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	09/29/2021

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34798 Based on record review and interviews during the Recertification Survey completed on 9/29/2021 the facility did not ensure that pain management was provided to each resident who requires such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #50) of 3 residents reviewed for Pain Management. Specifically, Resident #50 had a physician's order for an Aspercreme pain patch to be applied at 9 AM; however, the location to place the patch was not identified in the order, and on 9/27/2021 the patch was not applied until after 12 PM, when the resident returned from Rehabilitation Therapy (Rehab). The finding is: The facility policy titled Medication Policies and Procedures, dated 9/2020, under a heading titled Time/Hour of Medication Administration (pass), documented a one-hour window before or after the stated time is permissible. Resident #50 was admitted to the facility with diagnoses including Diabetes Mellitus, Cerebrovascular Accident, and Depression. The 8/20/2021 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A Comprehensive Care Plan (CCP) effective 8/16/2021 titled Pain/Actual/Potential documented that Resident #50 had Neuropathy, Chronic Abdominal Pain, and Spinal Stenosis with an intervention to administer pain medication as per the physician's order. A Physician's order dated 8/16/2021 and renewed on 9/8/2021 documented to apply Aspercreme (Lidocaine) 4% topical patch, one patch by topical route to the affected area once daily, place at 9 AM, remove at 9 PM, for diagnosis of pain, unspecified. On 9/23/2021 at 11:00 AM Resident #50 was interviewed. The resident stated that their whole body was in pain. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Registered Nurse (RN) #1, Resident #50's medication nurse, was interviewed on 9/27/2021 at 11:29 AM. RN #1 stated that they (RN #1) do not normally work on the unit. RN #1 stated that they (RN #1) had not placed the Aspercreme patch on the resident yet because earlier in the morning the resident was getting morning care and then went to Rehab therapy. RN #1 stated they (RN #1) did not know where the pain patch was supposed to be placed because the Physician's order does not specify where to place the patch, and they (RN #1) will have to ask the resident. RN #1 was re-interviewed on 9/27/2021 at 12:13 PM and stated that they (RN #1) just placed the Aspercreme patch on Resident #50's lower back after they (RN#1) asked the resident where the pain patch was supposed to be placed. RN #1 stated the location to place the patch should be specified in the physician's order. The RN unit supervisor (RN #2) was interviewed on 9/27/2021 at 12:21 PM. RN #2 stated that the Aspercreme patch should not have been late, and the physician's order should have indicated where to place the patch. Resident #50 was reinterviewed on 9/27/2021 at 1:13 PM and stated Resident #50 likes to have the pain patch placed before therapy because their (Resident #50) lower back is very sensitive and the pain relief from the patch helps Resident #50 concentrate on the therapy. Resident #50 stated that every little bit of pain relief helps, and that Resident #50 was in pain during therapy today (9/27/2021). The Director of Nursing Services (DNS) and the Medical Director were interviewed concurrently on 9/28/2021 at 10:36 AM. They both stated that the location of the pain patch placement should be indicated in the physician's order and the pain patch should have been applied before the resident went to therapy. 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on record review and interviews during the Recertification Survey completed on 9/29/2021, the facility did not ensure that resident records were accurately documented in accordance with professional standards of practice. This was evident for one resident (Resident #143) of three residents reviewed for Respiratory Care. Specifically, the facility did not have documented evidence that Tracheostomy care was provided to Resident #143 as per the facility protocol. The finding is: The facility Tracheostomy Care policy, protocol, and procedure dated 12/2020 documented that unless otherwise directed, the inner cannula is removed and cleaned every 8 hours; use tracheostomy care kit. Tracheostomy Wound Care is done every 8 hours unless otherwise ordered; sterile technique/dressing. Documentation in the care plan indicates tracheostomy needs and Treatment Record records inner cannula care by shift, nursing notes are not required unless untoward event or unusual findings. Resident #143 was admitted with diagnoses of Neoplasm of Tongue, Embolism/Thrombosis of unspecified artery, and Dysphagia. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #143 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented that Resident #143 actively received respiratory treatments which included oxygen therapy, suctioning and tracheostomy care. The Alteration in Respiratory System status post Tracheostomy dated 9/13/2021 documented that Resident #143 will be free of respiratory distress for 30 days. The interventions included Tracheostomy Care and suction as needed. The Physician's Order dated 9/13/2021 documented Tracheostomy Collar care per [facility] protocol. A review of the Nursing notes from 9/13/2021 to 9/29/2021 revealed no documentation that Tracheostomy care was provided to Resident #143 as ordered. Review of Nursing Admission Skilled Notes dated from 9/13/2021 to 9/29/2021 did not indicate that Tracheostomy care and Tracheostomy site cleaning was performed on 85 of 90 opportunities. The September 2021 Treatment Administration Record (TAR) for Resident #143 lacked documented evidence that Tracheostomy care was provided to Resident #143. The Licensed Practical Nurse (LPN) #1 was interviewed on 09/29/2021 at 9:18 AM. LPN #1 stated that Resident #143's Tracheostomy Collar was changed earlier in the morning on 9/29/2021 by another nurse. LPN #1 reviewed the Physician's orders and the treatment schedule. LPN #1 stated Resident #143 was scheduled for suctioning at 6 AM, 10 AM, 2 PM, 6 PM, and 10 PM. LPN #1 further stated that the Tracheostomy Collar care is completed when the collar is visibly soiled. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Registered Nurse (RN) #5 was interviewed on 9/29/21 at 10:27 AM. RN #5 stated they (RN#1) are the usual 7 AM-3 PM shift nurse on the unit. RN #5 stated that they witnessed Resident #143's tracheostomy collar care at approximately 6:30 AM by RN #2 on the 11 PM-7 AM shift. RN #5 stated that Tracheostomy Collar care is typically done during the 11 PM-7 AM shift. RN #5 reviewed the Physician's order and indicated that the Tracheostomy Collar care order is a general order and there was no schedule or frequency indicated for Tracheostomy Collar care. RN #5 reviewed the treatment administration record and stated there is no documentation for Tracheostomy Collar care. RN #5 stated that the Tracheostomy Collar care should be documented in the medical record and the frequency should be specified in the Physician's order. RN #6 was interviewed on 9/29/2021 at 11:10 AM. RN #6 stated that they are the regular 11 AM-7 PM shift nurse on the unit. RN #6 stated that they provide Resident #143's Tracheostomy Care every day as ordered after the early morning medications are administered to the residents on the unit. RN #6 stated that they do not remember if there is a place to document when Tracheostomy care is provided. RN #6 stated that sometimes they are busy, and they would verbally report to the next shift nurse that the Tracheostomy Collar care has to be completed for Resident #143. The Director of Nursing Services (DNS) was interviewed on 9/29/2021 at 11:57 AM. The DNS reviewed Resident #143's Physician's order for Tracheostomy Collar care on 9/13/2021 and reviewed the facility protocol. The DNS stated that as per protocol, the Tracheostomy Collar care should be done every 8 hours. The DNS reviewed Resident #143's medical record and the Treatment Administration Record. The DNS stated that the medical record for Resident #143 did not have any documentation of Tracheostomy Collar care provided. The DNS stated that the Tracheostomy Collar care is expected to be documented in the Treatment Administration Record as per the Physician's order. The Physician was interviewed concurrently with the [NAME] Director on 09/29/2021 at 12:28 PM. The Physician reviewed the 9/13/2021 Tracheostomy Collar care order and the facility protocol. The physician stated that the facility protocol indicated Tracheostomy Collar care every 8 hours, but the order for Resident #143 was intended to be completed once a day. The Physician stated that the discrepancy was an oversight, and the order should have been specific to once a day instead of the facility protocol. The Medical Director stated that Tracheostomy Collar care provided more often than once a day would be harmful to the resident. The facility protocol was not the standard for tracheostomy care. 415.22(a)(1-4)