STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335301	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Rehabilitation & Healthcare Center	275 Moriches Road St James, NY 11780

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on record review, and interviews conducted during the Recertification Survey initiated on 5/1/2024 and completed on 5/09/2024, the facility did not ensure each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. This was identified for one (Resident #82) of one resident reviewed for choices. Specifically, the facility did not allow Resident # 82 to have access to outside food brought in by their family member. The finding is: The facility's Policy and Procedure for Food Brought in by Family last revised in July 2019 documented that if a resident is found eating/being assisted to eat foods/liquids brought from visitors that are not of the proper consistency (per diet order), the resident/visitor will be educated regarding proper food/ drink safety. Staff will offer to modify the food/drink consistency to comply with the diet order. Any non-compliance by the visitor/resident will be brought to the attention of the nursing supervisor/administrator immediately. Resident # 82 has diagnoses that include Diabetes Mellitus and Morbid Obesity. The Minimum Data Set assessment dated [DATE] documented Resident #82 had a Brief Interview for Mental Status score of 11 which indicated the resident's cognitive function was moderately impaired. The Minimum Data Set further documented that the Resident had no behaviors. The Comprehensive Care Plan (CCP) for nutrition last revised on 2/14/2024 documented that Resident # 82 had diet restrictions and required fine-chopped texture and thin liquids; the resident was on a planned weight loss diet; and had a behavior problem related to noncompliance with eating with supervision in the dining room despite continuous education and encouragement; noncompliance with diet texture, was on aspiration precautions, and high choking risk; resident preferred ordering takeout from pizzeria and fast food restaurants. Interventions included explaining and reinforcing to the resident the importance of maintaining the diet ordered; encourage the resident to comply; explain the consequences of refusal and obesity/malnutrition risk factors; The resident preferred to eat in their room. The physician orders dated 2/27/2024 included Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 unit per milliliter (Insulin Lispro) with instructions to Inject 20 units subcutaneously before meals for Diabetes. Additionally, the physician's orders included a heart-healthy, Mechanically Altered Chopped texture diet, and Thin Liquids consistency. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's evaluation dated 4/18/2024 indicated that Resident #82 was competent to make informed medical decisions. The Progress Note, written by Registered Dietician # 6, dated 4/20/2024 at 12:47 documented Resident #82 was not interested in diet instructions. The resident acquires food and snacks from the family member who would bring [NAME]-Hoo drinks, Hawaiian Punch, family-sized Potato chip bags, and other High-salt snack foods. The current diet may promote slow weight loss, aid in better management of Diabetes Mellitus, and improve ambulation. The Resident has refused any type of diet instructions. The Social Services Note dated 5/1/2024 documented the Social Worker spoke with the family member, via telephone regarding sending healthy food items that are compliant with the resident's dietary restrictions. Educated the family member about the resident's diet. The family member was appreciative of the call and stated they did not want to go against dietary restrictions and would be picking up the items left at the front desk. The Physician's Progress Note dated 5/2/2024 documented Resident # 82 was seen today for noncompliance with their Diabetic diet. Cookies, soda, etc. were found in the resident's room. This has been an ongoing issue and the resident has been counseled numerous times. The resident also has presented as a choking hazard and has required observation. Resident # 82 was interviewed on 5/02/2024 at 1:48 PM and stated they were very upset because they were told by the Social Worker that they were not allowed to have food that was brought in by their family member. The food was confiscated by the facility and sent back to the family member a few days later. Registered Dietician # 6 was interviewed on 5/06/2024 at 2:04 PM and stated Resident # 82 was not allowed to eat certain foods because of Diabetes and Aspiration Precautions. Registered Dietician # 6 stated they sent the food back with the resident's family member. Registered Dietician # 6 further stated despite the education, the resident continues to be non-compliant and the facility has to ensure the resident does not eat food that is prohibited. Social Worker # 7 was interviewed on 5/07/2024 at 12:27 PM and stated they spoke to Resident # 82's family member who agreed the food that was brought in was not healthy for the resident. Social Worker #7 stated that the resident does have capacity based on the Physician evaluation; however, they did not feel the facility violated the resident's rights. The Director of Nursing Services (DNS) was interviewed on 5/06/2024 at 2:05 PM and stated We educated the family and the resident multiple times and the family continues to bring in food that is not allowed to the resident. The food was sent back with the family member last week. The Director of Nursing Services (DNS) further stated that despite the education, the resident continues to be non-compliant and the facility has to ensure the resident does not eat food that is prohibited. 10 NYCRR 415.5(b)(1-3)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observation, record review, and interviews conducted during the Recertification Survey initiated on 5/1/2024 and completed on 5/9/2024, the facility did not ensure that residents were free of any significant medication errors. This was identified for one (Resident #122), of five residents observed during the medication administration task. Specifically, the Physician's order for Resident #122 documented to hold Admelog insulin (a fast-acting insulin that starts to work about 15 minutes after injection, and peaks in about 1 hour) if the resident's blood sugar level was below 300 milligrams per deciliter. Resident #122's blood sugar level was documented as 137 milligrams per deciliter on 5/8/2024 at 6:00 AM. During a medication pass observation for Resident #122, on 5/8/2024 at 7:28 AM, Licensed Practical Nurse #4 intended to administer the physician-ordered Semglee-insulin Glargine (a long-acting insulin injected once daily and provides a steady insulin level throughout the day) 10 units of insulin; however, in error, they administered 10 units of the Admelog insulin. The findings are: The Facility Policy for Insulin Administration last revised on 1/14/2024 documented that for the safe administration of insulin; the type of insulin, strength, and method of administration must be verified with the physician's order before administration. Resident # 122 was admitted with diagnoses that include Type 2 Diabetes Mellitus without complications. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident's Brief Interview for Mental Status (BIMS) score was 2, which indicated severely impaired cognition. The Minimum Data Set documented the resident was receiving insulin treatments. The Diabetes Mellitus comprehensive care plan initiated on 8/24/2018 documented the resident will receive Diabetes medications as ordered by the Physician. On 5/8/2024 at 7:24 AM, Licensed Practical Nurse #4 was observed administering 10 units of Admelog SoloStar Solution Pen-injector 100 Units/milliliters Insulin Lispro to the resident's lower left abdomen. Licensed Practical Nurse #4 stated before administering the insulin, they had checked the resident's blood glucose level, which was 147 milligrams per deciliter. Licensed Practical Nurse #4 stated that they were supposed to administer the insulin to Resident #122 at 6:00 AM and they were late because they were providing care to other residents. The Medication Administration Record for 5/8/2024 indicated Resident #122's blood glucose level was 137 milligrams per deciliter at 6:00 AM. A review of the Physician Orders dated 4/12/2024 was conducted after the medication administration observation. The physician's orders indicated the following: -Semglee Solution Pen-injector 100 Units/milliliters Insulin Glargine Inject 10 units subcutaneously one time a day for Diabetes to be given daily at 6:00 AM; and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Administer Admelog SoloStar Solution Pen-injector 100 Unit/milliliters Insulin Lispro (1 Unit Dial), Inject 20 units subcutaneously at 8:00 AM daily for Diabetes. Hold for blood sugar level below 300 milligrams per deciliter or if breakfast is refused Upon reconciliation of physician orders on 5/8/2024 at 11:30 AM, it was determined that Licensed Practical Nurse #4 provided the incorrect type of Insulin and the incorrect dose to Resident #122. Registered Nurse Supervisor #1 was interviewed on 5/8/2024 at 12:51 PM and stated Resident #122 should receive all prescribed medications as ordered. Registered Nurse Supervisor #1 stated they would educate Licensed Practical Nurse #4 regarding insulin administration. Licensed Practical Nurse #4 was re-interviewed on 5/9/2024 at 7:00 AM and stated on 5/8/2024 they administered 10 units of Admelog insulin to Resident #122 instead of the Semglee long-acting insulin, in error. Licensed Practical Nurse #4 stated the resident should not have received the Admelog insulin because the resident's blood glucose was lower than 300 (milligrams per deciliter). The Director of Nursing Services was interviewed on 5/9/2024 at 12:28 PM and stated Resident #122 received the wrong type of insulin on 5/8/2024. The Director of Nursing Services stated that they spoke with Licensed Practical Nurse #4 who acknowledged that Resident #122 accidentally received 10 units of Admelog instead of Semglee, the long-acting insulin. The Director of Nursing Services stated that they expected Licensed Practical Nurse #4 to administer medications as per the Physician's orders. The Medical Doctor was interviewed on 5/9/2024 at 12:52 PM and stated Resident #122 received the short-acting insulin instead of the long-acting insulin. The Medical Doctor stated the Physician's order specifically indicated to not administer Admelog insulin when the resident's blood glucose level was lower than 300 milligrams per deciliter. The Medical Doctor stated when a wrong type or wrong dose of insulin is administered, the resident's blood glucose could drop significantly and could potentially harm the resident. 10 NYCRR 415.12(m)(2)

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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. 45349 Based on observation, record review, and interviews during the Recertification survey, initiated on 5/1/2024 and completed on 5/9/2024, 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 Dining and Kitchen Tasks. Specifically, 1) During the initial tour of the kitchen, opened and undated packages of food were observed in the walk-in freezer and the refrigerator; the walk-in refrigerators and freezer were noted with debris and food spills; and multiple food preparation surfaces in the kitchen were observed with built-up food residue, racks for can storage had a layer of dust; 2) Therapeutic Recreation Aide #1 did not perform hand hygiene after touching the garbage can and proceeded to open food container on a residents' meal trays. The findings are: 1) The facility policy and procedure titled, Cleaning Instructions Food Carts dated 1/1/2024, documented that food carts will be cleaned and sanitized immediately after each use; the refrigerators will be cleaned thoroughly inside and outside with a detergent and followed by a sanitizer at least once every month, or as needed. Spills and leaks will be cleaned up as they occur; the slicer will be cleaned and sanitized before and after each use, and clean and sanitize the countertop on which the slicer is located; the counter space will be cleaned and sanitized prior to and following food preparation and meal service, and as needed; small appliances (such as mixers and food processors) will be cleaned and sanitized before and after each use. The facility policy titled, Food Storage dated 2021 and last revised 1/2024, documented that food is stored in an area that is clean, dry, and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross-contamination. All foods that are removed from the original packaging must be labeled and dated with receiving date and expiration dates. Foods will be stored and handled to maintain the integrity of the packaging until ready to use. Refrigerated Storage: all refrigerator units are always kept clean. All foods should be covered, labeled, and dated. An initial tour of the kitchen was completed on 5/1/2024 at 9:59 AM with the Food Service Director and the Assistant Food Service Director. The following was observed: the walk-in combination refrigerator/freezer unit was observed with an open undated package of American cheese slices in the refrigerator; and an open undated package of hash browns in the freezer. The refrigerator floor was noted with black spots, which appeared like meat blood drippings,e, and other food and paper particles. In the dry storage area, the rack for storing canned foods was dusty. Multiple pieces of equipment not currently in use were noted to be dirty including the side of the steamer was splattered with food residue, the pellet system table and machine were left with food residue, the floor mat at the steam table was covered with egg and other food particles, the ice cream chest gaskets had a black residue all around the unit, an open, and the actively in-use garbage can was stored next to a clean stack of soup/salad bowls. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up tour of the kitchen was completed on 5/3/2024 at 11:10 AM with the Food Service Director. The base of the food slicer and its worktable were observed to have brown drips. The lip of the work table had a layer of built-up grease and food. A follow-up tour of the kitchen was completed on 5/9/2024 at 9:52 AM with the Assistant Food Service Director. A rack of uncovered and undated raw burger patties was observed in the walk-in combination refrigerator/freezer. The rack containing three pans of Jello was dirty with residual food. The freezer floor was covered with debris, and the freezer had an open, undated package of hash browns and an open, undated package of perogies, with ice build-up inside of the bag. Cook #1 was interviewed on 5/9/2024 at 9:59 AM and stated that they had panned out the burger patties and put them in the refrigerator. [NAME] #1 stated they should have covered the patties. The Assistant Food Service Director was interviewed on 5/9/2024 at 10:17 AM and stated they check the walk-in refrigerators twice a day for cleanliness. The Assistant Food Service Director stated that they make a list of what needs to be cleaned. A cleaning person comes in three times per week; however, everyone should be cleaning up after themselves. The Assistant Food Service Director stated that the walk-in refrigerators are swept and mopped every night. The Assistant Food Service Director stated that the cooks are responsible for sealing any open packages, dating, and properly storing the food packages. Each person is responsible for cleaning their workstation, including the top and bottom of the counters. At the time of the interview, the Surveyor and the Assistant Food Service Director toured the kitchen and noted that underneath the cook's table and the coffee urn table, there was food residue and grease buildup present. The Food Service Director was interviewed on 5/9/2024 at 10:38 AM and stated a cleaning person is assigned to perform special cleaning assignments three times a week, such as cleaning the mixer machine and food racks. The Food Service Director stated that daily cleaning is also done; however, there is no cleaning schedule. The food service director stated that the open packages of food in the freezer should have been sealed and dated. The rack of raw beef patties should have been covered and dated and the Jello should not have been placed on a dirty rack. The Food Service Director stated that each person is responsible for cleaning their workstation and acknowledged that the areas underneath the worktables are not being cleaned. 2). The facility policy and procedure titled, Meal Service dated 1/1/2024, documents the facility staff will serve resident trays and will help residents who require assistance with eating. All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. A facility policy and procedure titled, Hand Washing/Hand Hygiene created in 4/2024 documents the facility considers hand hygiene the primary means to prevent the spread of health-care-associated infections. Hand hygiene is indicated immediately before touching a resident, after touching a resident, and after touching the resident's environment. A Dining observation was completed on 5/1/2024 at 11:24 AM in the first-floor main dining room. Therapeutic Recreation Aide #1 was observed touching a garbage can and then opening food containers on a resident's tray without performing hand hygiene. Therapeutic Recreation #1 then proceeded to serve another meal tray without performing hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the Dining observation on 5/1/2024 at 11:30 AM in the first-floor main dining room the Registered Nurse Education Coordinator was observed fixing their hair and then setting up a resident meal tray without performing hand hygiene. The Registered Nurse Education Coordinator was immediately interviewed on 5/1/2024 after the observation and stated they should have performed hand hygiene prior to preparing the meal tray. Therapeutic Recreation Aide #1 was interviewed on 5/1/2024 at 11:31 AM and stated that they did receive education on infection control protocols and hand hygiene. Therapeutic Recreation Aide #1 acknowledged that they should have performed hand hygiene before serving meals to the residents. 10 NYCRR 415.14(h)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 28173 Based on observation, record review, and interviews during the Recertification Survey initiated on 5/1/2024 and completed on 5/9/2024 the facility did not provide a sanitary and comfortable environment for residents, staff, and the public. Specifically, four live roaches, one dead roach, and one unidentified crushed insect were observed in the first-floor conference room. Additionally, the kitchen shelf, where the Styrofoam cups were stored, was observed to have a heavy accumulation of dust and debris beneath it. The finding is: The facility policy titled Pest Control dated 10/18/2022 documented the facility has an ongoing pest management program that includes prevention, control of pest activity, and infestation, and ensures that proper handling of all pesticides is in place. On 5/1/2024 at 9:45 AM, two one-gallon beverage urns containing both coffee and hot water were served to the survey team along with a sleeve of Styrofoam coffee cups and individual creamers. Upon preparing one cup with coffee and creamer, 4 small live roaches were observed floating on the coffee surface. The facility Administrator was interviewed on 5/1/2024 immediately after the observations and stated that they believed that the insects may have originated from the cups which were supplied by the facility kitchen. The Pest Management Service Inspection Report Records dated 5/3/2023 through 4/28/2024 were reviewed. Roach activity was reported on 5/31/2023, 7/18/2023 and 8/1/2023. Reports documented observations of crawling bugs on 8/22/2023 at the 1st-floor nursing station on 2/12/2024. Multiple recommendations were made in the reports to the facility for better sanitation practices in the kitchen to prevent insect intrusion. On 5/1/2024 at 11:30 AM, the facility's coffee / hot water urns which supply resident coffee and hot water were inspected in the kitchen while accompanied by the Food Service Director. The coffee/hot water urns showed no evidence of insects; however, appeared to have an accumulation of dust on the surface of the machine. The Food Service Director stated that the coffee / hot water urns should have been cleaned every morning by the incoming shift but did not appear to have been cleaned at that time. Dietary Aide #1 was interviewed and stated that they were responsible for cleaning the coffee and hot water urns but did not conduct a thorough job of cleaning them that morning. The dry storage area where the Styrofoam cups originated from was inspected. The area beneath the shelf where the cups were stored was observed to have a heavy accumulation of dust and debris beneath it. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/2024 at 12:42 PM, the cabinet immediately below the coffee urns in the facility's conference room was inspected; one unidentified crushed insect within the cabinet and one dead roach in a glue trap behind the cabinet were found. This was immediately reported to the Administrator. The Administrator stated that the glue trap behind the cabinet was placed by the pest control company and denied any previous observations of roaches. 10 NYCRR 415.29