STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335702	A. Building B. Wing	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwell Health Stern Family Center for Rehab	300 Community Drive Manhasset, NY 11030

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review, observation, and interviews during the Recertification Survey and Abbreviated Survey (Complaint #NY00322792 and NY00317444), the facility did not ensure each resident received adequate supervision and assistance according to the plan of care to prevent accidents. This was identified for two (Resident #170 and #333) of five residents reviewed for Accidents. Specifically, 1) Resident #170's care plan documented the resident required two-person assistance for transfers. On 8/23/2023 Certified Nursing Assistant (CNA) #3 transferred Resident #170 from a shower chair to a wheelchair without utilizing assistance from a second person. Subsequently, Resident #170 fell sustaining an abrasion to the right knee; and 2) Resident #333 required extensive assistance of one person for toileting as per their Comprehensive Care Plan (CCP). On 5/30/2023 Rehabilitation Aide #1 brought Resident #333 back to their room after a therapy session. Resident #333 verbalized the need to use the restroom. Rehabilitation Aide #1 left Resident #333 unattended in their room and did not notify the nursing staff of the resident's request. Subsequently, Resident #333 attempted to toilet themselves, fell in the bathroom, and sustained a laceration to the scalp. The findings are: 1) The facility's policy titled Activities of Daily Living (ADL)/Bathing/Personal Care Equipment, last reviewed 12/2022, documented the CNAs are expected to review the CNA instructions prior to rendering care. Resident #170 was admitted with diagnoses including Hemiplegia, Chronic Kidney Disease, and Hypertension. The 6/6/2023 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS documented that the resident required extensive assistance of two persons for transfers and extensive assistance of one person for bathing. A CCP titled ADLs, Resident Preferences, effective 6/29/2023, documented under bathing the resident required extensive assistance in transferring back and forth from the wheelchair to the shower chair, and under transfers the resident required two-person physical assist. A Fall Risk assessment dated [DATE] documented the resident needed assistance standing, walking, and toileting. The resident required a yellow wrist band, which indicated that the resident was at risk for falls. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Nursing Instructions (instructions provided to the CNA regarding the resident's care needs) as of 8/23/2023 documented that the resident required two-person physical assistance for transfers and that the resident had left arm weakness. A nursing fall/occurrence note dated 8/23/2023 documented the resident's knees buckled while being transferred from the shower chair to the wheelchair. The resident sustained a right knee abrasion measuring 0.2 centimeter (cm) x 1 cm. The Accident and Incident (A/I) report dated 8/23/2023 documented that while CNA #3 was transferring the resident in the shower room from the shower chair to the wheelchair, the resident's knees buckled. CNA #3 attempted to hold the resident, but the resident slipped to the floor and sustained an abrasion to the right knee. The A/I report documented CNA #3 did not request assistance after the shower was completed to transfer the resident from the shower chair to the wheelchair. The A/I report documented that the resident needed extensive assistance of two persons for transfer activities and CNA #3 transferred the resident by themselves; CNA #3 did not review the transfer instructions prior to the shower; and CNA #3 admitted to not following the care instructions prior to rendering care. Resident #170 was observed in their room sitting in their wheelchair on 10/30/2023 at 11:30 AM. Resident #170 was wearing a yellow fall risk wrist band. Resident #170 stated they remembered the incident on 8/23/2023 but denied getting hurt. CNA #3 was interviewed on 11/1/2023 at 2:21 PM and stated they were the assigned CNA for Resident #170 on 8/23/2023 during the 3 PM-11 PM shift and had never worked with the resident before. CNA #3 stated they had transferred the resident from the shower chair to the wheelchair in the shower room after the shower by themselves. CNA #3 also stated that they transferred the resident right before the shower from the wheelchair to the shower chair by themselves, but there was no problem. CNA #3 stated they did not realize the resident required two-person assistance for transfers because they did not look at the resident's care profile. CNA #3 stated they did not have time to look at the care profile because they had to respond to call bells that were sounding. CNA #3 could not recall if the resident had a yellow wrist band that identified the resident to be at risk for falls. Registered Nurse (RN) #5, the Inservice Coordinator, was interviewed on 11/2/2023 at 8:06 AM. RN #5 stated CNAs are expected to check the resident's care profile before providing any care. RN #5 stated the CNAs must check the resident care profile every day, even if they had the resident the day before, because the residents' status related to their ADL needs could change overnight. The Director of Nursing Services (DNS) was interviewed on 11/2/2023 at 9:00 AM and stated a shower is not an emergency and it can wait until the CNA checks the resident care profile for the resident's transfer status, before providing care. 40696 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) #1 was interviewed on 11/2/2023 at 2:42 PM and stated that Rehabilitation Aide #1 did not inform them that Resident #333 had to use the restroom on 5/30/2023 when they brought the resident back to their room. (RN #7) was interviewed on 11/3/2023 at 9:12 AM. RN #7 stated that on 5/30/2023, Resident #333 was on their assignment. RN #7 stated that they did observe Rehabilitation Aide #1 escort Resident #333 to Resident #333's room. RN #7 was at the nurse's station on a phone call, walked to the medication cart to get information for the call, and then heard a loud noise in Resident #333's room. RN #7 stated that they went to Resident #333's room and observed that Resident #333 had a cut on their scalp. Rehabilitation Aide #1 did not stop by the nurse's station to let RN #7 know that Resident #333 had to use the bathroom. RN #7 stated that if a resident needs to use the bathroom, the Rehabilitation aides have to inform the nurse to ensure the resident's safety. The Director of Rehabilitation was interviewed on 11/3/2023 at 9:25 AM. The Director of Rehabilitation stated that when the residents are transported back to their rooms by the Rehabilitation Aides, the aides are expected to inform the nursing staff if the resident has to use the bathroom. The Rehabilitation Aides are not expected to assist with toileting and are not expected to know the resident's care needs since they do not provide direct care. The Director of Rehabilitation stated that Rehabilitation Aide #1 should have informed the nursing staff that Resident #333 needed to use the restroom. The Director of Nursing Services (DNS) was interviewed on 11/3/2023 at 9:56 AM. The DNS stated that Rehabilitation Aide #1 was expected to inform the nurse that Resident #333 needed to use the restroom. The Standards/Evaluation Criteria for Rehabilitation Aide orientation policy dated July 2023 documented that Rehabilitation Aides transport residents to and from the department according to the daily schedule established by the therapist. The Rehabilitation Aide informs nursing staff upon return to the floor and any change in status. Rehabilitation Aides maintain safety of residents at all times. Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement at the time of this survey: For the incident related to Resident #170 (NY00322792): --CNA #3 admitted to not reviewing the care profile before providing care on 8/23/2023 and was suspended. --CNA #3 confirmed that they received counseling and re-education after the 8/23/2023 incident regarding following the resident's care profile. --Following the incident of 8/23/2023, all facility CNAs and nurses were educated on following the care profile instructions by 9/15/2023. Lesson plans and in-service sign-in sheets were provided. --During the survey other staff were interviewed and confirmed that they had received education related to the need to follow instructions documented on the resident's care profile (continued on next page)

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