Director of Nursing Services stated if the resident was refusing to use the hand rolls then the Certified Nursing Assistants should have reported the resident's refusal to the nurses for further assessment and evaluation. 10 NYCRR 415.11(c)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024 the facility did not ensure that each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for one (Resident #55) of one resident reviewed for Pressure Ulcers. Specifically, Resident #55 had multiple Stage 4 pressure ulcers to the sacrum, right upper back, and left upper back. The resident was utilizing an air mattress as per the physician's order. The weight setting on the resident's air mattress was set at 240 pounds, while the resident's most recent weight was recorded as 123 pounds. The facility staff were unable to adjust the air mattress weight setting according to the resident's weight to provide appropriate pressure relief to the affected areas. The facility nursing staff reported the malfunction to the maintenance department; however, the mattress was not repaired. The finding is: The facility policy titled Impaired Skin Integrity, dated 5/2018, documented the skin integrity program will use a multidisciplinary approach for the prevention and treatment of wounds; the policy purpose is to reduce the incidence of pressure sores through effective assessment, prevention, and treatment; the wound team members are the facilitators of the skin integrity program, collaborating to develop and initiate prevention and healing continuums that provide a comprehensive plan of care. For Stage 4 pressure ulcers, a specialty mattress is an intervention to relieve pressure. Resident #55 was admitted with diagnoses including Respiratory Failure, Seizure Disorder, and an infection with a Multidrug-Resistant Organism. The 1/6/2024 Quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision making. The Minimum Data Set assessment documented that the resident had one Stage 2 pressure ulcer, one Stage 3 pressure ulcer, and three Stage 4 pressure ulcers. Resident #55 is a ventilator-dependent resident. A physician's order dated 7/3/2023 and last renewed on 4/11/2024 documented to use an air mattress related to wound care. A Comprehensive Care Plan titled, The Resident has Actual Impairment to Skin Integrity Related to Wound Care (Sacrum), initiated 7/1/2023 and last updated 3/2/2024, documented use of the Low Air Flow Mattress and for staff to identify potential causative factors related to impaired skin integrity and eliminate/resolve where possible. Resident #55's most recent weight documented in the electronic medical record dated 3/27/2024 was 123.8 pounds. The wound care consult dated 4/4/2024 documented the resident has a Stage 4 pressure ulcer to the sacrum, Stage 4 pressure ulcer to the right upper back, Stage 4 pressure ulcer to the left upper back, and an unstageable pressure ulcer to the left elbow. The wound care consult documented to utilize the pressure redistribution mattress as per facility protocol. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 10/17/2023 and last renewed on 4/11/2024 documented to cleanse the sacral wound with normal saline, pat dry, then loosely pack with calcium alginate (a highly absorbent wound dressing) rope to undermining (significant erosion occurs underneath the outwardly visible wound margins), then honey fiber to the wound bed, cover with foam dressing daily and when needed every day-shift. Resident #55 was observed in bed on 4/11/2024 at 8:38 AM. The air mattress weight setting dial was set to 240 pounds. Licensed Practical Nurse #1 (medication nurse) was interviewed on 4/11/2024 at 8:55 AM and stated they do not touch the weight setting on the air mattress; Licensed Practical Nurse #1 stated that is the wound care nurse's job. Wound Care Nurse #1 (Licensed Practical Nurse) was interviewed on 4/11/2024 at 9:00 AM. Wound Care Nurse #1 stated Resident #55's air mattress has had a problem, the weight has to be set at a higher setting than the resident's actual weight or the mattress deflates. Wound Care Nurse #1 stated the Maintenance Director was aware that the mattress had to be replaced. Wound Care Nurse #1 stated maintenance issues have to be reported via a computerized maintenance request reporting system and sometimes the issues are reported verbally to the Maintenance Director. Maintenance Director #1 was interviewed on 4/11/2024 at 9:10 AM and stated they knew nothing about Resident #55's air mattress problem. Maintenance Director #1 then went into Resident #55's room and was observed pressing on the resident's air mattress. The resident was in bed at this time. Maintenance Director #1 came out of the resident's room and acknowledged the weight setting on the air mattress was set at 240 pounds and there was an indicator light on the pump indicating low pressure. Maintenance Director #1 stated the nursing staff would have to get the resident out of bed because they (Maintenance Director #1) have to examine the mattress more closely. On 4/11/2024 at 10:11 AM the sacral Stage 4 pressure ulcer treatment was observed, which was performed by Registered Nurse #5 (treatment nurse). Certified Nursing Assistant #6 assisted Registered Nurse #5 during the treatment. The air mattress weight setting was set at 240 pounds. The sacral wound was approximately 4 centimeters long, 6 centimeters wide, and 1 centimeter deep with undermining (tissue loss underneath the visible wound boundaries) present. The wound dressing that was removed was completely saturated with serosanguinous (blood-tinged) drainage. Wound Care Nurse #1 was re-interviewed on 4/11/2024 at 10:41 AM. Wound Care Nurse #1 stated they searched the electronic maintenance reporting system and could not find any maintenance requests related to Resident #55's air mattress. Assistant Housekeeping Director #1 was interviewed on 4/11/2024 at 11:02 AM and stated they were not aware of any concerns related to Resident #55's air mattress until this morning. Assistant Housekeeping Director #1 further stated there were no requests regarding Resident #55's air mattress malfunction. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #4, Second Floor Supervisor, was interviewed on 4/11/2024 at 11:19 AM. Registered Nurse #4 stated they (Registered Nurse #4 and Wound Care Nurse #1) have told the Maintenance Director numerous times about Resident #55's air mattress malfunction. The mattress loses the pressure and deflates. Requests in the electronic system were placed; however, they (Registered Nurse #4) could not recall when and who had placed the request in the electronic system. Registered Nurse #4 stated they did not know since when the air mattress was not working properly. The Assistant Director of Nursing Services was interviewed on 4/11/2024 at 11:21 AM and stated the nursing staff enters the maintenance request in the system and if the Maintenance Director closes out the request in the system indicating the request has been acted upon, the request disappears from the system and is no longer available. The Director of Nursing Services was interviewed on 4/11/2024 at 11:31 AM and stated the air mattress weight setting should be consistent with the resident's weight to provide for optimal healing. The Director of Nursing Services stated the mattress should have been replaced when the problem was first identified, and staff should have followed up to ensure that the mattress was working properly. The wound care Nurse Practitioner #1 was interviewed on 4/11/2024 at 12:14 PM and stated the weight setting on the air mattress should correspond with the resident's weight. An inappropriate weight setting could adversely affect wound healing. 10 NYCRR 415.12(c)(2)

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South Shore Rehabilitation and Nursing Center	275 W Merrick Road Freeport, NY 11520

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024, the facility did not ensure that the staff implemented and provided care and services according to resident's needs and professional standard of practice for each resident with a feeding tube. This was identified for one (Resident # 302) of three residents reviewed for Tube Feeding. Specifically, on 4/7/2024 at 9:28 AM and 4/8/2024 at 6:11 AM, Resident #302 was observed receiving enteral tube feeding; the enteral tube feeding and the water bags were observed hanging on a feeding tube stand without a label including the resident's name, and the time the tube feeding was started. The finding is: The facility's Policy and Procedure titled, Enteral Feeding last revised in 12/2018 documented that the enteral tube feeding will be administered as per the order of a License Independent Practitioner to provide liquid nourishment and/or medication into the stomach through a gastrostomy/ jejunostomy tube when a resident cannot or will not take it by mouth. The feeding bottle must be labeled with the resident's information, including the resident's name, room number, date, start time, and rate. Resident #302 was admitted with diagnoses that included Respiratory Failure, Gastrostomy status, and Type II Diabetes. The Minimum Data Set assessment was not completed for Resident #302 as the resident was recently admitted to the facility. A Nursing Admission assessment dated [DATE] documented that Resident #302 was unable to make their needs known and could not communicate. Resident #302 required one-person assistance with all Activities of Daily Living (ADL). The Physician's order dated 4/5/2024 documented to administer [NAME] Farms 1.5 peptide (tuber feeding formula)1000 cubic centimeters per day with a flow rate of 50 cubic centimeters per hour via gastrostomy tube. The order was discontinued on 4/8/2024. The Comprehensive Care Plan (CCP) for Tube Feeding dated 4/6/2024 documented interventions to assess placement and patency of the tube. Monitor for signs and symptoms of aspiration, and intolerance. Ensure the head of the bed is elevated at 30 degrees or more during feeding and one hour after the feeding. A Nutritional/Admission assessment dated [DATE] documented that Resident #302 was to receive Nothing by Mouth (NPO) including liquids except through Tube Feeding. The Physician's order dated 4/8/2024 documented to administer Glucerna 1.5 (tube feeding formula), 1000 cubic centimeters, per day with a flow rate of 50 cubic centimeters per hour. Water Flushes via the feeding pump (an enteral pump that delivers thick formula) 50 cubic centimeters per hour for 20 hours at the start of feeding one time a day. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/7/2024 at 9:28 AM, Resident #302 was observed receiving enteral tube feeding via a feeding pump. The enteral feeding bag and a water bag were observed hanging from the feeding tube stand. The enteral tube feeding bag and the water bag did not have a label to identify the resident's name, the time feeding was started, and the feeding directions as prescribed by the Physician. In a subsequent observation on 4/8/2024 at 6:11 AM, Resident #302 was observed receiving enteral tube feeding via a feeding pump. The enteral feeding bag and a water bag were observed hanging from the feeding tube stand. The enteral tube feeding bag and the water bag did not have a label to identify the resident's name, the time feeding was started, and the feeding directions as prescribed by the Physician. Licensed Practical Nurse #1 was interviewed on 4/8/2024 at 6:11 AM and stated they did not start the enteral feeding and did not know there was no label on Resident #302's enteral bag. Licensed Practical Nurse #1 stated the enteral feeding was already running when they came in for the 11:00 PM-7:00 AM shift. Licensed Practical Nurse #1 Stated they should have checked the enteral tube feeding bag before pouring the [NAME] Farms 1.5 peptide (tube feeding formula) during their shift to ensure that a label was in place. Licensed Practical Nurse #3 was interviewed on 4/10/2024 at 11:07 AM and stated that they did not notice the enteral tube feeding bag was not labeled on 4/7/2024 during their 7:00 AM-3:00 PM shift. Licensed Practical Nurse #3 stated that they should have checked the enteral tube feeding bag when they administered the enteral feeding for Resident #302 during the 7:00 AM-3:00 PM shift to ensure a label was in place. The Director of Nursing Services was interviewed on 4/10/2024 at 2:09 PM and stated that it was not the responsibility of one shift to ensure a label was in place. All nurses should have checked and ensured that the enteral tube feeding bag had a label that included the name of the resident, room number, date, and start time. 10 NYCRR 415.12(g)(2)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024 the facility did not ensure a resident requiring dialysis services received such services consistent with professional standard of practice. This was identified for one (Resident #31) of two residents reviewed for Dialysis. Specifically, Resident #31, who receives Dialysis treatment three times a week, was observed on 4/7/2024 with swelling to their left upper arm. Resident #31 returned from their dialysis treatment on 4/6/2024 with recommendations to apply warm compresses to the left upper arm. The recommendations were communicated from the dialysis center staff to the facility staff via a Dialysis Communication Notebook. The facility staff did not address and apply the warm compresses to the resident's right upper arm as indicated by the Dialysis center. The finding is: The facility policy and procedure titled, Patient Care for Dialysis last reviewed on 9/2018 documented to ensure a maximum state of wellness and control of renal disease in dialysis patients, consistent method of communication among dialysis units, personnel, attending physicians, and nursing unit staff are essential. A Dialysis Communication Book will be prepared for the admission of all dialysis patients. This individual book will accompany each patient at every dialysis session and will contain timely, pertinent patient information, direction, and questions relevant to the care of the patient. The Licensed Nurse's responsibility, at the time of pickup, is to make sure the patient has his/her Dialysis Communication Notebook and at the time of return from the dialysis center, complete a post-dialysis assessment; read the Dialysis Communication Book and any recommendations in the dialysis notes should be addressed. Resident #31 was admitted with diagnoses of End-Stage Renal Disease, Right Ankle and Foot Acute Osteomyelitis (bone infection), and Type II Diabetes. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated that Resident #31 had intact cognition. Resident #31 was dependent on staff for all Activities of Daily Living (ADL). The Minimum Data Set documented the resident received Dialysis treatment. A Physician's Order dated 9/22/2023 documented, dialysis treatment every Tuesday, Thursday, and Saturday. A Comprehensive Care Plan (CCP) for Dialysis dated 9/7/2023 documented interventions including to check access dressing, to communicate patient information with the dialysis center via a Communication Notebook, and to monitor for peripheral edema (swelling). A Progress Note dated 4/6/2024 at 3:05 PM, written by Licensed Practical Nurse #3, documented that Resident #31 returned from dialysis treatment at 2:45 PM. No distress was noted. Safety precautions were maintained. Resident #31 was observed on 4/7/2024 at 9:35 AM. Resident #31 was lying in bed and was wearing a short-sleeved hospital gown. The resident's left arm was observed to have swelling above the Arteriovenous Fistula (AVF-a connection that's made between an artery and a vein for dialysis access). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31 was interviewed on 4/7/2024 at 9:35 AM and stated the nurses do not check the Communication Notebook after they return from the Dialysis treatment. Resident #31 stated the swelling on their left arm started while they were at Dialysis on 4/6/2024. Resident #31 stated when they returned from the dialysis center they told Licensed Practical Nurse #3 about the swelling. A review of the Dialysis Communication Notebook revealed that on 4/6/2024 the dialysis center documented recommendations for the facility staff to apply warm compresses to Resident #31's left arm (Dialysis access site) to reduce swelling. The 7:00 AM-3:00 PM Registered Nurse Supervisor #3 was interviewed on 4/7/2024 at 12:10 PM and stated that they did not notice any swelling on Resident #31's left arm on 4/6/2024 and 4/7/2024. Registered Nurse Supervisor #3 Stated the resident normally returned from their dialysis treatment at 2:45 PM. Licensed Practical Nurse #3 received the resident on 4/6/2024 when the resident came back from the dialysis and should have written a progress note and called the physician for orders related to the recommendations made by the dialysis center. Registered Nurse Supervisor #3 stated they would call to notify the Physician now about the swelling on Resident #31 left arm. The Registered Nurse from the dialysis center was interviewed on 4/10/2024 at 8:03 AM and stated that the Dialysis Center utilized the Communication Notebook for Resident #31. The Registered Nurse from the dialysis center stated they expected the facility staff to ensure the Communication Notebook is reviewed before and after dialysis for any communication and new recommendations provided by the dialysis center. Licensed Practical Nurse #3 was interviewed on 4/10/2024 at 10:42 AM and stated they received Resident #31 on 4/6/2024 at 2:45 PM when the resident returned from the dialysis center. Licensed Practical Nurse #3 stated they checked Resident #31's vital signs and gave the resident their medications. Licensed Practical Nurse #3 stated they forgot to check the Dialysis Communication Notebook. The Director of Nursing Services was interviewed on 4/10/2024 at 2:19 PM and stated the nurse should have assessed Resident #31 after the resident returned from their dialysis treatment. The assessment should have included vital signs, skin checks for the thrill (vibration sound by blood flowing through the fistula, and can be felt by placing fingers just above the incision line) and bruit (a whooshing sound near the fistula incision site), and monitoring of the dressing on the fistula site for any bleeding. The Director of Nursing Services stated that the Dialysis Communication Notebook should be checked after a resident comes back from the dialysis treatment to make sure any recommendations from the dialysis center are followed promptly. 10 NYCRR 415.12

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34798 Based on observation and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Specifically, during the initial kitchen tour on 4/7/2024, a carton of frozen egg product, that was intended to be used on 4/8/2024 for the breakfast meal, was observed on a table thawing at room temperature. The finding is: The facility's undated policy titled, Thawing Frozen Raw Food documented to ensure the proper temperature is maintained during food storage, plan ahead to allow enough time for proper thawing; remove raw food from the carton and place it on a sheet pan; place the sheet pan on the bottom shelf of the refrigerator, never above the ready to eat food; do not let food stay out of the refrigerator for a long period of time. During the initial kitchen tour with First [NAME] #1 on 4/7/2024 at 9:00 AM, a carton of frozen egg product was observed on a table in the kitchen thawing at room temperature. The carton label documented: Frozen Egg Product, keep frozen at zero degrees Fahrenheit or below. First [NAME] #1 was interviewed on 4/7/2024 immediately after the observation and stated they (First [NAME] #1) removed the carton from the freezer at approximately 6:45 AM this morning (4/7/2024) and intended to use the egg product for tomorrow's breakfast. First [NAME] #1 stated they are going to put the product in the refrigerator and if it is not thawed by tomorrow morning, they will let the egg product carton sit in a water bath. Food Service Director #1 was interviewed on 4/8/2024 at 9:23 AM and stated after the frozen egg product was removed from the freezer, we let the product sit at room temperature for a couple of hours before putting it back in the refrigerator. Food Service Director #1 stated this is done to get the initial frost thawed out. Food Service Director #1 stated if the product is still frozen tomorrow when we need it for breakfast, we will run it under cold water. First [NAME] #1 was re-interviewed on 4/9/2024 at 08:30 AM and stated they placed the frozen egg product outside to thaw instead of placing it in the refrigerator because they were in a rush. 10NYCRR 415.14(h)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (Complaint #NY 00326378) initiated on [DATE] and completed on [DATE], the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, facility administration allowed an unlicensed, graduate nurse to work in the capacity of a Registered Nurse until [DATE], almost four months beyond the Public Health Emergency (PHE) waiver expiration date of [DATE]. The finding is: Executive Order Number 4.22 dated [DATE] documented the Executive Order number 4 was extended until [DATE] which included a temporary Suspension and Modification of Subdivision 5 of Section 6907 of the Education Law and Regulations to the extent necessary to permit graduates of registered professional nurse and licensed practical nurse licensure qualifying education programs registered by the State Education Department to be employed to practice nursing under the supervision of a registered professional nurse and with the endorsement of the employing hospital or nursing home for 180 days immediately following graduation. The facility's undated policy titled Employment of Limited Permit Nursing Staff documented that in accordance with the New York State Education Law, the State Education Department issues limited permits that authorize the practice of nursing under the immediate and personal supervision of a registered professional nurse. An applicant for a limited permit must have completed all requirements for licensure except the licensing examination. The Nursing Home Facility Incident Report dated [DATE] documented that in the course of doing employee audits, it was discovered that Unlicensed Graduate Nurse #1 was hired by the facility in February of 2023 by the previous Administration, and their Nursing Diploma from college was dated May of 2021. Unlicensed Graduate Nurse #1 had never obtained their license. Unlicensed Graduate Nurse #1 was immediately terminated and reported to the Office of Professions. The facility's current Director of Nursing Services was interviewed on [DATE] at 10:10 AM and stated that they started working at the facility in April of 2023. The Director of Nursing Services stated that in October of 2023, they conducted an audit to make sure that all Nursing staff had their current licenses and Cardiopulmonary Resuscitation (CPR) credentials were up to date and discovered that Unlicensed Graduate Nurse #1 was still working in the facility as an 11:00 PM-7:00 AM Registered Nurse without a license. The Director of Nursing Services stated that unlicensed Registered Nurses were no longer allowed to practice as Registered Nurses because the limited COVID-19 Public Health Emergency waiver had expired sometime at the end of [DATE]. The Director of Nursing Services further stated that Unlicensed Graduate Nurse #1 was terminated by the facility on [DATE]. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrative Assistant was interviewed on [DATE] at 11:30 AM and stated they had made the prior Director of Nursing Services aware that Unlicensed Graduate Nurse #1 had not fulfilled the criteria of providing a test date to obtain their license. The Administrative Assistant stated they had always been in charge of keeping track of the license expiration dates of the Nurses; however, the prior Director of Nursing Services had told them (Administrative Assistant) that they (Director of Nursing Services) were in charge of the licenses of the Nurses. The Administrative Assistant stated they thought the prior Director of Nursing Services would follow up with Unlicensed Graduate Nurse #1. The Administrative Assistant stated that no one in the facility had told her them that the COVID-19 Public Health Emergency waiver related to the use of Unlicensed Nurses had expired in June of 2023. The facility's Administrator was interviewed on [DATE] at 10:15 AM and stated that Unlicensed Graduate Nurse #1 should never have been allowed to work as a Registered Nurse in the facility after the COVID-19 waiver expired in June of 2023. 10 NYCRR 415.26

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024 the facility did not ensure that it maintained medical records for each resident in accordance with accepted professional standards and practices. This was identified for one (Resident #39) of five residents reviewed for Unnecessary Medications. Specifically, Resident #39 had a physician's order to self-administer their insulin and obtain their blood glucose via finger stick. The results of the blood glucose readings and self-administered insulin dosage were not accurately recorded in the resident's medication administration record on 4/9/2024 at 11:30 AM. The finding is: The facility's policy titled, Self Medication, dated 2/2003, documented it is the responsibility of the primary team nurse to check with the resident all the dispensed medication was given, sign documentation in the medication administration record, including date and time; and monitor resident on a self-medication program on a daily basis Resident #39 was admitted with diagnoses including Diabetes Mellitus, Morbid Obesity, and Depression. The 3/7/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A physician's order dated 1/31/2023 and effective as of 4/9/2024 documented the resident may keep insulin at the bedside, perform their own blood sugar checks, and self-administer medication. A physician's order dated 1/31/2023 and effective as of 4/9/2024 documented Novolin insulin, FlexPen injector 100 units/milliliter (Insulin Regular Human), Inject as per sliding scale subcutaneously before meals and at bedtime for diagnosis of Type 2 Diabetes Mellitus. If the fingerstick is: 150 milligrams per deciliter- 199 milligrams per deciliter then administer 4 units of insulin, 200 milligrams per deciliter - 249 milligrams per deciliter then administer 6 units of insulin, 250 milligrams per deciliter - 299 milligrams per deciliter then administer 8 units of insulin, 300 milligrams per deciliter - 349 milligrams per deciliter then administer 10 units of insulin, 350 milligrams per deciliter - 400 milligrams per deciliter then administer 12 units of insulin and Call a physician for blood sugar of less than 70 or greater than 400. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/2024 at 11:30 AM the surveyor observed Resident #39 check their blood glucose and administer insulin before the lunch meal. The insulin and fingerstick supplies were kept on the resident's overbed table inside a bag with the resident's name and medication label documenting the physician's order. There was also a sliding scale chart on the resident's overbed table, consistent with the physician's order. The resident's blood sugar reading was 255 milligrams per deciliter. The resident administered eight (8) units of insulin to their abdomen, as per the sliding scale. There were no concerns identified with the resident's ability to check blood sugar via the finger stick and to administer their insulin. A review of the medication administration record for 4/9/2024, 11:30 AM, revealed Licensed Practical Nurse #2 documented the blood sugar reading was 210 milligrams per deciliter and six (6) units of insulin was administered. Licensed Practical Nurse #2, who was the covering medication nurse on 4/9/2024 for Resident #39, was interviewed on 4/10/2024 at 8:24 AM and stated We have to just go by what the resident tells us; unfortunately, we ask the resident to call us when it is time to check the blood glucose and administer insulin, but they (the resident) do not call us. Licensed Practical Nurse #3, who was the regularly assigned medication nurse for Resident #39, was interviewed on 4/10/2024 at 8:31 AM. Licensed Practical Nurse #3 stated they always go into the resident's room to watch the resident check the blood glucose and administer insulin so that they (Licensed Practical Nurse #3) know exactly what to document in the medical record. Registered Nurse #4, the second-floor supervisor, was interviewed on 4/10/2024 at 8:52 AM. Registered Nurse #4 stated the nurses watch the resident when the resident checks the blood glucose. The nurses also ensure the resident is administering the right insulin dosage. The nurse is not supposed to just rely on the resident to provide the information. The nurses should verify the blood sugar reading on the glucometer and ensure the resident administers the right insulin dose as per the sliding scale. The Director of Nursing Services was interviewed on 4/10/2024 at 10:24 AM and stated even though the resident has the order to self-administer their medications and perform their blood sugar checks, as per the facility policy, the nurses should watch the resident check the blood glucose and give insulin just to ensure it is being done correctly and the documentation is accurate. 10 NYCRR 415.22(a)(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 4/7/2024 and completed on 4/11/2024, the facility did not ensure it maintained an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #55) of one resident reviewed for Pressure Ulcers. Specifically, on 4/11/2024 Resident #55 was on contact precautions for Candida Auris (a fungal infection). There was a contact precautions sign at the doorway directing staff and visitors to wear appropriate personal protective equipment. The Director of Maintenance was observed in the resident's room examining the resident's air mattress and coming in substantial contact with the resident's environment (bed sheets, privacy curtain, air pump). The Director of Maintenance was not wearing any personal protective equipment. The finding is: The facility's policy titled Contact Precautions, last revised 11/2023, documented it is the policy of the facility to prevent the transmission of organisms among residents, staff, and visitors. The decision to isolate a resident and the type of isolation required is determined by the source of infection, the mode of transmission, and the susceptibility of the host. The purpose is to enhance interdisciplinary communication in regard to individual isolation and the accompanying precautions needed. Resident #55 was admitted with diagnoses including Respiratory Failure, Seizure Disorder, and an infection with a Multidrug-Resistant Organism. The 1/6/2024 Quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision-making. A physician's order dated 11/17/2023 and active as of 4/11/2024 documented Contact Isolation: Candida Auris infection. The physician's order did not include the site of the infection. A Comprehensive Care Plan titled, Resident is on Contact Isolation secondary to Candida Auris effective 10/13/2023 and last revised 11/17/2023, documented staff will maintain contact precautions at all times, always perform proper hand hygiene, and apply and remove personal protective equipment as per Centers for Disease Control guidelines. A nursing progress note dated 11/17/2023 documented a prevalence survey (A data collection tool used to identify the number of people with a disease or condition at a specific point in time) mandated by the New York State Department of Health (NYSDOH) on 11/14/2023 for Candida Auris was conducted. The laboratory results were received on 11/17/2023 and this resident (#55) tested positive for Candida Auris infection and was placed on contact isolation. During an observation of Resident #55's unit, a precaution sign was observed posted outside Resident #55's door on 4/11/2024 at 8:55 AM. The sign documented Contact Precautions, Everyone Must: clean their hands, including before entering and when leaving the room; put on gloves before room entry, discard gloves before room exit; put on gown before room entry, discard gown before room exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335156	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation and Nursing Center	275 W Merrick Road Freeport, NY 11520

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care Nurse #1 was interviewed on 4/11/2024 at 9:00 AM and stated Resident #55's air mattress has had a problem, the weight has to be set at a higher amount or the mattress deflates. Wound Care Nurse #1 stated the Maintenance Director was aware that the air mattress had to be replaced. Maintenance Director #1 was interviewed outside Resident #55's room on 4/11/2024 at 9:10 AM. Maintenance Director #1 stated they knew nothing about Resident #55's mattress problem and then entered Resident #55's room without putting on a gown or gloves and did not wash their hands. Maintenance Director #1 handled the air mattress pump and then walked to the side of the resident's bed, touched the bed sheets, felt the mattress, and came in contact with the privacy curtain. The resident was in bed at this time. When Maintenance Director #1 came out of the room, the surveyor directed the Maintenance Director to the contact precautions sign and the need for personal protective equipment. Maintenance Director #1 stated they went into the room without personal protective equipment because they thought addressing the air mattress malfunction was an emergency. Maintenance Director #1 stated they were going to the basement to remove and wash their clothing. The Director of Nursing Services, who was also the Infection Preventionist, was interviewed on 4/11/2024 at 11:31 AM and stated Maintenance Director #1 should have worn full personal protective equipment as the sign indicated, especially because the resident was on contact precautions for Candida Auris infection, which is a Multidrug-Resistant Organism. The Director of Nursing Services stated checking the resident's mattress was not an emergency, and the personal protective equipment should have been put on prior to entering the resident's room to prevent the spread of the infection. 10 NYCRR 415.19(a)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335156	A. Building B. Wing	04/11/2024

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/7/2024 and completed on 4/11/2024 the facility did not ensure that it took measures to eradicate or contain a pest control concern in the kitchen. Specifically, the exit door from the kitchen, which is used to remove refuse and leads to the parking lot and the garbage disposal bins, had an approximate half-inch gap at the bottom of the door. Kitchen staff reported sightings of mice in the kitchen. The finding is: The undated facility policy titled, Pest Control, documented to maintain an effective pest control system. The facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. On 4/7/2024 at 9:00 AM during the initial kitchen tour with First [NAME] #1 the exit door from the kitchen, which is used to remove refuse and leads to the parking lot and the garbage disposal bins, had an approximate half-inch gap at the bottom of the door. Maintenance Director #1 was interviewed on 4/8/2024 at 1:30 PM and stated the facility uses a pest control company that comes regularly to apply pest/rodent treatments and as needed. Maintenance Director #1 stated they also call the pest control company if pests are sighted by the facility staff, or if there is a complaint. The Pest Control Company representative was interviewed on 4/8/2024 at 1:35 PM and stated the pest control representative comes to the facility twice a month and provides pest control services. A review of a recent pest control service ticket dated 4/1/2024 documented target pests of water bugs, roaches, and mice and that kitchen storage was treated. Food Service Director #1 and the Maintenance Director were interviewed concurrently on 4/9/2024 at 8:32 AM. The Maintenance Director observed the kitchen exit door and acknowledged the proximity of the exit door to the garbage refuse and that the gap at the bottom of the door was large enough to allow vermin to enter. The Maintenance Director stated water comes through the gap when there is heavy rain that causes puddles in the kitchen as well. Food Service Director #1 stated they recently found dead mice, about five, in glue traps in the kitchen. Both the Maintenance Director and Food Service Director #1 stated that the gap at the bottom of the door should be corrected to deter vermin from entering the kitchen. 10 NYCRR 415.29(j)(5)