STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335250	A. Building B. Wing	04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highfield Gardens Care Center of Great Neck	199 Community Drive Great Neck, NY 11021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and interviews during the Recertification Survey initiated on 4/3/2023 and completed on 4/11/2023, the facility did not ensure that each resident maintained, to the extent possible, acceptable parameters of nutritional and hydration status. This was identified for two (Resident #156 and Resident #142) of five residents reviewed for Nutrition. Specifically, 1) Resident #156 had a 7% significant weight loss in eight days, identified in June 2022, which was not addressed by the Registered Dietitian (RD). 2) Resident #142 was identified with a significant weight loss of 12.7 pounds (lbs) from 3/14/2023 to 3/28/2023; however, there was no dietary assessment nor dietary interventions put in place until 4/3/2023. The findings are: The facility's policy titled, Weight Policy and Procedure last reviewed in 4/2023 documented that the RD would review the medical record of residents with significant weight changes (i.e. 5% loss/gain in one month, 7.5% loss/gain in 3 months, 10% loss/gain in 6 months). Dietary interventions will be recommended as needed. All significant weight changes will be reported to the Medical Doctor (MD). 1) Resident #156 has diagnoses which Diabetes with Diabetic Nephropathy and Hypertension. The admission Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance of one person for eating. The resident's height was 63 inches and they weighed 141 pounds. The MDS documented the resident had loss of liquids/solids from mouth when eating or drinking. The Physician's Order dated 4/30/2022 and renewed on 5/11/2022 and 6/6/2022 documented for the resident to have Weekly Weights for one month. The resident's Weight Monitoring Report documented that on 5/24/2022 the resident weighed 146.4 pounds (lbs) and on 6/2/2022 the resident weighed 138 lbs which indicated an 8.4 lb or a 7% significant weight loss in eight days. The resident's weight record also documented that the resident also weighed 138 lbs on 6/8/2022 at 7:48 AM and 136.9 lbs on 6/8/2022 at 7:50 AM. The resident's diet orders dated 5/26/2022 documented Diet Type: No Concentrated Sweets (NCS) No Added Salt (NAS), Solid Consistency: Ground, and Fluid Consistency: Thin. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Electronic Medical Record (EMR) revealed no documented evidence that the resident's significant weight loss was addressed by the facility's RD employed at that time (RD #3). The facility's current RD (RD #1) who began their employment at the facility on 1/10/2023 was interviewed on 4/10/2023 at 2:50 PM and stated that once the monthly or weekly weights are received from Nursing, the dietitians enter them into the EMR for each resident and then run a weight report by each nursing unit which identifies 30-, 90-, and 180-day significant weight losses or gains. RD #1 stated that if they (RD #1) would identify a 5 lbs gain or loss between weights, they (RD #1) would request a re-weight to confirm the weight's accuracy. RD #1 stated that the resident's next weekly weights taken on 6/8/2022 were still on a downward trend, so they (RD#1) would have considered the resident's weight of 138 lbs taken on 6/2/2022 to be an accurate weight. RD #1 stated that then they (RD #1) would talk to the resident to get updated food preferences and if the resident was unable to voice their preferences themselves, they (RD #1) would have called the resident's family to try to get updated preferences and initiated a supplement for the resident. RD #1 stated that they (RD#1) would have notified the resident's Physician. RD #1 stated that there is also a Weight Change Communication Form that they (RD #1) fill out and give to the Director of Nursing Services (DNS) during morning report. RD #1 stated that they (RD #1) would also write a Weight Change Nutrition Note documenting the resident's significant weight change and the interventions they (RD #1) had put in place. RD #1 stated that they (RD #1) would also document the etiology if known of the resident's significant weight change as well and update the Nutritional Comprehensive Care Plan (CCP). RD #1 was re-interviewed on 4/11/2023 at 9:40 AM and stated that from 5/24/2022 to 6/2/2022 the resident had an 8.4 lb or a 7% weight loss which was a significant weight loss. The Regional RD (RD #2) was interviewed on 4/11/2023 at 9:45 AM and stated that they (RD #2) would have updated the resident's food preferences and given the resident nourishments between meals until a baseline for the resident's weight was established and the resident's weight became stable. RD #2 stated that RD #3 should have also used the facility's Weight Change Communication Form to notify the DNS and the resident's Physician. RD #2 stated that this form is discussed during morning report when all the facility's team members are present. RD #2 stated that they (RD #2) did not know if a form was filled out for the change in the resident's weight from 5/24/2022 to 6/2/2022. The DNS was interviewed on 4/11/2023 at 11:25 AM and stated that the RDs are responsible to put the residents' weights into the EMR and then if a weight gain or loss of 5 lbs is identified, the RD should make the Registered Nurse (RN) Supervisor and MD aware. The DNS was re-interviewed on 4/11/2023 at 12:15 PM and stated that they (DNS) had no Weight Change Communication Form for the resident's significant weight loss from 5/24/2022 to 6/2/2022. The facility's former RD (RD #3) was interviewed on 4/11/2023 at 3:45 PM and stated that the change in the resident's weight from 5/24/2022 to 6/2/2022 was significant and they (RD #3) should have documented the weight changes in the resident's EMR. RD #3 stated that they (RD #3) were also not sure why they (RD #3) had not filled out a Weight Change Communication Form for the resident's significant weight loss. 46058 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #142 was admitted with diagnoses of Malnutrition, Parkinson's Disease, and Non-Alzheimer's Dementia. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severely impaired cognition. The MDS documented that the resident required extensive assistance with eating. The Comprehensive Care Plan (CCP) for Nutritional Status, effective 2/26/2023, documented Resident #142 will be monitored for Malnutrition and significant weight loss. The Physician's orders dated 3/27/2023 documented weekly weights and to provide a regular diet, with pureed consistency and honey thickened liquids. The Physician's orders dated 4/03/2023 documented to administer 4 ounces of Boost Pudding (nutritional supplement) every day at 10:00 AM and 2:00 PM. The weight records for Resident #142 documented the following: - on 3/14/2023 the resident weighed 139 pounds (lbs) -on 3/24/2023 the resident weighed 130.4 lbs -on 3/28/2023 the resident weighed 126.3 lbs. The Dietary note Weight Change Note dated 4/03/2023 documented that the resident had a 7.5% significant weight loss in one month. Interventions included weekly weights until stable, boost pudding at 10:00 AM and 2:00 PM. The Registered Dietician (RD) #1 was interviewed on 4/11/2023 at 10:22 AM and stated that Resident #142 was stable for the first two weeks of admission on 2/24/2023 until they lost 9 lbs. during the week of 3/14/2023 to 3/24/2023. The RD was not sure why there was a delay from 3/24/2023 to 4/03/2023 to implement dietary interventions. RD #1 stated they first documented a note for significant weight loss on 4/03/2023. The RD stated they did not discuss the significant weight loss with the unit Charge Nurse, the Director of Nursing Services (DNS), nor the Physician. RD #1 further stated that the Physician was not notified and should have been. The DNS was interviewed on 4/11/2023 at 11:36 AM and stated that when there is a significant weight loss, the dietician is responsible for alerting the charge nurse, DNS, Physician, and the resident's family. The RD must do this within 24 hours of the significant weight loss being discovered. The practice is to fill out a Weight Change Communication Form. The DNS stated that the form was filled on 4/11/2023 for Resident #142. The DNS stated RD #1 said they wanted to wait until the monthly weight was recorded before telling someone. The DNS was not aware of the significant weight loss until today, 4/11/2023. The DNS stated they (DNS) and Physician should have been made aware of the significant weight loss when the weight loss was identified. Physician #1 was interviewed on 4/11/2023 at 11:58 AM and stated they were not aware of a significant weight loss for Resident #142. The Physician stated they should have been made aware within 24 hours of the weight loss being triggered as significant. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medical Director (MD) was interviewed on 4/11/2023 at 12:02 PM and stated the Physician should have been notified at the earliest possible opportunity, within 48 hours of the significant weight loss and that a 9 lbs weight loss should have been brought to the attention of the Physician. The DNS and nursing staff needed to be notified as well. 10NYCRR 415.12(i)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/3/2023 and completed on 4/11/2023 the facility did not ensure that each resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences. This was identified for one (Resident #176) of four residents reviewed for Respiratory Care. Specifically, Resident #176 had an order for continuous oxygen administration within a range of 2-4 liters per minutes (lpm); however, the resident was observed without supplemental oxygen administration on multiple occasions. There were no physician's orders or parameters established regarding when to administer 2 liters oxygen, 3 liters of oxygen, or 4 liters of oxygen. Additionally, Resident #176's oxygen tubing was observed without a label indicating when the oxygen tubing was last replaced, and facility staff were not knowledgeable of the time frames of when to change the oxygen tubing. The finding is: The facility's policy, titled Oxygen Administration, last reviewed 3/2023, documented to date the tubing when initiated, and at least every two weeks when changed; more often if the tubing malfunctioned or was visibly soiled. Resident #176 was admitted with diagnoses including Diabetes Mellitus, Respiratory Failure, and Morbid Obesity. The 2/8/2023 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS did not document that the resident received oxygen therapy. A physician's order dated 1/31/2023 and renewed on 4/5/2023 documented to administer oxygen via nasal cannula at 2-4 liters per minute (lpm) continuously. Review of the medical record revealed There were no physician's orders or parameters established regarding when to administer 2 liters oxygen, 3 liters of oxygen, or 4 liters of oxygen. A Respiratory Comprehensive Care Plan (CCP) effective 2/1/2023 and last reviewed on 4/4/2023, documented that the resident was on continuous oxygen via nasal cannula. Resident #176 was observed in bed on 4/3/2023 at 12:25 PM. The nasal cannula was observed on the side of the bed, not attached to the resident. The resident stated they were fine and may need the oxygen later but not at the moment. The oxygen tubing was not dated. The resident did not know when the tubing was last changed. Resident #176 was observed in bed on 4/6/2023 at 10:38 AM. The resident stated they place the nasal cannula on and off themselves. The oxygen tubing was hanging off the bedside table attached to the concentrator, and the nasal cannula was not attached to the resident. There was tape on the tubing dated 3/2023. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/6/2023 at 10:40 AM Licensed Practical Nurse (LPN) #1 came into the resident's room and confirmed that the documentation on the tubing was 3/2023 and that the resident was not wearing the nasal cannula and was not receiving oxygen therapy. LPN #1 could not explain what the 3/2023 label on the tubing indicated. In addition, there was oxygen tubing hanging on the resident's wheelchair connected to a portable oxygen tank. The tubing on the chair from the portable oxygen tank was not dated. LPN #1 left the room and returned a moment later and stated they (LPN #1) spoke to the Registered Nurse (RN) Supervisor who stated the tubing should be changed and dated every day and that is the policy. RN #1, Supervisor, was interviewed on 4/6/2023 at 10:47 AM. RN #1 observed the oxygen tubing in Resident #176's room and stated the policy is to change the oxygen tubing every day and date it every day. Review of the medical records revealed that there was no physician order to change the oxygen tubing. Review of nursing progress notes dated 4/3/2023 and 4/6/2023 revealed there was no assessment of the resident's respiratory status or documentation related to the resident not receiving oxygen therapy continuously as prescribed by the Physician. The Physician's order dated 4/6/2023 at 11:09 AM documented to change the oxygen tubing every week on Sunday at 6 AM. The Assistant Director of Nursing (ADNS) was interviewed on 4/7/2023 at 8:46 AM and stated the facility's policy was to change tubing once a week and that the nurses did not have to label the tubing. The ADNS stated the nurses sign off on the Treatment Administration Record (TAR) or write a nursing note. Review of the medical record revealed no documentation in the progress notes indicating that oxygen tubing was changed weekly. Review of the TAR revealed there was documented evidence that the oxygen tubing was changed until 4/6/2023 when the physician's order was obtained. The Director of Nursing was unavailable for interview. 10NYCRR 415.12(k)(6)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interviews during the Recertification Survey initiated on 4/3/2023 and completed on 4/11/2023, the facility did not ensure that the medical care of each resident was supervised by the Physician including monitoring changes in the resident's medical status. This was identified for one(Resident #156) of five residents reviewed for Nutrition. Specifically, Resident #156 had a 7% significant weight loss in eight days, identified in June 2022; and a 5.8% significant weight loss in 30 days/8% significant weight loss in 90 days, identified in September 2022. The significant weight loss was not addressed by their Primary Care Physician (PCP). The finding is: The facility's policy titled, Weight Policy and Procedure last reviewed in 4/2023 documented that the RD would review the medical record of residents with significant weight changes (i.e. 5% loss/gain in one month, 7.5% loss/gain in 3 months, 10% loss/gain in 6 months). Dietary interventions will be recommended as needed. All significant weight changes will be reported to the Medical Doctor (MD). Resident #156 has diagnoses that include Diabetes with Diabetic Nephropathy and Hypertension. The admission Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance of one person for eating. The resident's height was 63 inches and they weighed 141 pounds. The MDS documented the resident had a loss of liquids/solids from the mouth when eating or drinking. The Physician's Order dated 4/30/2022 and renewed on 5/11/2022 and 6/6/2022 documented the resident to have Weekly Weights for one month. The resident's Weight Monitoring Report documented that on 5/24/2022 the resident weighed 146.4 lbs (pounds) and on 6/2/2022 the resident weighed 138 lbs which indicated an 8.4 lbs or a 7% significant weight loss in eight days. The resident's diet orders dated 5/26/2022 documented Diet Type: No Concentrated Sweets (NCS), No Added Salt (NAS), Solid Consistency: Ground, and Fluid Consistency: Thin. The Medical Progress Note originally dated 7/13/2022 at 6:02 AM and updated on 7/22/2022 at 6:04 AM, written by Physician #2, documented that the resident was seen and examined at the bedside on 6/2/2022 for a monthly follow-up. The Note also documented that the resident had Malnutrition and to encourage/assist with oral intake and monitor the resident's weight. The Note did not identify the resident's current weight nor address the resident's significant weight loss that was identified on 6/2/2022. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Weight Monitoring Report documented that on 8/1/2022 the resident weighed 133.8 lbs and on 9/7/2022 the resident weighed 126 lbs which indicated an 7.8 lbs or a 5.8% significant weight loss in 30 days. The Report also documented that on 6/8/2022 the resident weighed 136.9 lbs and on 9/7/2022 the resident weighed 126 lbs which indicated a 10.9 lbs or a 8.0% significant weight loss in 90 days. The resident's diet orders dated 6/6/2022 and last renewed on 8/30/2022 documented Diet Type: No Concentrated Sweets (NCS) No Added Salt (NAS), Solid Consistency: Chopped, and Fluid Consistency: Thin. The Change in Weight Nutrition assessment dated [DATE], written by Registered Dietitian (RD) #3, documented that the resident's current weight on 9/7/2022 was 126 lbs. The resident's weight history reflected in the past 30 days the resident had a 7.8 lbs/5.8% significant weight loss and in the past 90 days a 10.9 lbs/8.0% significant weight loss. The Assessment also documented that the Medical Doctor (MD) was made aware of the resident's weight loss. The Medical Progress Note dated 10/6/2022 at 10:46 PM, written by Physician #2, documented that the resident was seen and examined at the bedside on 9/29/2022 for a scheduled monthly follow-up. The Note also documented that the resident had Malnutrition and to encourage/assist with oral intake and monitor the resident's weight and nutrition follow-up. The Note did not identify the resident's current weight or address the resident's significant weight loss that was identified on 9/7/2022. RD #1 was interviewed on 4/11/2023 at 9:40 AM and stated that from 5/24/2022 to 6/2/2022 the resident had an 8.4 lb or a 7% weight loss which was a significant wt loss. The Director of Nursing Services (DNS) was interviewed on 4/11/2023 at 11:25 AM and stated that the RDs are responsible to put the residents' weights into the EMR and then if a weight gain or loss of 5 lbs is seen, the RD should make the RN Supervisor and MD aware. The facility's Medical Director (Physician #1) was interviewed on 4/11/2023 at 11:35 AM and stated that they (Physician #1) would have expected Physician #2 to have a discussion with facility staff and the resident's family about the resident's significant weight loss. Physician #1 stated that Physician #2 should have identified the resident's significant weight losses in their monthly notes and documented a rationale as to what was causing the weight loss such as heart failure, edema, or not eating. The resident's Primary Care Physician (Physician #2) was interviewed on 4/11/2023 at 12:50 PM and stated that they (Physician #2) do not document every single detail about a resident when writing notes. Physician #2 stated that they (Physician #2) could do better when writing their notes and they (Physician #2) would be more careful about putting the words weight loss or significant weight loss in their notes if the resident lost weight. Physician #2 stated that they (Physician #2) would usually be made aware of significant weight losses by the RD and sometimes by the Nurse on the unit. The DNS was interviewed on 4/11/2023 at 1:30 PM and stated that Physician #2 was made aware of the resident's significant weight loss on 9/7/2022 by RD #3 via a message sent through the facility's Electronic Medical Record (EMR) computer system. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A message through the facility's EMR computer system dated 9/7/2022 from RD #3 to Physician #2 documented that the resident presented with significant weight loss due to refusal of foods. The facility's former RD (RD #3) was interviewed on 4/11/2023 at 3:45 PM and stated that they (RD #3) were not sure why they (RD #3) had not filled out a Weight Change Communication Form for the resident's two significant weight losses. RD #3 stated that they (RD #3) had created that tool (the Weight Change Communication Form) to make sure they (RD #3) were getting confirmation from Nursing and the Physician as a second layer of protection that they (RD #3) were not missing anyone as far as notifying them of when a significant weight loss occurred in case they (RD #3) would forget to send a message through the facility's EMR computer system. 10 NYCRR 415.15(b)(1)(i)(ii)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interview. during the Recertification Survey initiated on 4/3/2023 and completed on 4/11/2023, the facility did not ensure that residents were seen by a Physician at least once every 30 days for the first 90 days after being admitted to the facility. This was identified for one (Resident #156) of five residents reviewed for Nutrition. Specifically, Resident #156 was admitted to the facility on [DATE] and there was no documented evidence in their Electronic Medical Record (EMR) the resident was seen by a Physician timely at least once every 30 days for the first 90 days after admission. The finding is: The facility's policy titled Physician Services/Visits last revised on 2/22/2022 documented that the first Physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days after admission and then at 30-day intervals up until 90 days after the admitted . The policy also documented that during the required visits, the Physician/designee must document a review of the resident's total program of care, including the resident's current condition, progress and problems and problems in maintaining or improving their physical, mental, and psychosocial well-being and decisions about the continued appropriateness of the resident's current medical regimen. The Physician need not review the total plan of care at each visit but must review the total plan of care at visits required by federal/state regulations. Resident #156 has diagnoses which include Diabetes with Diabetic Nephropathy and Hypertension. The admission Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severely impaired cognitive skills for daily decision making. The Medical Progress Note dated 7/13/2022 at 5:57 AM, written by Physician #2, documented that the resident was seen and examined at bedside on 5/3/2022 status post admission on 5/2/2022. The Medical Progress Note originally dated 7/13/2022 at 6:02 AM and later updated on 7/22/2022 6:04 AM, written by Physician #2, documented that the resident was seen and examined at bedside on 6/2/2022 for monthly follow-up. The Medical Progress Note dated 7/22/2022 at 5:52 AM, written by Physician #2, documented that the resident was seen and examined at bedside on 6/30/2022 for monthly follow-up. The Medical Progress Note dated 9/19/2022 at 5:44 AM, written by Physician #2, documented that the resident was seen and examined at bedside on 7/29/2022 for follow-up after incident reported by staff. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medical Director (Physician #1) was interviewed on 4/11/2023 at 11:35 AM and stated that Physician #2 makes regular visits to the facility; however, they (Physician #2) fell behind in their documentation and they (Physician #1) did not know that their notes were late. Physician #1 stated that they (Physician #1) do not approve of late Physician Notes, but the issue came to their attention too late. Physician #1 stated that Physician #2 was seeing their residents, but it was difficult for Physician #2 to catch up on their notes. Physician #1 stated that their (Physician #1) expectation is for a resident to be seen within 48-72 hours after admission for their initial assessment. The resident's Primary Care Physician (Physician #2) was interviewed on 4/11/2023 at 12:05 PM and stated that they (Physician #2) sometimes do not have time to write notes after seeing a resident. Physician #2 stated that they (Physician #2) prioritize patient care over writing notes. Physician #2 stated that they (Physician #2) know that is not ideal, but that is what happens sometimes. 10 NYCRR 415.15(b)(2)(ii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335250	A. Building B. Wing	04/11/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 44963 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/3/2023 and completed on 4/11/2023, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was identified during the initial tour of the kitchen on 4/3/2023. Specifically, 12 unopened boxes of food including raw chicken drumsticks, raw fresh ground beef, and cooked turkey breast were observed placed on the patio outside the front entrance of the facility. These boxes of food were observed to be left during multiple observations between 11:16 AM and 2:06 PM when the outside temperature was between 50 to 53 degrees Fahrenheit. The finding is: The facility's undated policy on Food Service documented that every effort is made to ensure all foods are safely received, stored, prepared, and served. The policy did not include guidance related to temperatures that fresh and frozen foods are to be stored at to prevent the outbreak of foodborne illness. During an initial tour of the kitchen on 4/3/2023 at 11:16 AM, an inspection of the garbage area was conducted outside the facility. Crates of milk products and 12 unopened boxes of food were observed on the front entrance patio. The boxes contained raw chicken drumsticks, raw fresh ground beef, and cooked turkey breast. Two food service workers were observed standing where the items were placed. Food Service Worker (FSW) #1 and the Food Service Director (FSD) were interviewed immediately after the observation. FSW #1 stated that a rental freezer truck was expected to arrive at the facility since 8 AM this morning (4/3/2023). FSW #1 stated that the food that was observed outside on the patio will be loaded into the rental freezer container once the rental freezer arrives. FSW #1 stated that the food would be moved into the kitchen if the rental freezer does not arrive soon. The FSD stated that an excessive amount of food was delivered today in preparation for the Jewish holiday. The FSD stated that the facility kitchen did not have enough room to hold all the food. The FSD stated that the plan was to rent a remote freezer for three weeks to provide extra storage onsite and the freezer should have arrived before the food was delivered. The outside temperature was recorded at 50 degrees Fahrenheit at 11:16 AM. The patio of the front entrance was observed again on 4/3/2023 at 11:51 AM and dietary staff were observed transporting the milk into the kitchen. The 12 unopened boxes of food including raw chicken drumsticks, raw fresh ground beef, and cooked turkey breast that were observed in the same location on the patio. FSW #1 was re-interviewed at 11:53 AM and stated that they (FSW #1) and other workers were moving the milk into the kitchen. FSW #1 stated when they came to the facility at 9:30 AM they saw the food items outside; however, they did not know how long the food items had been there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335250	A. Building B. Wing	04/11/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The outside temperature was recorded at 50 degrees Fahrenheit at 11:51 AM. The patio area was observed on 4/3/2023 at 2:05 PM. No staff were seen nearby. The 12 unopened boxes of food including raw chicken drumsticks, raw fresh ground beef, and cooked turkey breast that were observed in the same location on the patio. The outside temperature was recorded at 53 degrees Fahrenheit. The Administrator came outside to the patio and was interviewed on 4/3/2023 at 2:08 PM. The Administrator stated that they (Administrator) knew a freezer container was rented; however, has not yet arrived. The Administrator stated that items in the boxes contained meat products that are perishable items and should not be left outside, unrefrigerated. The Administrator stated that the meat will be discarded. The FSD was re-interviewed on 4/3/2023 at 2:29 PM and stated that they were not aware that the meat was still outside until the Administrator told them to throw the meat out. The FSD stated that no food should be stored outside under any circumstance; however, they had an excess delivery of food this morning and had no room in the kitchen refrigerator and freezer. The FSD stated that they knew they had to hold a lot of food in preparation for the holiday and that was why they had rented a freezer. The FSD stated that the freezer still had not arrived. 10NYCRR 415.14(h)