STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335383	A. Building B. Wing	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Cabrini Nursing Home	115 Broadway Dobbs Ferry, NY 10522

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation, interview, and record review during the 5/10/23 to 5/18/23 recertification survey, the facility did not ensure all residents had the right to a dignified existence for 2 of 2 residents (Residents #153 and #43) reviewed for dignity. Specifically, (1) A Nurse was observed removing an Intravenous Therapy (IV) from the arm of Resident #153 in the dining room and (2) Resident #43 had a urinary drainage bag that was not covered and was visible from the hallway. Findings include: The policy and procedure titled Quality of Life-Dignity last revised 5/2022 documented staff shall promote, maintain, and protect resident privacy, including bodily privacy, during assistance with personal care and treatment procedures. 1) Resident #153 was admitted to the facility on [DATE] with diagnoses including Benign Prostatic Hyperplasia, history of Malignant Thyroid Neoplasm and Secondary Malignant Neoplasm of Unspecified Lung. The 3/1/23 Quarterly Minimum Data Set (MDS, a resident assessment tool) Assessment documented Resident #153 had moderately impaired cognition. The 5/3/23 physician order documented Cefepime HCL Intravenous Solution 1 gram (gm)/50 milliliter (ml)-use 1 gm intravenously two times a day for Urinary Tract Infection (UTI) for 7 days. The 5/3/23 physician order Dextrose- Sodium Chloride (NaCl) IV solution 5-0.45% use 80 ml/hour intravenously every shift for 7 days. On 05/10/23 at 11:40 AM Licensed Practical Nurse (LPN) #1 was observed removing the IV line from the arm of Resident #153 while the resident was sitting in the dining area. During an interview on 5/10/23 at 11:42 AM LPN #1 stated Resident #153 pulled on the IV and the site was bleeding, so they just removed the IV. LPN #1 stated they were aware that they should not have attended to the IV line in the dining room. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/18/23 at 10:33 AM, Registered Nurse Unit Manager (RNUM) #2 stated LPN #1 informed them that Resident #153's IV site was bleeding heavily so they attended to the IV site in the dining room. RNUM #2 stated the resident's room was at the end of the hallway, so LPN #1 decided to attend to the IV site in the dining room. RNUM #2 stated they informed LPN #1 if the resident was bleeding heavy they should apply pressure and return the resident to their room to provide care. 41666 2) Resident #43 had diagnoses including Hypertension, Neurogenic Bladder and Heart Disease. The 2/28/23 Quarterly MDS documented Resident #43 was cognitively intact and used a urinary catheter for urine output. On 5/10/23 at 11:42 AM, 5/11/23 at 10:05 AM, and 5/15/23 at 8:05 AM, Resident #43 was observed in bed with the resident's urinary drainage bag hanging from the bed frame. The urinary drainage bag was visible from the hallway and not concealed to prevent direct observation by other residents and visitors. During an interview on 5/10/23 at 2:19 PM, Certified Nursing Assistant (CNA) #9 stated that they did not know urinary drainage bags needed to be covered. During an interview on 5/10/23 at 2:25 PM, Registered Nurse Unit Manager (RNUM) #4 stated urinary drainage bags should be covered for privacy and did not know why a pillow case or dignity cover was not used to cover the bag. During a follow interview on 5/15/23 at 11:03 AM RNUM #4 was asked why the urinary drainage bag was still not covered and RNUM #4 stated they forgot to cover it. 415.5(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on record review, and interview conducted during the 5/10/23 to 5/18/23 Recertification Survey, the facility did not ensure that the Minimum Data Set Assessments (MDS, a resident assessment tool) accurately reflected the resident's status. Specifically, Resident #224's diagnosis of Psychosis was not documented on MDS Assessments dated 5/07/21, 8/03/21, 11/01/21, 1/28/22, 4/18/22, 7/01/22, 9/29/22, and 1/30/23. This was evident for 1 of 5 residents reviewed for Unnecessary Medications. The finding is: The facility policy and procedure titled Minimum Data Set effective date: 1/11, last revised 5/2019, documented the facility will use the MDS 3.0 RAI User's Manual for completing the Minimum Data Set to establish and maintain an ongoing process of assessment, care planning, evaluating and revising resident's care in order to attain or maintain the highest practical physical, mental and psycho-social functioning as possible the assessment process will include reviewing the resident medical record Resident # 224 was admitted on [DATE] with diagnoses which included Alzheimer's Disease, Anxiety Disorder, Unspecified Dementia, and Major Depressive Disorder. Review of the Physician's Orders included: 4/30/21 to 5/07/21 Ativan 0.5 mg twice a day, 4/30/21 to 4/05/23 Seroquel 25 mg three times a day for Anxiety, 5/01/21 Lexapro 20 mg daily for depression, 5/03/21 Psychiatric Consult, 5/07/21 to 12/03/22 Clonazepam 0.5 mg three times a day for Anxiety, 12/03/22 Clonazepam 0.5 mg every 12 hours for Anxiety and 4/05/23 Seroquel 25 mg twice a day. A review of the Psychiatrist Consultation Reports dated 5/20/2021, 6/17/21, 7/29/21, 9/30/21, 11/11/21, 1/6/22, 8/19/22 documented diagnoses which included history of early onset Dementia with Depression, Anxiety and reported history of Psychosis. There was no documented evidence for the diagnosis of Psychosis in the Minimum Data Set (MDS) Admission assessment dated [DATE], 8/03/21, 11/01/21, 1/28/22, 4/18/22, 7/01/22, 9/29/22, 11/28/22 and 1/30/23. A review of the Care Plan Psychotropic Drug Use dated 6/01/21, last reviewed 3/15/23 documented the resident continues on Clonazapam 0.5 mg, Seroquel 25 mg for anxiety and Lexapro 20 mg for depression. Interventions included Psychiatry consult as needed and administer medications as ordered, monitor for changes in activities of daily living (ADLs), mood, behavior, weight, labs as ordered. On 5/18/23 at 9:25 AM, an interview was conducted with the resident's primary physician, who stated they are aware that the resident has diagnoses which include Depression, Anxiety, Delusional Disorder, and Psychosis, as listed in the Psychiatrist's Consultation reports. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/18/23 at 9:50 AM, an interview was conducted with the covering MDS Coordinator. The MDS Coordinator stated the MDS assessor should review all the consults from the quarter and add any new diagnoses. The covering MDS coordinator reviewed the resident's MDS assessments dated 5/07/21, 8/03/21, 11/01/21, 1/28/22, 4/18/22, 7/01/22, 9/29/22, 11/28/22, 1/30/23, and confirmed that the diagnoses of Psychotic Disorder or Delusional Disorder were not added to the assessments. On 5/18/23 at 9:10 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who stated that the MDS nurse who is completing the assessment should review all consultation reports including the Psychiatrist's Consultation Reports and should add diagnoses as appropriate. 415.11

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 45478 Based on observation, record review and interview conducted during the 5/10/23 to 5/18/23 recertification survey it was determined for 1 of 1 resident (Resident #127) reviewed for range of motion/position mobility, the facility did not ensure all residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent a further decrease in range of motion. Specifically, Resident #127 required left hand resting splint as per therapy evaluations and recommendations and was observed without the resting splint in place. The findings are: The Policy and Procedure titled Range of Motion last revised 5/2019 documented the nurse manager, or nursing supervisor in collaboration with the Rehabilitation Department determined the type and frequency of Range of Motion (ROM) to be done on selected joints. This determination and approach were to be documented on the care plan. Resident # 127 was admitted to the facility 3/23/22 and had diagnoses that included Non-Alzheimer's Dementia, Muscle Weakness and Abnormalities of Gait and Mobility. The 2/8/23 Occupational Therapy (OT) note documented to evaluate and treat for contracture of the left hand and the goal was to exhibit decreased pain with movement, and during splint management to decrease pain level of 2/10 in the left hand and in the left wrist. The 2/24/23 Quarterly Minimum Data Set (MDS, resident assessment tool) Assessment documented Resident #127 had severe cognitive impairment with both short term and long-term memory problems; required extensive assist of one person for bed mobility; extensive assist of two persons for transfer and toileting; and extensive assist of one for eating. The 2/24/23 Occupational Therapy (OT) Discharge Assessment documented that Passive Range of Motion (PROM) was done to left hand/wrist with resident still in some degree of pain during maneuver. Splint placement to left hand was done after mobilization and noted less degree of stiffness/contracture. Nursing was informed that the last day of OT was today, and that staff were to continue with splint management and to refer to OT for any issues with the splint. The 4/17/23 Physician Order documented to apply the resting splint to the left hand every day and evening shift for contracture; and to remove at night and during hygiene. There was no documented evidence in the April 2023 Treatment Administration Record (TAR) for the use of the left-hand splint on 4/20/23 day shift, 4/22/23 day shift, 4/22/23 evening shift-blank, and 4/29/23 day shift. There was no documented evidence in the May 2023 Treatment Administration Record (TAR) for the use of the left-hand splint on 5/2/23 day and evening shift, 5/3/23 day and evening shift, 5/5 evening, 5/11/23 day shift, 5/12/23 evening shift, 5/14/23 day shift, 5/15/23 evening shift and 5/16/23 day shift. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence on the Activities of Daily Living Comprehensive Care Plan (CCP) dated 3/23/22 for the use of the left-hand resting splint. During observations on 5/11/23 at 12:21 PM and 5/16/23 at 2:53 PM, Resident #127 did not have the left-hand resting splint in place. During an interview on 5/18/23 at 9:48 AM, Certified Nurse Assistant (CNA) #2 stated Resident #127 had a contracture and cried in pain when CNA #2 would attempt to apply the splint. CNA #2 stated they did not put the splint on Resident #127 because it was painful for the resident. CNA #2 stated they informed the nurse that the resident was in pain and even when the nurse tried to apply the splint the resident cried. During an interview on 5/18/23 at 9:55 AM, Licensed Practical Nurse (LPN) #2 stated that the CNAs informed LPN #2 that Resident #127 was crying in pain when they tried to put the splint on. LPN #2 stated they had to sign for the splint in the TAR and stated that they signed and indicated 9 for (other) because the resident could not tolerate the splint due to the pain. LPN #2 stated they informed the therapist from rehab about the pain but was tolerating the splint when the resident was discharged from program. During an interview with Occupational Therapist (OT#1) on 05/18/23 10:08 AM, OT #1 stated the only way rehab would be aware of any concerns with a splint or device would be dependent upon a referral from nursing for reassessment. OT #1 stated they were not informed verbally or in writing of the pain the resident was having with the splint. During an interview on 5/18/23 at 10:15 AM, the Director of Rehabilitation stated the formal procedure for therapy was for the staff to inform the nurse or nurse manager of any concerns and the nurse should send an OT referral. The Director of Rehabilitation stated they were not able to find a referral from nursing regarding resident #127 having pain with the use of the splint. The Director of Rehabilitation stated they have a tracker of referrals and did not find Resident #127 on the list. During an interview on 5/18/23 at 10:39 AM, Registered Nurse Unit Manager (RNUM) #2 stated there was no need for a referral to OT for pain with the splint. RNUM #2 stated resident #127 was not in pain and that the resident was just confused and resisted cares. 10 NYCRR 415.12(e)(1)

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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. 45478 Based on record review, observation, and interviews during the 5/10/23 to 5/18/23 recertification survey, the facility did not ensure residents were provided nutritional supplementation consistent with the resident's plan of care for one of two residents (Resident #135) reviewed for Nutrition. Specifically, Resident #135 did not receive their nutritional supplement as ordered by the physician. The findings are: The Policy and Procedure titled Nutrition Supplement Monitoring dated 2/2020, documented residents with weight loss or at risk for weight loss were provided with nutritional supplements as ordered by physician. Resident #135 was admitted to facility on 4/26/19 with diagnoses including Unspecified Dementia, Hypo-Osmolality and Hyponatremia. The physician orders documented on: - 10/21/22, 120 milliliter (ml) Milkshakes 3 times a day with meals; - 12/19/22, Magic cup 4 oz. at lunch meals; - 2/17/23, Liquid Protein Supplement (LPS) Sugar Free (SF) 30 ml 3 times a day; - 3/17/23, HI Cal 4 oz. 3 times a day; and - 5/11/23, Magic cup 4 oz. at supper. The 11/4/22 weight report documented Resident #135 weighed 85.3 pounds. The 2/23/23 Significant Change Minimum Data Set (MDS) Assessment documented Resident #135 had severe cognitive impairment, and required extensive assist of 1 person for eating. Resident #135's height was documented as 64 inches and Resident #135 weighed 77 pounds. The 3/3/23 Significant Change Nutrition Assessment documented resident's current weight: 76.8 pounds, loss of 8.5 pounds (9.9%) x 3 months. Current diet ordered was regular diet, mechanical soft texture, thin liquids. Appetite/fluid intakes remained varied approximately 25-75% per observations/staffing reports. Resident required extensive assist with feeding. Food preferences were reviewed with staff/designated representative on an ongoing basis. Supplements included LPS SF 30 ml 3 x daily, Ensure Enlive 4 oz- 3 x daily (25-100% per MAR), 4 oz Milkshakes 3 x daily (75-100% per MAR), Magic cup @ lunch and supper L-S (100% per MAR), fortified foods; super cereal at breakfast, super potatoes at lunch and supper. The 4/10/23 weight report documented Resident #135 weighed 74 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/16/23 at 12:05 PM the lunch tray ticket documented egg salad sandwich with no crust, 1/2 cup super-potato, 1/2 cup chopped broccoli, 1 cup vanilla magic cup, 4-ounce milk shake, cranberry juice, tea, water, salt, pepper, and sugar. The tray for Resident #135 was missing the supplements including the super potato, magic cup, 4 oz. milkshake and the 1/2 cup of chopped broccoli. During an observation on 5/17/23 at 8:43 AM, the breakfast tray ticket documented hard cooked egg, super cereal, 8 oz milk, 4 oz vanilla milkshake, butter, coffee, orange juice, water, salt, pepper, and sugar. The tray for Resident #135 was missing the 4 oz vanilla milkshake. During interviews on 5/16/23 at 12:14 PM and 5/18/23 at 12:03 PM, the Registered Dietician (RD) #2 stated they were unsure why Resident #135 was not provided with the supplements on their tray. RD #2 stated when the food comes up from the kitchen the dietary staff should put the supplements on the tray. RD #2 stated they tried to keep the supplements on the tray to help Resident #135 since their weight fluctuated. RD #2 stated the nurses documented in the Medication Administration Record (MAR) the intake of the supplements and the dietician monitors the MAR monthly. If there was a recent change in a supplement RD #2 would review 7 days of supplements in the MAR to see how the resident was accepting the supplement. During an interview on 5/16/23 at 12:40 PM Certified Nurse Assistant (CNA) # 1 stated dietary staff were responsible for putting all the food items on the tray including the supplements. CNA # 1 stated when they took the tray from the dietary staff they double checked the tickets. When CNA #1 was asked why the supplements were not on Resident #135's tray, CNA # 1 stated the resident was constantly refusing food/supplements so they did not put it on the tray. CNA # 1 stated they did inform the dietician previously and that the dietician should have removed the supplements from the diet. During an interview on 5/16/23 at 12:51 PM Dietary Aide #3 stated that when they prepared a tray, they looked at the tray ticket and put the food and drinks that were listed on the ticket on the tray, including the supplements. Dietary Aide #3 stated they were never told to remove supplements from the tray of Resident #135. Dietary Aide #3 stated the reason for not putting the supplement on the tray of Resident #135 was because they knew Resident #135 well and that Resident #135 refused the supplements. During interviews on 5/17/23 at 3:20 PM and 5/18/23 at 11:44 AM the Food Service Director (FSD) stated they received the order for who needs the supplements, and the kitchen would ensure the residents received it on their trays. The FSD stated if a resident was refusing supplements; the process was the CNA should go their nursing supervisor and inform them resident was refusing, then the nursing supervisor would inform dietician and then they would proceed to make a decision with the MD and discuss a plan. 415.12(i)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43478 Based on observations, interviews and record review during a recertification survey from 5/10/23 to 5/18/23, the facility did not ensure that an infection surveillance plan based on the facility assessment was implemented for identifying, tracking, and monitoring infections, communicable diseases, and outbreaks. Specifically, infections were not being documented on the infection line list at onset of signs and symptoms of infection. The findings are: The facility Policy and Procedure Infection Surveillance effective 9/2002, and last updated 6/2022, documented an infection control program is developed and implemented to identify and investigate infections, to control the spread of infections The Infection line listing is to collect data on each potential or actual infection and to evaluate the infection control methods and to identify and clarify problems with policies or techniques, and bring to the attention of the Safety Committee and QAPI Committee. A review of the Infection Preventionist's Infections logs documented: Skin & Wound Infections Methycillin Resistant Staff Aureus (MRSA) and Cellulitis, three residents did not have documented onset dates of signs and symptoms, whether lab testing was collected, or whether lab results were obtained although they were documented to be on an antibiotic treatment. Urinary Tract Infections (UTI), four residents did not have documented onset dates of signs and symptoms, whether the Physician (MD) or Nurse Practitioner (NP) were notified, whether lab testing was collected, or whether lab results were obtained although they were documented to be on antibiotic treatment. COVID, seven residents did not have documented onset date of signs and symptoms or whether treatment was ordered and in progress. Pneumonia (PNA), BRONCHITIS, Upper Respiratory Infection (URI) and INFLUENZA, fifteen residents did not have documented onset date of signs and symptoms. On 5/18/23 at 1:22 PM, an interview was conducted with the Infection Preventionist/Director of Nursing (IP/DON). The IP/DON stated they were made aware of infections when the nurse managers gave morning report and infections were documented on the end of shift report, but they did not add those residents to their line list of infections until treatment was started. The IP/DON stated the Nurse Managers were responsible for completing assessments, notifying the MD or NP, transcribing orders, collecting specimens, getting lab results, and notifying the MD/NP of the lab results. The IP/DON stated that although they were aware of residents with signs and symptoms of infection, they did not evaluate if there were clusters of infection on a particular unit or provide staff education for prevention purposes. When asked, the IP/DON stated they did not know how many residents were on precautions at the time or how many UTI's were currently in house. The IP/DON stated their role as Infection Preventionist was to provide staff education regarding hand hygiene, hand washing, and personal protective equipment (PPE). On 5/18/23 at 2:13 PM an interview was conducted with the facility Administrator. The Administrator stated that infections and specimens and physician's orders for labs were documented on the end of shift reports by the Registered Nurse Unit Managers (RNUMs) or Registered Nurse (RN) Supervisors on the evenings, weekends, and nights, and were not entered onto the infection line lists until treatment was started. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	415.19