STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335486	A. Building B. Wing	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelham Parkway Nursing Care & Rehab Facility L L C	2401 Laconia Ave Bronx, NY 10469

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey, the facility did not ensure a resident received notice of their rights and services upon admission. This was evident for 1 of 30 total sampled residents. Specifically, Resident #64 was not provided with an Admission Agreement explaining their rights and services upon admission to the facility. The findings are: The facility policy titled Resident Rights and dated 1/23 documented each resident has the right to exercise their personal rights and to not be discriminated against for admission to the facility. Resident #64 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus and osteomyelitis. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #64 was cognitively intact. On 6/16/23 at 11:01 AM, Resident Council Meeting was held with Resident #64 in attendance. Resident #64 stated they were not aware of their rights and responsibilities as a resident and had not signed an admission agreement since heir admission a few weeks prior. There was no documented evidence Resident #64 was provided with an Admission Agreement defining their rights and responsibilities as a resident of the facility. On 06/16/23 at 12:10 PM and 06/21/23 at 02:20 PM, the Admissions Director (AD) was interviewed and stated Resident #64 did not have an Admission Agreement signed and the AD was in the process of going to meet with the resident to them sign. The AD stated they complete Admission Agreements with new admissions to the facility timely, within 3 weeks of admission, but the AD is the only one reviewing there Admission Agreements with residents and their families. On 06/21/23 at 03:23 PM, the Administrator was interviewed and stated Administration was responsible for putting together the Admission and contents. If there is a change in resident rights it will be reviewed at resident council meetings. 415.3(g)(2)(i)

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

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 40686 Based on observations, interviews, and record review conducted during the recertification survey from 6/13/23 to 6/21/23, the facility did not ensure residents received notices orally and in writing with the list of names and addresses of the State regulatory agencies, resident advocacy groups, and Ombudsman information. This was evident for 6 (Resident #s 133, 113, 64, 30, 96, 109) of 8 residents in attendance at Residnt Council out of 30 total sampled residents. Specifically, Resident #s 133, 113, 64, 30, 96, and 109 stated they were not aware of their rights and were not provided with contact information for State agencies and advocates. The findings are: The facility policy titled Resident Rights dated 1/23 did not document the method or procedure of informing and educating residents of their rights. On 6/16/23 at 11:01 AM, Resident Council Meeting was held with 8 residents in attendance. The Council was asked whether their resident rights had been reviewed with them and provided to them in a format an language they can understand. There were 6 (Resident #s 133, 113, 30, 109, and 96) of the 8 residents that stated they did not recall being educated about their resident rights and were not provided with the contact information for State agencies of the Ombudsman. There was no documented evidence Resident #64 was provided with an Admission Agreement with the resident's rights included. The facility Admission Agreement sample documented a section for your Rights and Protection as a Nursing Home Resident. The Admission Agreement did not contain written information related to State agency contact numbers and the Ombudsman contact information. An Admission Agreement dated 7/23/12 documented Resident #30's signature with a [NAME] of Rights included and no contact information for State agencies or the Ombudsman. - signed and bill of rights included. An Admission Agreement dated 12/7/21 did not document Resident #96's or a designated representative's signature confirming receipt of the Admission Agreement. An Admission Agreement dated 2/17/21 documented Resident #109's signature with a [NAME] of Rights included and no contact information for State agencies or the Ombudsman. - signed and bill of rights included. An Admission Agreement dated 3/24/21 documented Resident #113's signature with a [NAME] of Rights included and no contact information for State agencies or the Ombudsman. - signed and bill of rights included. An Admission Agreement dated 11/4/22 documented Resident #133's signature with a [NAME] of Rights included and no contact information for State agencies or the Ombudsman. - signed and bill of rights included. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council Meeting Minutes dated 3/6/23, 4/3/23, 5/3/23, and 6/5/23 were reviewed with no mention of educating or informing residents of their rights as a resident of a facility. On 06/16/23 at 12:10 PM and 06/21/23 at 02:20 PM, the Admission Director (AD) was interviewed and stated the only patient [NAME] of Rights they are of is in the Admission Agreement that is provided to a resident when they are admitted to the facility. The Administrator compiled the Admission Agreement. There have been changes to the Admission Agreement over the years and the patient [NAME] of Rights was revised 7/29/2020. On 06/21/23 at 12:06 PM, the Director of Social Work (DSW) was interviewed and stated Administration determined the appropriateness of documents provided to residents in their Admission package upon admission. The DSW reviewed the Your Rights and Protection as a Nursing Home Resident and they are the correct version of resident rights for nursing home residents. Admissions reviews the admission package with the residents. During the admission assessment, the Social Worker (SW) verbally tells the resident about their rights. Recreation reviews the resident rights at resident council meetings. The residents are informed of their rights upon admission and they are told that the rights are posted on each floor. The DSW would have to check with recreation to find out when they last reviewed resident rights at resident council. The residents do not sign that their rights were reviewed with them except upon admission. Resident rights are only verbally discuss with them. The DSW was not sure if the resident rights were available in multiple languages. The DSW stated the resident rights are only available in English. On 06/21/23 at 03:23 PM, the Administrator was interviewed and stated they were responsible for putting together the Admission Agreements. The version of Your Rights and Protection as a Nursing Home Resident is a version the facility determined was appropriate and the Administrator was unable to recall how the facility came across the current version of resident rights they use in their Admission Agreement but believes they were given to the facility by another facility. The admission package was updated 7/2020 but the Administrator was unable to say when the resident rights section was updated. If the resident does not speak English, a translator will be used to interpret the Admission Agreement and the facility only uses a English version for resident to sign. If there is a change in resident rights, this is discussed during resident council meeting. Residents do not get regular reeducation of their resident rights they do not receive it in writing. The resident bill of Rights should be posted on every unit. 415.3

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interviews, and record review conducted the recertification survey from 6/13/23 to 6/21/23, the facility did not ensure incorporate the recommendations from the Pre-Admission Screening and Resident Review) PASARR level II determination into the resident's assessment, care planning, and transitions of care. This was evident for 1 (Resident #123) of 30 total sampled residents. Specifically, The facility did not obtain a neurology consult for Resident #123 after the resident was admitted with a PASARR level II recommendation for a neurology consult. The findings are: The facility policy titled SCREEN dated 2/20 documented the Social Worker (SW) will make sure that the PASARR recommendation are incorporated in the resident's care plan. Resident #123 was admitted [DATE] with diagnoses of anxiety disorder and schizophrenia. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #123 was cognitively intact and received antipsychotic 7 out of 7 days prior to the assessment. On 06/14/23 at 01:45 PM, Resident #123 was interviewed and stated they were having right hand tremors that started upon their admission to the facility. Resident #123 stated they were recently hospitalized in a psychiatric facility, is receiving psychotropic medication, and requested to see the neurologist over a month ago. A Notice of PASRR Level II Outcome dated 11/24/22 documented Resident #123 will need to be provided with a neurology consult to evaluate cognition due to the diagnosis of dementia. Physician Orders renewed 5/23/23 documented Resident #123 received Donepezil 10mg daily for Alzheimer's dementia, Zyprexa 10mg at bedtime and 5 mg daily (12/21/22). Psychiatry consult as needed. No order for Neurology consult. NP note dated 5/1/23, 5/16/23, 5/24/23 and 6/7/23 documented Resident #123 had a right arm resting tremor with no evidence of metabolic changes and no dyskinesia. On multiple medications that may cause Parkinson/tremors. Psychiatry consult ordered to reduce medication however no recommendation for dose decrease or alternative made. Neurology consult placed. NP Note dated 2/17/23 documented Resident #123 was exhibiting right hand tremor and psychiatry consult will be placed. The NP Note also documented Resident #123 exhibited right hand tremor on 3/29/23, 3/15/23, 4/25/23. A Neurology Consult form dated 4/25/23 documented Resident #123 was referred to the neurology clinic and had an appointment schedule for 12/4/23 at 10:45 AM. There was no documented evidence the facility followed the PASARR level II recommendation for Resident #123 to have a neurology consult upon admission not the facility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/21/23 at 11:52 AM, the Director of Social Work (DSW) was interviewed and stated, as soon as the admission department send them a an expected admission's medical records's fro the hospital, the DSW checks the SCREEN's for any resident that trigger a level II evaluation. There is a log that DSW keeps of all residents with level II recommendations. The DSW evaluates the PASARR and lets the interdisciplinary team know so that recommendations can be followed. The DSW does not really seeing Resident #123's PASARR level II recommendation for the resident to have a neurology consult. The nurses really should be reading through this and addressing the medical concerns. The SW Department ensures that psychological and behavioral recommendations are addressed but it is a team effort and the nursing should be looking through for medical recommendations. It is part of the admission record and the team looks at it to address what their discipline is responsible for. On 06/20/23 at 11:50 AM, an interview was conducted with the Nurse Practitioner (NP) who stated the PASARR level II recommendations are generally reviewed by the SW upon admission. The NP was unaware Resident #123's PASARR level II recommended for the resident to have a neurology consult. Resident #123 has a neurology appointment in December 2023 and this is not an acceptable time for a resident to wait for an appointment to see a specialist. On 06/21/23 at 03:00 PM, the Director of Nursing (DNS) was interviewed and stated the SW is responsible for reviewing the SCREEN and PASARR level II recommendations for prospective admissions to the facility. The SW is involved when the resident has a psychiatric diagnosis. Prior to a resident's admission to the facility, the DNS reviews the hospital information. 415.11(e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interviews, and record review conducted during the recertification survey from 6/13/23 to 6/21/23 the facility did not ensure a Comprehensive Care Plan (CCP) was developed and implemented to address resident needs. This was evident for 1 (Resident #149) of 30 total sampled residents. Specifically, a CCP related to oxygen use was not developed and implemented for Resident #149. The findings are: The facility policy titled Respiratory Therapy and Evaluation dated 4/2014 documented the resident's respiratory status will be monitored pre and post therapy and documented in the medical record. The nurse will notify the primary medical doctor regarding any unstable resident conditions and follow up as directed. Resident #149 had diagnoses of hydrocephalus, shortness of breath and intracerebral hemorrhage. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #149 was severely cognitively impaired and did not have shortness of breath. On 06/14/23 at 01:30 PM, Resident #149 was observed lying in bed with oxygen flowing from an oxygen concentrator at 3 Liters Per Minute (LPM) to the resident via tubing and a full facemask. On 06/14/23 at 11:48 AM, Resident #149 was observed in a recliner in the floor dayroom without oxygen in place. On 06/14/23 at 01:33 PM, Resident #149 was observed in recliner in the hallway with no oxygen in place. On 06/15/23 at 12:24 PM, Resident #149 was observed lying in bed with the oxygen full facemask pulled down under their chin and oxygen flowing at 2 LPM. On 06/20/23 at 12:46 PM, Resident #149 was observed in a recliner in their room. Licensed Practical Nurse was administering a supplement to the Resident #149 via their feeding tube. Resident #149 was receiving oxygen via a full facemask at 2 LPM. The Medical Doctor Orders (MDO) dated 5/19/23 documented Resident #149 was to receive oxygen at 2 LPM via nasal canula every shift. There was no MDO for oxygen saturation monitoring. Treatment Administration Record (TAR) for June 2023 documented Resident #149 had oxygen tubing changed weekly and received oxygen via nasal canula per shift. There was no documented evidence a CCP related to oxygen use was developed and implemented for Resident #149. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/23 at 03:08 PM, Registered Nurse (RN) #3 was interviewed and stated RN #3 is responsible for completing the CCPs for the residents on the unit. After checking Resident #149's CCPs, RN #3 stated there is no CCP related to respiratory therapy or oxygen care. RN #3 missed the CCP by mistake. RN #3 did not admit Resident #149 from the hospital but subsequent RNs should pick up that a resident is missing a CCP even if the admission nurse misses one. When the resident is admitted , the RN does the initial baseline care plan. Then the RN will initiate the longer term CCPs. 415.11(c)(1)

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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** 45349 Based on observation, interviews, and record review conducted during the recertification survey from 6/13/23 through 6/21/23, the facility did not ensure the comprehensive care plans (CCP) were reviewed and revised after each assessment. This was evident for 2 of 2 residents (#101 and #21) reviewed for Nutrition out of 30 total sampled residents. Specifically, 1) the CCP related to oral care/dental and cancer for Resident #101 were not reviewed upon significant change assessment, and 2) the CCP related to diabetes mellitus (DM) was not reviewed or reviewed or revised upon change in the resident's medication regime. The findings are: A facility policy titled Comprehensive Assessment and Care Planning dated 5/9/21 documented the resident is assessed in keeping with regulatory requirements, and when the resident/patient's physical, psychosocial, functional, or nutritional status significantly changes. The Interdisciplinary Team (IDT) updates the CCP for readmissions, hospital returns, and episodic events. 1. Resident #101 had a diagnoses of Basal cell carcinoma and thrombocytopenia. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] and significant change MDS dated [DATE] documented Resident #101 was severely cognitively impaired with likely cavities of broke natural teeth. The CCP related to Oral Care/Dental initiated 3/20/20 was last reviewed 3/23/23, Resident #101 had a likely cavity or broken natural teeth and was at risk for decline related to cognitive deficit. The CCP related to Cancer (Basal cell carcinoma of Resident #101's left cheek) initiated 5/19/21, was last reviewed 3/23/23, and documented a goal that resident will be able to express fears/concerns surrounding the cancer diagnosis. There was no documented evidence the CCPs related to oral/dental and cancer were reviewed and revised upon each MDS assessment. On 6/20/23 at 9:53 AM, the Registered Nurse (RN) #2 was interviewed and states the RN is responsible for completing, updating, and initiating the CCPs. The RN assesses the resident and devises the CCP. CCPs are updated every quarterly and if there is any change in condition. RN #2 stated they update the CCPs every time an MDS is done. On 6/20/23 at 10:02 AM, the MDSC was interviewed and stated initiating CCPs is done (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by RNs. The review and revision is based on the changes in the resident condition and on a quarterly basis based on the dashboard on the electronic medical record. The MDSC stated updating care plans does not have anything to do with the MDS schedule. CCPs are updated based on the date of the target goals. The MDSC checks to make sure CCPs are updated and current when they complete the MDS. CCPs are expected to be updated upon a resident's readmission. After reviewing Resident #101's CCPs related to cancer and oral/dental status, the MDSC stated the CCPs should have been reviewed and revised when Resident #101 was readmitted to the hospital and upon significant change. 45988 Resident #21 had diagnoses of non-Alzheimer's dementia and DM. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #21 was cognitively intact and received insulin injections 5 of 7 days prior to the assessment. A physician's order dated 4/21/23 documented Resident #21 was ordered 4 units of Lantus 100 units/ml subcutaneously every night for DM. On 6/8/23, the Lantus insulin was discontinued and Resident #21 was started on Farxiga 5 mg daily for DM. The Medication Administration Record (MAR) for June 2023 documented Resident #21 received DM medications according to physician's order. A physician's note dated 6/8/23 documented Lantus was to be discontinued and Farxiga started at 5mg by mouth daily. The CCP related to Diabetes Mellitus initiated 2/1/22 documented Resident #21 was receiving Lantus insulin. The CCP was last updated on 3/2/23. There was no documented evidence the CCP related to Resident #21's DM diagnosis was reviewed and revised upon MDS assessment and change in DM medication. On 06/21/23 at 11:49 AM, Registered Nurse (RN) #1 was interviewed and stated they are still learning the computer system for medical record documentation. CCPs are initiated by RNs on admission according to diagnosis, behaviors, and medications. CCPs are revised every 90 days and if there is a change in a medication. The CCP related to DM should have been updated for Resident #21 because they are not on insulin anymore. If a resident's insulin is discontinued and switched to oral medications, the CCP should be updated. On 6/20/23 at 3:21 PM and 06/21/23 at 1:26 PM, the Director of Nursing (DNS) was interviewed and stated Resident #21's CCP related to DM should have been updated to reflect the change in their medication. It seems there was a miscommunication between the doctor, the nurse, and the RN Manager. The facility increased their RN Managers and hired new staff and they are behind on CCP updates but are catching up now. The RN Managers do the CCPs which are updated with a change of condition/acute issue, significant change, readmission, and with the MDS schedule. CCPs are audited via a list from MDS of outstanding CCPs or anything that needs to be updated. The DNS stated the MDSC would not update the care plan unless there is a change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/20/23 at 3:39 pm with the Administrator who stated that they were not aware of a larger issue with CCPs and the facility has been working on making sure that CCPs are up to date. 415.11(c)(2) (i-iii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 6/13/23 to 6/21/23, the facility did not ensure a resident received treatment and care in accordance with professional standards of practice. This was evident for 1 (Resident #123) of 30 total sampled residents. Specifically, Resident #123 was delayed in receiving an appointment to be seen by the neurologist. The findings are: The facility policy titled Communication with Physician Consultants dated 7/22/01 documented timely discussion between a resident's primary care physician and the consultant are important. Consultation sheets are to be given to the nursing office who will schedule appointments. Resident #123 was admitted to the facility 12/20/22 with diagnoses of anxiety disorder and schizophrenia. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #123 was cognitively intact, did not exhibit behavior, had trouble sleeping and disrupted appetite, and received antipsychotic medications 7 out of 7 days prior to the assessment. On 06/14/23 at 01:45 PM, Resident #123 was interviewed and stated they have a right hand tremor that began after being admitted to the facility from a psychiatric hospital on psychotropic medication. Resident #123 requested to see the neurologist over a month ago and stated the tremor is uncomfortable. Resident #123 stated no one followed up with them about scheduling a neurology consult. A Notice of PASARR Level II Outcome dated 11/24/22 documented Resident #123 will need to be provided with a neurology consult to evaluate cognition due to the diagnosis of dementia. Physician Orders renewed 5/23/23 documented Resident #123 received Donepezil 10mg daily for Alzheimer's dementia, Zyprexa 10mg at bedtime and 5 mg daily (12/21/22). Psychiatry consult as needed. No order for Neurology consult was documented. Comprehensive Care Plan (CCP) related to psychotropic drug use initiated 12/21/22 documented Resident #123 has a diagnosis of schizophrenia, receives antipsychotic medication, and should be observed for signs of inventory movement. The CCP was updated 5/11/23 with the Psychiatrist recommendation for Resident #123 to have Melatonin. NP Note dated 2/17/23 documented Resident #123 was exhibiting right hand tremor and psychiatry consult will be placed. Tremor also documented 3/29/23, 3/15/23, 4/25/23, Psychiatry consult dated 3/17/23 and 5/10/23 documented Resident #123 reported feeling better. The Psychiatrist documented Resident #123 did not display akathesia, Parkinson, or tardive dyskinesia. There was no documentation referencing NP recommendation for medication review or resident's right hand tremors. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NP note dated 5/1/23, 5/16/23, 5/24/23 and 6/7/23 documented Resident #123 had a right arm resting tremor with no evidence of metabolic changes and no dyskinesia. Resident #123 was on multiple medications that may cause Parkinson/tremors. Psychiatry consult ordered to reduce medication however no recommendation for dose decrease or alternative made. Neurology consult placed. A Neurology Consult form dated 4/25/23 documented Resident #123 was referred to the neurology clinic and had an appointment schedule for 12/4/23 at 10:45 AM. There was no documented evidence a neurology consult was obtained within timely manner for Resident #123's right hand tremors. On 06/20/23 at 02:59 PM, the Registered Nurse (RN) #3 was interviewed and stated there was no Medical Doctor Order for Resident #123 to have a neurology consult. It takes a long time for the Nursing Secretary to schedule clinic appointments. The RN gets alerted to orders for consults when the Medical Doctor (MD) writes an order and it is flagged to be cosigned. Then the RN prints out the consult and send it to the Nursing Secretary to make the appointment and arrangements. Sometimes the MD might write the note and forget to write the order. RN #3 was unable to find a consult request for Resident #123 to have a neurology consult and was unaware Resident #123 was referred for a neurology consult. The resident has been having right hand tremors. On 06/21/23 at 02:27 PM, the Nursing Secretary was interviewed and stated they referred Resident #123 for a neurology consult on 4/25/23. When the Nursing Secretary requested an appointment, they were originally told there were no appointments at all for Resident #123 to see the neurologist. The neurology clinic found another location and, a few weeks ago, was able to get Residnt #123 an appointment 12/4/2023. The Nursing Secretary is uncertain who requested for Resident #123 to use an outside clinic. On 06/20/23 at 11:50 AM, the NP was interviewed and stated they did not see a recommendation for Resident #123 to have a neurology consult in their admission level II referral. Resident #123 was referred to Psychiatry to evaluate their medication regime since Zyprexa can cause tremors. The NP then reviewed the Psychiatrist consult that recommended to continue with medications and then decided to order the neurology consult. Resident #123 has an appointment to see the neurologist in December 2023. NPO stated that wither they or the Nursing Secretary will attempt to get Resident #123 a sooner appointment. Residnt #123 did discuss the discomfort and concern with right hand tremors. This is not acceptable time for a resident to wait for specialist referrals. On 06/21/23 at 12:45 PM, the Medical Doctor (MD) was interviewed and stated they do not recall a recommendation from admission that Resident #123 see the neurologist. Resident #123 began to show right hand tremors in March/[DATE]. Because the tremor was not deemed to be an acute life threatening condition, the psychiatrist was asked to give their advice whether a reduction of antipsychotic medication would be indicated. The outcome was that it was not indicated. The MD does not recall speaking with the psychiatrist about their recommendation. Neurology consult was then recommended. This is to see if any medication could be causing the tremor and if they can be reduced. The expectation is that the consult would be obtained. It is disappointing that Resident #123 is scheduled for a neurology appointment 6-7 months out. (continued on next page)

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	335486	A. Building B. Wing	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelham Parkway Nursing Care & Rehab Facility L L C	2401 Laconia Ave Bronx, NY 10469

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/21/23 at 03:00 PM, the Director of Nursing (DNS) was interviewed and stated resident should not have to wait extensive periods of time for outside clinic appointments. The NP recommended for Resident #123 to see a specific Neurology Clinic. The DNS was unable to say what specialty within neurology and was unable to give a reason the resident was referred for neurology consult with an outside clinic. The DNS then stated the facility has a in-house neurologist that would be able to see Resident #123 within 2 weeks of a referral for evaluation. The DNS stated they are going to determine whether Resident #123 can be seen by the facility's neurologist. 415.12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interviews, and record review conducted during the recertification survey from 6/13/23 to 6/21/23 the facility did not ensure a resident was provided with respiratory care in accordance with professional standards of practice. This was evident for 1 (Resident #149) of 30 total sampled residents. Specifically, Resident #149 was ordered to receive oxygen via nasal canula and was observed with a oxygen face mask and received no oxygen saturation monitored. The findings are: The facility policy titled Respiratory Therapy and Evaluation dated 4/2014 documented the resident's respiratory status will be monitored pre and post therapy and documented in the medical record. The nurse will notify the primary medical doctor regarding any unstable resident conditions and follow up as directed. Resident #149 had diagnoses of hydrocephalus, shortness of breath and intracerebral hemorrhage. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #149 was severely cognitively impaired and did not have shortness of breath. On 06/14/23 at 01:30 PM, Resident #149 was observed lying in bed with oxygen flowing from an oxygen concentrator at 3 Liters Per Minute (LPM) to the resident via tubing and a full facemask. On 06/14/23 at 11:48 AM, Resident #149 was observed in a recliner in the floor dayroom without oxygen in place. On 06/14/23 at 01:33 PM, Resident #149 was observed in recliner in the hallway with no oxygen in place. On 06/15/23 at 12:24 PM, Resident #149 was observed lying in bed with the oxygen full facemask pulled down under their chin and oxygen flowing at 2 LPM. On 06/20/23 at 12:46 PM, Resident #149 was observed in a recliner in their room. Licensed Practical Nurse was administering a supplement to the Resident #149 via their feeding tube. Resident #149 was receiving oxygen via a full facemask at 2 LPM. The Medical Doctor Orders (MDO) dated 5/19/23 documented Resident #149 was to receive oxygen at 2 LPM via nasal canula every shift. There was no MDO for oxygen saturation monitoring. Treatment Administration Record (TAR) for June 2023 documented Resident #149 had oxygen tubing changed weekly and received oxygen via nasal canula per shift. There was no documented evidence a CCP related to respiratory therapy of oxygen use was developed for Resident #149. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence oxygen saturation monitoring was done since Resident #149's admission to the facility on [DATE] until 6/20/23. On 06/20/23 at 02:40 PM, the Licensed Practical Nurse (LPN) #4 was interviewed and stated they take Resident #149's vitals every morning. If the oxygen saturation drops below 90, then Resident #149 will be provided with oxygen therapy. When medications are given to Resident #149, their oxygen saturation is assessed while oxygen therapy is ongoing. Resident #149 frequently removes the oxygen mask. Every nurse is responsible for checking the settings for the flow rate of the oxygen to ensure the LPM are according to MDO. Sometimes patients play with oxygen concentrator and the flow rate gets turned up or down inadvertently. The face mask and the nasal canula are interchangeable. Resident #149 might have a face mask instead of nasal canula because the nasal canula may have gotten dirty. The resident did not have a face mask on this morning when I rounded. Unless the MDO says as needed, the oxygen should be provided continuously. Resident #149 had a standing order for continuous oxygen. Regardless of oxygen saturation, the resident should be getting oxygen. The only thing I can think of is that the nasal canula got dirty or something happened to it so we replaced the face mask. If the Medical Doctor (MD) does not specify parameters, the basic protocol is to call the MD if below 90. On 06/20/23 at 03:08 PM, Registered Nurse (RN) #3 was interviewed and stated Resident #149 was admitted from the hospital on oxygen therapy. There is no reason the Resident #149 should have a face mask instead of nasal canula when the MDO says nasal canula. Resident #149 is ordered to receive oxygen continuously. Oxygen saturation is to be taken every shift depending on what the MDO says. If the oxygen saturation is improving, then the MD is made aware. If the oxygen saturation is below 90 then the MD should be contacted. Oxygen saturation is taken with the vital signs. Resident #149 does not have a MDO in place to monitor their oxygen saturation. If the MD does not write the oxygen sat monitoring MDO, the nurse still checks the vital signs as part of the protocol. Even with that, the MD needs to order the parameters. On 06/21/23 at 02:39 PM, the Director of Nursing (DNS) was interviewed and stated when a resident is admitted on oxygen, the nurse obtains the oxygen, transcribes the order, and the MD signs. The MD reviews the transcribed order to determine if adequate and changes may be needed. Oxygen was given to Resident #149 as a comfort measure. The DNS stated that when they have observed Resident #149, the resident appear short of breath. Acceptable oxygen saturation would be 92 and above. This would be determined upon assessment by the nurse or MD. If their oxygen saturation is high then the nurse may tell the MD and the oxygen maybe changed to as needed. The oxygen saturation is taken with the vitals upon admission for at least for 3 days. The MD order states oxygen via nasal canula In an emergency situation, staff can use the face mask instead of nasal canula. If the oxygen saturation is below 90, the MD should be contacted. It should be in the facility policy. This applies to every resident. oxygen saturation should be read for Resident #149 every shift. The facility policy does not require the nurses to take oxygen saturation readings for residents who are on oxygen. An MD order would communicate to the nurse the frequency and parameters of treatment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/23 at 01:03 PM, the MD #2 was interviewed and stated Resident #149 uses oxygen to keep their oxygen saturation at 90-92. There is no need for face mask. Nasal canula would be better. Resident #149 is supposed to be receiving oxygen as needed but MD #2 stated they did not pay attention to how the MDO was written. Any oxygen saturation over 90 is okay. Oxygen saturation monitoring is automatic from admission. MS #2 does not need to write orders for monitoring. Resident #149 is not on oxygen saturation monitoring. MD #2 checks the nursing notes for oxygen saturation readings. Nursing should know if the oxygen saturation falls below 90, they call the MD. The general practice us that if oxygen saturation is high enough, then possibly no oxygen is needed. MD #2 will tell the nurses to check the oxygen saturation. 415.12(k)(6)

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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, interviews, and record review conducted during the recertification survey from 6/13/23 through 6/21/23, the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety. This was evident during the Kitchen facility task. Specifically, 2 cold sandwiches were not held at a safe temperature of 41 F or below. The findings are: A undated facility policy titled Food Temperatures documented cold foods are kept refrigerated and are taken out in small batches to maintain a temperature of 40 degrees Fahrenheit or lower during meal service. Daily temperatures are recorded at meals to ensure proper procedure is being followed. On 6/20/23 at 10:53 AM, lunch meal service was being observed in the Kitchen and a dietary aide was observed making cold sandwiches and placing them in the refrigerator. On 6/20/23 at 11:07 AM, dietary staff were observed taking the prepared cold sandwiches out of the refrigerator. The cold sandwiches were lying on a pan of ice. Staff began placing the cold sandwiches onto residnt trays. The temperature of 2 random sample sandwiches (1 turkey and 1 tuna) were taken and both sandwiches were at 65 F. On 06/20/23 at 11:10 am, the Food Service Director (FSD) was interviewed and stated they do not typically check the temperature of the sandwiches. The sandwiches are usually made before 9:30 AM. The FSD did not know why the dietary aide was still making sandwiches so late. 415.14