STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335434	A. Building B. Wing	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Neck Care Center	260 19 Nassau Blvd Little Neck, NY 11362

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/12/22 to 10/18/22, the facility did not ensure a resident remained free from physical restraints. This was evident for 1 (Resident # 25) out of 2 residents reviewed for Restraints. Specifically, Resident # 25 was observed on several occasions lying in bed with 2 pillows placed underneath the fitted sheet on each side of the resident, bordering the length of the body to prevent Resident # 25 from getting out bed. The findings are: The facility policy titled Restraints / Siderail - Bed System with no effective date and the last review date 4/29/22 documented Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot easily remove which restricts freedom of movement or normal access to one's body. It also documented that physical restraint will only be utilized after less restrictive alternatives have been attempted and considered as a last resort. Resident #25 was admitted to facility with diagnoses of Other cerebral infarction due to occlusion or stenosis of small artery, Spastic Hemiplegia affecting left nondominant side, and Aphasia following cerebral infarction. The Admission Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident # 25 had severely impaired cognition, required extensive assistance with 2 persons for bed mobility, was totally dependent on two persons for transfer, and did not use physical restraints. On 10/12/22 at 1:57 PM, 10/13/22 at 10:16 AM, 10/14/22 at 02:47 PM and 10/17/22 at 10:06 AM and other occasions, Resident # 25 was observed lying in bed with two pillows placed underneath the fitted sheet on each side of the resident bordering the length of the body. The pillows were not supporting or positioning Resident #25 in bed on these occasions. There was no floor mat observed. The bed was observed about 2 feet above the floor level. The Comprehensive Care Plan (CCP) related to falls, initiated 7/18/2022, documented the interventions of placing bed in the lowest position and call bell within easy reach and providing assistance in ADL's to prevent Resident #25 from falling. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Nursing Assessment started on 7/14/22 and completed on 7/18/22 documented the safety measures included to orient resident to room, unit & safety precautions and call-bell usage; place call-bell and frequently used items within reach; refer to PT /OT for screen/evaluation; place bed low; and wear non-skid footwear. The Rehabilitation Screening Form started and completed on 7/15/2022 documented Resident #25 required extensive assist of 2 persons for transfer and bed mobility. There was no physician's order to use physical restraints in bed for Resident #25. On 10/17/22 at 10:48 AM, Certified Nursing Assistant (CNA) #4 was interviewed and stated Resident #25 puts their lower extremities out of bed to push themselves out of bed about twice per week. CNA #4 also stated Resident #25 was unable to stand or walk by themselves without assistance. CNA #4 further stated they put two pillows underneath the fitted sheet on each side of Resident #25 to prevent them from getting out of bed and falling. On 10/17/22 at 11:11 AM, Licensed Practical Nurse (LPN) #1 was interviewed and stated Resident #25 was very restless in bed and tried to get out of bed all the time. LPN #1 also stated it was nursing judgment to do something like placing the pillows under the bed sheet on both sides to prevent Resident #25 from falling. LPN # 1 stated they did not have a floor mat for Resident #25 because it required a physician's order. LPN #1 also stated the bed was at the lowest position already, and it could not be lowered to the floor level. On 10/17/22 at 11:42 AM, the Physical Therapist Assistant (PTA) was interviewed and stated Resident #25 liked to put their legs over the edge of the bed. The PTA also stated Resident #25 would fall onto the floor if they got out of bed. PTA further stated Resident #25 was unable to get out of bed when the pillows were placed under the sheets on both sides of the bed. The PTA stated they were not involved in the decision to place the pillows underneath the fitted sheet, and they could not recall if the pillows were used before Resident #25 was discharged from rehab last month. On 10/17/22 at 12:06 PM, Registered Nurse (RN) #1 was interviewed and stated anything that restricts a resident's movement is considered a physical restraint. RN #1 also stated they had to perform an assessment, have a meeting with the representative, obtain a physician's order, create a care plan before applying a physical restraint. The resident should also be assessed after using the restraint. RN #1 stated they made rounds on the units 1 to 2 times per day to ensure safety of residents and if the care provided aligned to facility policies and government regulations. RN # 1 also stated they were not aware the staff placed pillows on each each side of the resident underneath the fitted sheet, which prevented Resident #25 from getting out of bed. On 10/17/22 at 12:26 PM, the Director of Nursing (DON) was interviewed and stated they did not use physical restraints for residents in the facility. The DON also stated they made rounds on the units 1 to 2 times every day to ensure compliance of care and resident's safety. The DON stated they were not aware that staff placed pillows underneath the fitted sheet on both sides of bed and was not able to explain why they did so. The DON stated the staff should not put pillows under the fitted sheet, and they should have reported any concerns about falls regarding Resident #25 to the nursing supervisor. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/22 at 01:44 PM, the Nurse Practitioner (NP) was interviewed and stated Resident #25 did not have a medical doctor order for physical restraints. The NP stated the nursing staff should lower the bed to the floor level and use floor mats to prevent injuries from falls for Resident #25. 415.4(a)(2-7)

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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** 40565 Based on observation, record review and interviews conducted during the Recertification and Complaint survey (NY00292535), the facility did not ensure the Minimum Data Set (MDS) 3.0 assessment accurately reflected the resident's status. This was evident for 2 of 28 sampled residents (Resident #29 and Resident #305). Specifically, 1) Resident #29's use of anticoagulant and antidepressant medication were not documented on the MDS. 2) Resident #305's insulin injections were not documented on the MDS. The findings are: The facility policy and procedure titled Minimum Data Set (MDS) 3.0 revised 3/18/22 documented as mandated by OBRA, facility will complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs. The results of the assessment, which must accurately reflect the resident's status and needs, will be used to develop, review, and revise each resident's comprehensive plan of care. 1). Resident #29 was admitted to the facility with diagnoses that included Heart Failure, Paroxysmal Atrial Fibrillation, and Depression. The Quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented that the resident has moderate impairment in cognition, and required extensive assistance of staff for bed mobility, transfer, toilet use, and limited assistance of staff locomotion, dressing, personal hygiene. The MDS documented that Resident did not receive Anticoagulant and Antidepressant during the last 7 days. On 10/12/22 at 11:24 AM, Resident #29 was observed in the room, noted with some discoloration and small bruising on the right hand. Resident #29 was interviewed and stated that they are on Anticoagulant therapy. The Comprehensive Care Plan (CCP) for Anticoagulant Therapy dated 9/8/2022 documented Resident #29 has potential for bleeding and is at risk for signs and symptoms of bleeding related to (r/t) the use of Anticoagulant medication, and the resident was on Eliquis therapy r/t Paroxysmal atrial fibrillation. The CCP interventions included: - Administer anticoagulant therapy as per MD order; Assess for signs of abnormal bleeding; Report for any changes of in skin condition (e.g., discoloration, ecchymosis), signs of abnormal bleeding, or side effects of medication to physician. Physician's orders dated 09/08/2022 and 10/08/2022 documented orders for Eliquis 2.5 mg tablet by oral route 2 times per day for Paroxysmal atrial fibrillation and Escitalopram 20 mg tablet by oral route once daily for Major depressive disorder, recurrent, moderate. The Medication Administration Record (MAR) for September and October 2022 documented that Resident #29 received Eliquis 2.5 mg tablet by oral route 2 times daily and Escitalopram 20 mg tablet by oral route once daily from 09/08/2022 to the current date. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/22 at 12:05 PM, an interview was conducted with the RN Supervisor (RN #1). RN #1 stated RNs are responsible for residents' assessment and care plan initiation and updates, while the MDS coordinators are responsible for documenting the resident MDS. RN #1 also stated that they know that Resident #29 is on anticoagulant (AC) medication, which is documented in the care plan, but they did not know the resident's use of anticoagulant and antidepressant were not documented in the resident MDS. On 10/18/22 at 12:26 PM, an interview was conducted with the MDS Coordinator (MDSC). MDSC stated that as per the resident's Medication Administration Records just reviewed, Resident #29 was on AC and antidepressant prior to the Assessment Reference Date of the MDS, and the medications should be documented in the MDS. MDSC stated that the omission must have been an error on the part of the MDS assessor which was not caught by the MDS Coordinator before submission. On 10/18/22 at 12:34 PM, an interview was conducted with the Assistant director of Nursing (ADON). The ADON stated that the accuracy of the MDS should be checked by the MDS Coordinator, who is presently not available. The ADON stated they were not aware that Resident #29's MDS was not accurately documented. On 10/18/22 at 01:03 PM, an interview was conducted with the Director of Nursing (DNS). DNS stated that MDS Coordinator is responsible for checking the accuracy of documentation of the resident's MDS before submission. DNS stated that they are not aware of the inaccurate documentation noted. 45351 2). Resident #350 was admitted to the facility with diagnosis of Alzheimer's disease, Aphasia and Type 2 Diabetes Mellitus. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #350 had severely impaired cognition and was not able to complete a Brief Interview of Mental Status. Required total dependence with two persons assist for bed mobility and transfer. It did not document that Resident #350 received insulin injections. The Comprehensive Care Plan (CCP) titled Diabetes Mellitus: DM 2 dated 3/2/22 documented interventions included to administer medications as ordered and monitor blood glucose level as ordered by MD. The physician's orders dated 3/2/22 documented Humalog KwikPen Insulin 100 unit/mL subcutaneous with FS TID 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units . The Medication Administration Record (MAR) for March 2022 documented that Humalog Insulin with finger stick were administered at 7:15 AM on 3/3/22 to 3/8/22, 3/10/22 and 3/11/22; 11:30 AM on 3/4/22, 3/6/22, 3/8/22 3/10/22 and 3/11/22; 4:30 PM on 3/3/22, 3/4/22, 3/8/22, and 3/10/22. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/22 at 1:48 PM, MDS Coordinator #2 was interviewed and stated the physician's order for insulin injections was initiated on 3/2/22, but it was not captured in the MDS assessment dated [DATE] for Resident #350. MDS Coordinator #2 stated that it was an oversight and was probably missed because the insulin order was newly initiated after the resident was readmitted to the facility. MDS Coordinator #2 stated the staff will have to review more thoroughly to ensure that any new changes are reflected in the MDS assessments. In addition, the assessments will be checked by another staff to ensure all information are accurately reflected in the resident's MDS assessments. On 10/18/22 at 3:58 PM, the Director of Nursing (DON) was interviewed and stated they were not aware of the missing medication in Resident #350's MDS assessment. The DON stated resident's insulin injection should have been indicated in the medication section since the resident was given insulin injections during the 7-day look back period. 415.11(b)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on record review and staff interviews conducted during a Recertification/Complaint Survey from 10/12/2022 to 10/18/2022, the facility did not ensure that the resident and their representative were provided with a written summary of the baseline care plan. This was evident for 1 (Resident #203) of 3 residents reviewed for Care Plan out of 28 sampled residents. The findings are: The facility policy titled Baseline Care Plan (BCP) with review/updates dates 11/10/17, 4/16/19 documented that the Baseline Care Plan shall be given to the resident/resident representative within 48hrs of admission by the RN Supervisor or designee and signature shall be obtained by receiving party. It also documented that if the receiving party is not able to sign or prefers not to, documentation shall be obtained as to the circumstances. It further documented that the facility shall make every effort to provide documents to resident/resident's representative within 48hrs of admission including but not limited to certified mail, telephone notification, and/or hand delivery by the RN Supervisor or designee. Resident #203 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Unspecified dementia without behavioral disturbance; and Cerebral ischemia. The Admission Minimum Data Set (MDS) dated [DATE] documented Resident # 203 had Brief Interview of Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. The MDS also documented only Resident #203 participated in the assessment. On 10/12/22 at 10:15 AM, Resident #203 was interviewed and stated they made decisions for themselves. Resident #203 also stated they were admitted to the facility about 3 weeks ago and did not receive any hard copy of the initial baseline care plan. The Baseline Care Plan (BCP) was documented as created on 9/27/2022 and completed on 9/29/2022. The acknowledgement of receipt section of the BCP had a Registered Nurse signature on 9/29/2022. There were no signatures for Resident #203 or their designated representative. Review of progress notes from 9/27/2022 to 10/13/2022 in the EMR and the hard copy chart revealed no documented evidence that Resident #203 and/or their designated representative were provided with a copy of or signed the baseline care plan. On 10/14/22 at 12:39 PM, Registered Nurse (RN) # 1 was interviewed and stated that Baseline Care Plan (BCP) was created and completed within 2 to 3 days of resident's admission. RN # 1 also stated they did not know who was responsible for giving the BCP to the resident and/or representative and where this would be documented in the medical chart. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/22 at 12:52 PM, Director of Nursing (DON) was interviewed and stated the RN supervisors or DON were responsible to check if the BCP was completed within 48 hours of admission. The DON also stated the Social Worker was responsible to give a hard copy of Baseline Care Plan to resident and/or representative in 48 hours after its completion and should document it in the medical record. On 10/14/22 at 01:23 PM, the Care Manager/Social Worker (CM) was interviewed and stated the Social Worker (SW) was responsible to complete the section I and IV in Baseline Care Plan within 24 hours of resident admission. CM also stated it was not the responsibility of Social Worker to give a hard copy of Baseline Care Plan to resident and/or representative. On 10/14/22 at 01:39 PM, the Director of Social Work (DSW) was interviewed and stated the nursing staff were responsible for providing a hard copy of Baseline Care Plan to the resident and/or representative, and it should be documented in the medical record. On 10/17/22 at 09:31 AM, the DON was interviewed again and stated they signed the acknowledgement of receipt section of the BCP. The DON also stated they forgot to print a copy of the BCP for the RN supervisor to give to the resident and/or representative 415.11 (c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on record review and interview conducted during the recertification survey from 10/12/22 to 10/18/22, the facility did not ensure a resident was offered the opportunity to participate in the development of their comprehensive care plan (CCP). This was evident for 1 (Resident #20) of 2 residents reviewed for care plan meeting (CPM). Specifically, Resident #20 was not invited to participate in quarterly CPMs. The findings are: The facility policy titled Care Plans - Comprehensive Person-Centered dated 05/01/2022 documented residents have the right to participate in the development and implementation their care plan. Resident #20 had diagnoses of coronary artery disease (CAD) and hypertension. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #20 was moderately cognitively impaired. On 10/12/22 at 10:02 AM, Resident #20 was interviewed and stated they are not invited to participate in their CPM with the interdisciplinary team. There was no documented evidence Resident #20 or their representative was invited to scheduled CPM upon comprehensive assessments dated 10/28/21, 1/28/22, 4/28/22, and 7/25/22. On 10/18/22 at 11:50 AM, the Social Worker was interviewed and stated residents admitted for short term care are invited to their initial CPM within 2 weeks of their admission. Long term residents are not invited to their quarterly CPM. On 10/18/22 at 03:21 PM, an interview was conducted with the Director of Social Services (DSS). DSS stated that new admissions and their family members are invited to the initial CPM held within 2 weeks of admission and documented in electronic medical record. The quarterly CPMs are done by the Interdisciplinary Team Members, without inviting the residents/family members. 415.11(c) (1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observation, record review, and staff interview conducted during the Recertification and Complaint survey (NY00292455) from 10/12/22 to 10/18/22, the facility did not ensure that residents are provided pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This was evident for 1 (Unit 3) of the 3 units medication storage rooms and 1 (Resident #257) of 1 resident(s) reviewed for pain management out of 28 sampled residents. Specifically, 1) the facility did not ensure that expired medications were removed and discarded according to the manufacturer's recommendation, and 2) the facility did not ensure Trulance and Clozapine were dispensed to Resident #257 as ordered upon admission. The findings are: The facility Policy on Medication Storage dated 08/21/2021 documented: .Discontinued, contaminated, expired, or deteriorated medications are removed from the medication/treatment storage area and disposed of per facility policy. The facility's policy titled Laboratory Services, dated 06/19 and reviewed 12/21, documented that it is the policy of this facility to perform laboratory tests at appropriate intervals per M.D. order and in accordance with federal indicators/ or state regulations and to ensure that the laboratory request are expedited as quickly as possible. 1) On 10/13/22 at 10:11 AM during the Medication Storage Room Observation on the 3rd Floor, 2 bottles of Aspirin low dose 81 mg tablet with expiration date of 07/2022 were observed in the medication cabinet. On 10/14/22 at 12:04 PM, an interview was conducted with the Licensed Practical Nurse, LPN #2. LPN #2 stated that the medication storage room is checked monthly by the nurses and the pharmacy to remove any expired medication noted, and report to the nursing office. LPN #2 also stated that the expired meds noted in the storage room must be part of medications recently brought up during the week by the supply staff. On 10/14/22 at 12:17 PM, an interview was conducted with the Central Supply Manager/Medical record, (CSM) that supplies medication to the unit. CSM stated that medications are delivered to the units at least 2 times a week; the medication was last delivered to the floor this week Tuesday, 10/11/22 from the medication storage downstairs. CSM also stated that medications are checked for expiration date before delivering them to the units, but the expired meds could have mixed up while bringing them, or it could have been an oversight to check the expired meds while delivering to the unit. CSM further stated that they are not sure if, and when the pharmacy consultant comes to check for the facility expired medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/22 at 10:47 AM, the Pharmacy consultant (PC) was interviewed. PC stated that inspection is done monthly on each of the 3 units of the facility to check the medication carts, the medication rooms and the refrigerators, any expired medication noted is removed and reported to the Director of nursing. PC stated that they do not check the facility main storage, but the facility is notified of any expired items noted on the units for them to check their storage for any similar items found expired to be removed and discarded. PC also stated that they were in the facility last on September 28, 2022, for the inspection, and no expired medication was found then. On 10/18/22 at 01:09 PM, an interview was conducted with the Director of Nursing. DNS stated that a staff was assigned to check the medication supplied to the facility (Central Supply Medical Manager), who is also responsible for ordering and checking the expiration of the medication supplied to the facility prior delivery to the units. 44864 2) Resident #257 was admitted [DATE] with diagnoses which include Schizoaffective Disorder, Irritable Bowel Syndrome, and Rhabdomyolysis. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #257 received 3/7 days of antianxiety medication, 4/7 days of antipsychotics. The New York State ASPEN Complaint Tracking System (ACTS) intake dated 3/11/22 documented the complainant reported Resident #257's medications were delayed in arriving to the facility upon admission and administration was delayed once they arrived to the facility. The Physician's Orders dated 2/12/22 documented the following medication orders: Clozapine 200 mg (milligrams) tablet: give 1 tablet (200 mg) by oral route once daily at bedtime. Give with 150mg to = 350 mg Clozapine 100 mg tablet : give 1 tablet (100 mg) by oral route once daily at bedtime Give with 200mg to = 350 mg at bedtime. Trulance 3 mg tablet: give 1 tablet (3 mg) by oral route once daily. The Clozapine tablets ordered totaled 300 mg instead of 350 mg. The Physician's order dated 2/12/22 at 5:11PM further documented a routine lab order for a Comprehensive Metabolic Panel (CMP). The order was not a stat order. An undated fax sent to the surveyor by the pharmacy documented that the dosage of the Clozapine was incorrect and needed clarification prior to sending the medication. The Comprehensive Care Plan (CCP) related to Psychotropic Drug initiated 2/13/22 documented a note dated 2/14/22 that medications were held as per Medical Doctor (MD) order since admit and a meeting was held with the complainant. There is no documented evidence the complainant attended a CCP meeting with facility staff on 2/14/22. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse Practioner (NP) Admission Note dated 2/14/22 documented Resident #257 was evaluated by the NP. The note documented a plan to continue with Clozapine and Trulance. The Medication Administration Record (MAR) for February 2022 documented Resident #257 did not receive the bedtime dose of Clozapine on 12/12/22 and 12/13/22. The resident did not receive the 9:00AM dose of Trulance on 2/13/22 and 2/14/22. The MAR further documented a note for all of the missed doses indicating the medication was Held as per Physician's Order: The pharmacy delivery packing slip documented Clozapine and Trulance were sent and received by the facility on 2/14/22. There was no documented evidence the Medical Doctor or NP ordered Resident #257's Trulance and Clozapine to be held from 2/12/22 to 2/15/22. There was no documented evidence the physician or NP were informed the medications were not available on from 2/12/22 to 2/14/22 or that the Clozapine order needed clarification. There was no documented evidence in the medical record that the Pharmacy informed the facility a lab was required to dispense Clozapine or Trulance on 2/12/22 or 2/13/22. A Physician's Order dated 2/15/22 documented an additional order for one Clozapine 50 mg tablet to be given at bedtime with the 200mg and 100mg tabs to total 350 mg. On 10/17/22 at 10:39 AM the Pharmacy Technician was interviewed and stated when medication orders are placed in the electronic medical record, the orders are received by the Pharmacy, and are sent to the facility within 24 hrs. If there is an issue with the order, for example, the dosage is incorrect, a call will be made to the facility and the information will be faxed for clarification. In the case with the Clozapine, there was a fax sent for clarification of the dosage and then the medication was sent 2 days later. On 10/17/22 at 10:46 AM and 10/18/22 at 05:25 PM, the Director of Nursing (DON) was interviewed. DON stated if the MD knows that the medication is not here, then the medication needs to be held, based on the MD's recommendation. The medication should be there on the next delivery. Normally the pharmacy would call the facility and then the facility would follow up and would send an email. There should be a progress note in the chart because the pharmacy would not always call, and that the facility does not usually get the clarification. The DON said that they have never gotten a clarification from the pharmacy. Labs are drawn Monday Wednesday, and Friday, but if a lab is ordered on Saturday and it is not stat, then it's not picked up on that day, and there is a delay. This issue was discussed by the NP, to see if the blood work is not done, then the medication can still be given, but this medication was held until the blood work came back and given on Monday. The facility has stock medications, but those medications are not part of the stock. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335434	A. Building B. Wing	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/22 at 2:04 PM the NP was interviewed and stated that for the medications, Clozapine and Trulance, the Pharmacy does not deliver the medication until the facility sets up the blood works (CBC differential). Resident #257 was admitted on a Saturday, 02/12/22, the blood work, CBC, would have had to be ordered Stat (immediate) otherwise it wouldn't be done until Monday, 2/14/22. NP also said that the facility is making changes, since blood work is not done on weekends, so that the blood work can be done to get these medications timely. There are certain medications in stock, but if the facility does not have them, then the Staff monitors the resident. 415.18(a-d).

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observations, record review, and interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure safe food storage was practiced. This was evident during the kitchen observation. Specifically, expired liquid nutritional supplements, expired thickened juice and expired thickened water were observed in the kitchen's Emergency Food Storage Room (EMSR). The findings are: The facility policy titled Disaster/Plan for Food Service effective ,d+[DATE] documented the residents will be supplies with adequate and appropriate diets, adhering as close to the prescribed medical nutritional regimen as possible. It is the policy of this facility to keep a three-day supply of food. On [DATE] at 12:26 PM -12:39 PM during the tour of the EMSR observed there was an unopened box of , d+[DATE]-ounce containers of Hormel Thick and easy clear hydrolyte thickened water with a use by date of [DATE]. An unopened box of ,d+[DATE] ounce cartons of Hormel thick and easy thickened apple juice with use by date of [DATE] and an unopened box of ,d+[DATE] ounce containers of Glucerna chocolate supplement with use by date of [DATE]. On [DATE] at 12:56 PM, an interview was conducted with Dietary Aide who stated this week, they put away delivered items in the emergency area. They did look at the emergency area. The emergency areas were put together a few months ago. Items have to be rotated. The Kitchen rotates food items every three to six months to make sure items are not expired, On [DATE] at 1:00 PM, an interview was conducted with the [NAME] who stated that they used to be in charge of the emergency storeroom, and they stock items in there as needed. They stated that they stocked the storeroom two weeks ago and they looked at the dates for the food, liquid nutritional supplements and thickened water. They stated three weeks ago they switched out the thickened water and residents cannot be given spoiled, rotten and expired items. They stated they did First In First Out (FIFO) training about 6 months ago. On [DATE] at 12:36 PM and 2:12 PM, an interview was conducted with the Food Service Department Supervisor (FSDS) who stated they check every two to three months and items have a good shelf life. On [DATE] at 10:56 AM, an interview was conducted with the Food Service Manager (FSM) who stated they check the EMSR periodically and every six months stock should be rotated. The expired date is written on the outside of stock. FIFO training was done with store room personnel and with other food service staff. 415.14 (h)