STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335839	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

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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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure that comprehensive assessments of residents were conducted within 14 calendar days after admission and not less than once every 12 months. This was identified for one (Resident #18) of seven residents reviewed for the Resident Assessment Task. Specifically, Resident #18's Annual Minimum Data Set assessment was not completed until 31 days from the Assessment Reference Date of 8/6/2024. The finding is: The facility's policy and procedure for Minimum Data Set, last revised on 8/2023 documented that a Registered Nurse shall be designated for conducting and coordinating each resident's assessment. The Assessment Coordinator must date and sign each assessment to certify that the assessment has been completed. Each individual who completes a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying that each section was completed. The policy did not include the timeframe for the completion of the assessment. Resident #18 was admitted with diagnoses including Parkinson's Disease, Schizophrenia, and Traumatic Subdural Hemorrhage (brain bleed). The Annual Minimum Data Set assessment dated [DATE] documented that Resident #18 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #18 had moderately impaired cognition. The Annual Minimum Data Set assessment, dated 8/6/2024, documented a completion date of 9/6/2024. The Minimum Data Set (MDS) Director was interviewed on 9/6/2024 at 10:51 AM and stated they completed the Minimum Data Set (MDS) assessment for Resident #18 today, 9/6/2024. The Minimum Data Set Director stated they were responsible for ensuring that all Minimum Data Set assessments were completed on time. The Minimum Data Set Director stated that Resident #18's Minimum Data Set should have been completed on 8/20/2024, 14 days after the Minimum Data Set reference date. The Administrator was interviewed on 9/9/2024 at 8:14 AM and stated they were unaware of any issues with Minimum Data Set assessment completion. The Administrator stated the facility had hired a consulting firm to assist with completing the Minimum Data Set assessments as per the requirements because the Minimum Data Set Director had resigned and the current Minimum Data Set Director started employment with the facility in late August 2024. The Administrator stated they thought the Minimum Data Set Consulting firm was helping in the timely completion of the assessments. (continued on next page)

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

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	The Director of Nursing Service was interviewed on 9/9/2024 at 9:31 AM and stated they were unaware of any issues with Minimum Data Set assessment completion. The Director of Nursing Service stated the Minimum Data Set Director and the Minimum Data Set Assessors should have notified them about the delay in completion of the assessments. The Director of Nursing Service stated all Minimum Data Set assessments should have been completed within 14 days of the resident assessment reference date. 10 NYCRR 415.11(a)(3)(i)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 49245 Based on record review and interviews during the Recertification survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure that all completed Minimum Data Set assessments were electronically transmitted to the Center for Medicare and Medicaid Services within 14 days of the resident assessment completion date. This was identified for seven (Residents #99, #18, #95, #31, #211, #130, #105) of seven residents reviewed for the Resident Assessment Facility Task. Specifically, the Minimum Data Set assessments for Resident #99, #18, #95, #31, #211, #130, and #105 were not transmitted within 14 days of the assessment completion date. The finding is: The facility policy for Minimum Data Set, last revised on 8/2023, documented the Registered Nurse shall be responsible for conducting and coordinating the development and completion of the resident's assessment. The policy did not document the timeframe of when the assessments should be transmitted. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report dated 9/5/2024 documented the following Minimum Data Set assessments were transmitted to Centers for Medicare and Medicaid Services on 9/5/2024: -Resident #99's Comprehensive Minimum Data Set assessment had an assessment reference date of 8/2/2024, a completion date of 8/16/2024, and a transmittal due date of 8/30/2024. Resident #99's Minimum Data Set assessment was transmitted six days late. -Resident #18's Annual Minimum Data Set assessment had an assessment reference date of 8/6/2024, a completion date of 8/20/2024, and a transmittal due date of 9/3/2024. Resident #18's Minimum Data Set assessment was transmitted three days late. -Resident #95's Quarterly Minimum Data Set assessment had an assessment reference date of 8/7/2024, a completion date of 8/21/2024, and a transmittal due date of 9/4/2024. Resident #99's Minimum Data Set assessment was transmitted one day late. -Resident #31's Quarterly Minimum Data Set assessment had an assessment reference date of 8/6/2024, a completion date of 8/20/2024, and a transmittal due date of 9/3/2024. Resident #31's Minimum Data Set assessment was transmitted two days late. -Resident #211's Quarterly Minimum Data Set assessment had an assessment reference date of 8/3/2024, a completion date of 8/17/2024, and a transmittal due date of 8/31/2024. Resident #99's Minimum Data Set assessment was transmitted five days late. -Resident #130's Quarterly Minimum Data Set assessment had an assessment reference date of 8/7/2024, a completion date of 8/21/2024, and a transmittal due date of 9/4/2024. Resident #130's Minimum Data Set assessment was transmitted one day late. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	-Resident #105's Quarterly Minimum Data Set assessment had an assessment reference date of 8/2/2024, a completion date of 8/16/2024, and a transmittal due date of 8/30/2024. Resident #105's Minimum Data Set assessment was transmitted six days late. The Minimum Data Set Director was interviewed on 9/6/2024 at 10:51 AM and stated they were responsible for ensuring that all Minimum Data Set assessments were transmitted on time. They reviewed the Validation Report today (9/6/2024) and identified seven Minimum Data Set assessments that were transmitted late. The Minimum Data Set Director stated they recently started working at the facility and were having difficulty tracking and transmitting the Minimum Data Set assessments. The Minimum Data Set Assessor was interviewed on 9/6/2024 at 11:16 AM and stated they maintained an Excel spreadsheet and had to manually enter which assessments were due because they could not print a report from the electronic medical record system. The Minimum Data Set Assessor stated they had a Minimum Data Set Consulting firm that would assist with completing and transmitting Minimum Data Set assessments, but they ended their contract in August 2024. Minimum Data Set Consulting firm was hired because the previous Minimum Data Set Director resigned. The Minimum Data Set Assessor stated they had spoken with the current Administrator regarding the lateness of Minimum Data Set assessment transmittals. The Minimum Data Set Assessor stated they could not remember when they spoke to the Administrator and could not remember the Administrator's response. The Administrator was interviewed on 9/9/2024 at 8:14 AM and stated they were unaware of any Minimum Data Set transmittal issues. The Administrator stated they only learned about the late Minimum Data Set assessments on 9/6/2024. The Administrator stated they thought that the Minimum Data Set Consulting firm assisted with the Minimum Data Set transmittals. The Director of Nursing Service was interviewed on 9/9/2024 at 9:31 AM and stated they were unaware of any issues with Minimum Data Set assessment transmittals. The Director of Nursing Service stated the Minimum Data Set Director and Minimum Data Set Assessors should have told them of the issue. The Director of Nursing Service stated all Minimum Data Set assessments should be transmitted to the Center for Medicare and Medicaid Services within 14 days of the resident assessment completion. 10 NYCRR 415.11

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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 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** 50423 Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (Complaint #NY 00346145) initiated on 9/4/2024 and completed on 9/11/2024 the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (Resident #544) of two residents reviewed for hospitalization s, one (Resident #10) of four residents reviewed for skin conditions, and one (Resident #193) of five residents reviewed for tube feeding. Specifically, 1) Resident #544 was admitted to the facility with an abdominal surgical incision and treatment recommendations from the hospital and was also seen by the facility's wound care consultant with recommendations to treat the abdominal surgical site. The facility did not follow the hospital or the wound care consultant's recommendation and no physician's orders were obtained to treat the surgical wound. Additionally, there was no documented evidence that treatment of the abdominal surgical site wound was administered. 2) Resident #10, with a history of a Vascular Ulcer to the second left toe, was observed on 9/04/2024 with a gauze dressing in between the left great toe and second toe. There was no physician's order for the treatment of the second left toe. 3) Resident # 193, had a gastronomy (feeding) tube which was no longer being utilized as the resident was eating their meals by mouth. There was no physician's order to monitor or flush the gastronomy tube for patency. The findings are: 1) Resident #544 was admitted with diagnoses including Malignant Neoplasm (a type of abnormal and excessive growth of tissue) of the uterus, Surgical wound, and Moderate Protein-Calorie Malnutrition. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment. The Minimum Date Set assessment documented the resident received surgical wound care during the assessment period. A hospital discharge summary dated 6/13/2024 documented instructions for wound care as follows: dressing change twice daily or as needed. Apply dry gauze to the midline (surgical) incision and secure with tape. A Patient Review Instrument (PRI) completed on 6/13/2024 documented treatment of dressing changes twice daily to the surgical wound. The physician's orders were reviewed from date 6/13/2024 to 6/25/2024. There were no physician's orders indicating treatment administration to the abdominal surgical incision. The comprehensive care plan titled Resident has an Infection Related to Abdominal Surgical Site dated 6/17/2024 and revised on 6/27/2024, documented interventions including but not limited to administer wound care as per physician's order, implement infection control protocol as needed, and medical management of the underlying condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound care consultation progress note, written by Nurse Practitioner #1, dated 6/18/2024 documented Resident #544 had an abdominal surgical incision that measured 15 centimeters in length with 18 staples. There were three areas of dehiscence (separation of a wound's edges) with moderate serous exudate (drainage from a wound). The progress note documented a recommended treatment of Calcium Alginate (a treatment typically used for draining wounds). The medical record lacked documented evidence of a treatment order for Calcium Alginate to the abdominal surgical wound as recommended by the wound care consultant. The nursing progress note dated 6/20/2024 documented Resident #544 was sent to the hospital on 6/20/2024 for evaluation of the open surgical incision site. The nursing progress note dated 6/21/2024 documented Resident #544 returned from the hospital to the facility on [DATE] and was returned back to the hospital again on 6/21/2024. The nursing progress note dated 6/22/2024 documented Resident #544 returned to the facility on [DATE] with instructions for wound care: daily wound care with Bacitracin (an antibiotic ointment), dry gauze, and tape. The Resident may wear an abdominal binder while out of bed. The nursing progress note dated 6/24/2024 written by Licensed Practical Nurse #17 documented that treatment to the abdomen was administered by the floor nurse. A wound care consultation progress note dated 6/25/2024, written by Nurse Practitioner #1, documented the following wound care treatment for Resident #544's abdominal incision site: normal saline cleanse followed by Xeroform (an occlusive dressing used for wound care) to the wound bed then Calcium alginate, and cover with a dry, clean, dressing daily and as needed. The medical record from 6/1/2024 to 6/26/2024 lacked documented evidence of a physician's orders related to the treatment to the surgical incision site. The Treatment Administration Record from 6/1/2024 to 6/26/2024 did not indicate documentation related to the treatment administration to the surgical incision site. Licensed Practical Nurse #17, the nurse manager, was interviewed on 9/11/2024 at 8:03 AM and stated there should be a physician's order for any wound care treatment and that treatment should be documented in the Treatment Administration Record by the administering nurse. Registered Nurse #3, the wound care nurse and nursing supervisor, was interviewed on 9/11/2024 at 8:41 AM and stated any wound care treatment recommended by the hospital or wound care consult should have been reconciled and documented in the Treatment Administration Record. Registered Nurse #3 stated if the wound care treatment was not administered to a resident, the wound could deteriorate or become infected. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #3 was re-interviewed on 9/11/2024 at 10:37 AM and stated when a resident is admitted they review the Patient Review Instrument (PRI) and hospital discharge paperwork. Registered Nurse #3 stated they were responsible for reconciling and transcribing orders when Resident #544 was admitted . Registered Nurse #3 stated the resident should have had an order for wound care treatment as recommended by the hospital upon admission and readmission. Registered Nurse #3 further stated they did not know Resident #544 did not have an active physician's order for wound care treatment in the medical record, this was an oversight. Nurse Practitioner #1 was interviewed on 9/11/2024 at 1:42 PM and stated they provided wound care consultation for Resident #544 on 6/18/2024 and 6/25/2024 and recommended treatment for the abdominal surgical incision site. Nurse Practitioner #1 stated nursing staff is responsible for obtaining the physician's order. Nurse Practitioner #1 stated any open wound, including Resident #544's surgical incision wound, should have an order in place for wound treatment. The Director of Nursing Services was interviewed on 9/11/2024 at 1:42 PM and stated there should have been an order for the wound care treatment for Resident #544's surgical incision site. Nurses are responsible for contacting the Physician for wound care treatment orders. The Director of Nursing Services stated if a wound care treatment is being administered to a resident, it should be based on the physician's orders. Resident #544 did not have a physician's order and the treatment was not administered to their abdominal surgical site and this was an oversight. 48827 2) The facility's Undated policy titled Pressure Ulcer Management and Treatment Program documented the Certified Nursing Assistants are responsible for daily reporting of changes in the resident's skin integrity. The Wound Care Clinician and the interdisciplinary team will meet after the identification of a wound within seventy-two hours to assess the need for additional interventions and treatments. In addition, each wound/ulcer will be evaluated weekly. Resident #10 was admitted with diagnoses including Acute Respiratory Failure, Non-Pressure Chronic Ulcer of part of the left foot, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident had intact cognition. The Minimum Data Set assessment documented the resident is at risk of developing pressure ulcers/injuries. A wound care note dated 3/12/2024 documented that the resident had a resolved Vascular Ulcer on the second left toe and was at high risk for recurrence. The Comprehensive Care Plan titled Skin Integrity last revised on 7/31/2024 documented interventions that included applying bilateral heel booties when in bed. A nursing progress note dated 9/1/2024, written by Licensed Practical Nurse #14, documented Resident #10 complained of itching and pain to their left toes. Licensed Practical Nurse #14 cleansed the left foot with soap and water and requested a physician's consult. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician communication book revealed a note written by Licensed Practical Nurse #14 on 9/01/2024 indicating Resident #10 complained of itching and pain to the left foot and toes. In this communication book, the Physician responded that the resident was seen and no new orders were provided. The Physician did not date their note. The Physician's signature was illegible. There was no corresponding physician's progress note related to an assessment or evaluation of the left foot and toes on 9/1/2024. Resident #10 was observed in bed on 9/4/2024 at 11:55 AM. The resident had a piece of gauze between the resident's left big toe and left second toe. Resident #10 was interviewed on 9/4/2024 at 11:55 AM and stated the nurses do not look at their toes every day. Resident #10 stated they scraped their toe a few weeks ago and it has not healed and the nurse had put the gauze between their toes. Resident#10 was observed in bed watching television on 9/6/2024 at 12:50 PM. The resident had a band-aid on their left second toe. Resident #10 stated their band-aid was changed a few days ago by a nurse. Licensed Practical Nurse #14 was interviewed on 9/9/2024 at 8:41 AM and stated they notified the Physician that the resident complained of discomfort and they observed a scab on the left second toe by documenting in the physician's communication book. Licensed Practical Nurse #14 stated the resident had a previous breakdown on a toe on the left foot but they could not recall which toe. Licensed Practical Nurse #14 stated they did not alert the unit manager, or apply a dressing to the site. Resident #10 was observed sitting in their bed watching television on 9/9/24 at 8:45 AM. The resident had a band-aid on their left second toe. A review of the medical record revealed that there was no physician's order for the gauze dressing or band-aid or any treatment to the resident's left second toe. A review of the Treatment Administration Record indicated no treatment administration to the resident's left second toe. The progress note written by the Wound Care Nurse dated 9/09/2024 documented the resident had a re-opened vascular wound to the left second toe measuring 1 centimeter by 1.2 centimeters. The wound was observed with 100% red tissue, scant drainage, and slight erythema (redness of the surrounding skin). The Comprehensive Care Plan titled Left second toe (VASCULAR ULCER) dated 9/09/2024 documented interventions that included monitoring skin integrity daily and bilateral heel booties when in bed. Licensed Practical Nurse #5, the Unit Manager, was interviewed on 9/9/2024 at 8:50 AM and stated they were not aware of the wound on the resident's left second toe. Licensed Practical Nurse #5 stated the treatments should not be applied without a physician's order. Licensed Practical Nurse #5 stated Licensed Practical Nurse #14 should have notified the wound care nurse or the Unit Manager regarding the scab on the resident's second toe so the resident could be assessed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician #1 was interviewed on 9/10/2024 at 8:32 AM and stated they were not made aware of a concern regarding Resident #10's toes. Physician #1 stated medical progress notes should have been written to address the condition of Resident #10's left toes. Physician #1 stated the Nursing staff should have called the wound care nurse to assess and decide if treatment was needed. Physician #1 stated the nurses should not have just put a band-aid on without alerting the wound care nurse or the Physician. Registered Nurse #3, the Wound Care Nurse, was interviewed on 9/10/2024 at 10:31 AM and stated they should have been notified of Resident #10's wounds. The Wound Care Nurse stated if a wound is not treated correctly, it can deteriorate. The Director of Nursing Services was interviewed on 9/10/2024 at 2:29 PM and stated the nursing staff should have called the Physician to obtain a treatment order and should have referred the resident to the wound care nurse for further evaluation. 3) The facility's policy titled Gastronomy Feedings revised 6/2022 documented instill water as ordered and cleanse the skin around the gastronomy tube. Resident #193 was admitted with diagnoses including Acute Respiratory Failure, Type 2 Diabetes Mellitus, and Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, indicating the resident was unable to complete the interview due to severely impaired cognition. The Minimum Data Set assessment documented the resident had a gastronomy tube. The physician's order dated 7/30/2024 documented to discontinue the tube feeding. A review of the medical record revealed there was no physician's order to flush Resident #193's Gastronomy Tube. A physician's order dated 8/5/2024 documented that Resident #193 received a regular ground meal diet by mouth. Certified Nursing Assistant #3 was interviewed on 9/6/2024 at 2:12 PM and stated Resident #193 still has a gastronomy tube but it is not used. Resident #193 receives a meal tray three times a day and eats their meals by mouth. Licensed Practical Nurse #4, the Unit Nurse Manager, was interviewed on 9/9/2024 at 11:45 AM and stated there should be a Physician's order to flush the gastronomy tube. Licensed Practical Nurse #3 was interviewed on 9/9/2024 at 11:54 AM and stated the resident did not use the gastronomy tube as of 8/05/2024. Licensed Practical Nurse #3 stated they did not flush the resident's gastronomy tube because there was no order and they did not contact the Physician to obtain an order to flush the feeding tube. The Chief Dietician was interviewed on 9/10/2024 at 8:07 AM and stated the gastronomy tube feeding order for Resident #193 was discontinued on 7/30/2024. The Chief Dietician stated the Dieticians were responsible for placing the physician's order to flush the gastronomy tube to keep the tube patent and it was an oversight. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician #1 was interviewed on 9/10/2024 at 8:36 AM and stated they if the gastrostomy tube is not flushed the tube may become clogged and would have to be removed and replaced. The Director of Nursing Services was interviewed on 9/10/2024 at 2:27 PM and stated there should be an order to flush the gastronomy tube to maintain patency. The nurses need to monitor the gastronomy tube and should have alerted the nurse manager or the Dietician that there was no order in place to flush the resident's gastronomy tube. 10 NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This was identified for one (Resident #2) of three residents reviewed for Pressure Ulcers. Specifically, Resident #2 had a Stage 4 pressure ulcer and an unstageable pressure ulcer to their back. Resident #2 had a care plan intervention and recommendations for an air mattress. During several observations, the adjustable weight setting for the air mattress was not set accurately. The finding is: The facility's undated policy titled Pressure Ulcer Prevention, Management, and Treatment Program documented to initiate preventive measures and promote wound healing. The nurse assigned to administer the pressure ulcer treatment will administer specific treatment and sign for having administered such treatment on the treatment record. The facility's Low Air Loss Mattress Operator's Manual under Operating Instructions documented: determine the resident's weight and set the control knob to that weight setting on the control unit. Resident #2 was admitted with diagnoses including Traumatic Brain Injury, Respiratory Failure, and Depression. The 6/29/2024 Quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognition for daily decision-making. The Minimum Data Set assessment documented the resident had two unstageable pressure ulcers. A Comprehensive Care Plan effective 6/19/2024 documented the resident has a right Inferior (lower) Back Unstageable Pressure Injury with an intervention to use an air mattress. A Comprehensive Care Plan effective 6/19/2024 documented the resident has a right Superior (upper) Back Unstageable Pressure Injury with an intervention to use an air mattress. A physician's order dated 8/1/2024 documented for a nurse to check the air mattress for proper placement, setting (based on weight), and functioning every shift twice a day: 7:00 PM-7:00 AM, 7:00 AM-7:00 PM. A wound consultant note dated 9/3/2024 documented an intervention for an air mattress. The wound consult documented that the resident's current weight as of 9/3/2024 was 156.2 pounds. The resident had an unstageable right superior back wound. The wound was debrided (removal of damaged tissues) of a thick cap of necrotic (dead) tissue. The wound measured three centimeters in length and two centimeters in width. The right inferior back Stage 4 pressure measured four centimeters in length, four centimeters in width, and two centimeters in depth. The resident's weight in the electronic medical record as of 9/3/2024 was 156.2 pounds. (continued on next page)

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	335839	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/2024 at 11:50 AM, Resident #2 was observed sitting in the gerichair adjacent to their bed. The air mattress weight setting was set at 265 pounds. On 9/10/2024 at 9:14 AM, Resident #2 was observed lying in bed. The air mattress weight setting was set at 265 pounds. A review of the Treatment Administration Record for September 2024 revealed the resident's air mattress was checked for proper placement, setting (based on weight), and functioning as indicated by the nurses' signatures on 9/9/2024 for the 7:00 AM-7:00 PM shift, and on 9/9/2024-9/10/2024 for the 7:00 PM-7:00 AM shift. Registered Nurse #3, the wound care nurse, was interviewed on 9/10/2024 at 11:40 AM. Registered Nurse #3 observed Resident #2's air mattress and confirmed that the weight setting was set at 265 pounds. Registered Nurse #3 stated the weight setting on the air mattress should be consistent with the resident's weight of 156 pounds. Registered Nurse #3 stated they observed the resident earlier in the morning during wound rounds but did not check the weight setting on the mattress. Registered Nurse #3 stated, I think that if the weight setting on the mattress is set higher than the resident's weight, it could cause discomfort to the resident. Registered Nurse #3 stated they were not sure if an inaccurate weight setting affected wound healing. Nurse Practitioner #1, the wound care consultant, was interviewed on 9/10/2024 at 12:32 PM and stated the weight setting on the air mattress is supposed to be consistent with the resident's weight to properly redistribute the weight to assist with wound healing. The Director of Nursing Services was interviewed on 9/10/2024 at 1:09 PM and stated the weight setting on the air mattress should be consistent with the resident's weight. The Director of Nursing Services stated if the weight setting on the air mattress is not consistent with the resident's weight, this could affect wound healing or prolong the healing process. Registered Nurse #2 was interviewed on 09/11/2024 at 10:34 AM and stated they signed the Treatment Administration Record on 9/9/2024 during the 7:00 AM-7:00 PM shift to indicate that they checked the air mattress for proper placement, setting (based on weight), and functioning. Registered Nurse #2 stated when they checked the mattress weight setting on 9/9/2024, the weight setting was accurate according to the resident's actual weight. 10 NYCRR 415.12(c)(1)

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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. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure the resident environment remained as free of accident hazards as possible. This was identified for one (Resident #208) of four residents reviewed for Accidents. Specifically, on 9/4/2024, Resident #208 had an aerosol container of Lysol spray on their bedside table. Facility staff were aware of the aerosol spray container but did not remove it. The finding is: The facility's policy titled Environmental Hazard, dated 8/2023, documented aerosols (air fresheners, deodorants, hair sprays, disinfectants) are prohibited for use inside of the facility. The Occupational Safety and Health Administration Safety Data Sheet, titled Professional Lysol Disinfectant Spray - All Scents, dated 9/21/2020, documented the Lysol was a flammable aerosol; contains gas under pressure; may explode if heated; and causes eye irritation. In a fire or if heated, a pressure increase will occur and the container may burst, with the risk of a subsequent explosion. Gas may accumulate in low or confined areas or travel a considerable distance to a source of ignition and flash back, causing fire or explosion. Resident #208 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, and Anxiety Disorder. The 7/20/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 12, indicating the resident had moderately impaired cognition. A physician's order dated 8/9/2024 documented to administer oxygen therapy at 3 liters per minute via a nasal cannula continuously for Chronic Obstructive Pulmonary Disease. On 9/4/2024 at 11:35 AM, an aerosol spray container of Lysol Disinfectant Spray was observed on Resident #208's bedside table. The resident was lying in bed and was receiving oxygen via a nasal cannula. The resident stated their family brought in the Lysol spray and the aides used it to spray the room. On 9/4/2024 at 11:40 AM, the Lysol spray was brought to the attention of Registered Nurse #1 (charge nurse). Registered Nurse #1 stated they were not aware of the Lysol aerosol spray being present in Resident #208's room. Registered Nurse #1 stated did not know if the Lysol aerosol spray was allowed to be kept in the resident's room. On 9/4/2024 at 11:45 AM, Registered Nurse #1 returned to Resident #208's room, removed the Lysol aerosol spray from the room and told the resident that the aerosol sprays were not permitted. (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 #1 was interviewed on 9/4/2024 at 12:22 PM and stated they had seen the aerosol spray in Resident #208's room but did not use it because the staff are not allowed to use aerosol sprays. Certified Nursing Assistant #1 stated they did not tell anyone about the spray because they assumed the resident had approval to have the spray. Resident #208 was interviewed on 9/5/2024 at 8:52 AM and stated their family brought the aerosol spray and the resident has been using it for a couple of months. Resident #208 stated the staff saw the Lysol spray as it was kept on the bedside table in plain view. Licensed Practical Nurse #1, the unit nurse manager, was interviewed on 9/6/2024 at 10:55 AM. Licensed Practical Nurse #1 stated aerosol sprays were not allowed in resident rooms. Social workers need to speak to Resident #208's family about not bringing in the aerosol spray for the resident. The Director of Nursing Services was interviewed on 9/9/2024 at 9:24 AM and stated aerosol sprays were not permitted in the facility because these sprays are flammable. The Director of Nursing Services stated the aerosol spray should have been removed from the resident's room when the staff first noticed it. 10 NYCRR 415.12(h)(1)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure intravenous (IV) fluids (fluids that were administered directly into a vein) were administered consistent with professional standards of practice and in accordance with physician orders. This was identified for one (Resident #58) of one resident reviewed for Hydration. Specifically, Resident #58 had a physician's order to receive Dextrose fluids at 70 cubic centimeters (cc)/hour via intravenous route. On two separate occasions on 9/6/2024, the resident was observed receiving the Dextrose fluid at 50 cubic centimeters (cc) /hour intravenously instead of the Physician's ordered 70 cubic centimeters (cc)/hour intravenously. The finding is: The facility's Intravenous Therapy policy last reviewed in August 2023, documented that the physician's order for intravenous therapy shall specify the type, amount, and rate of solution to be administered. Intravenous therapy including the solution type and rate of infusion must be documented by nursing staff at least once per shift. Resident #58 was admitted with diagnoses of Parkinson's Disease, Hypoglycemia, and Pneumonia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #58 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had intact cognition. The Minimum Data Set assessment documented Resident #58 had intravenous access and received intravenous medication in the past 14 days of the look-back period. The Comprehensive Care Plan for Dehydration dated 9/18/2022 documented the resident was at risk for dehydration secondary to Edema, Dementia, and altered mental status. Interventions included to monitor laboratory results as ordered by the Physician, and to monitor signs and symptoms of dehydration such as poor skin turgor, dry mouth, thirst, and change in mental status. The Comprehensive Care Plan for Intravenous Therapy dated 9/7/2024 documented the resident was at risk for complications secondary to intravenous therapy. Interventions included to monitor changes in the resident's condition, and to monitor medication per physician order. The Physician Assistant progress note dated 9/5/2024 documented that Resident #58's glucose level was 57 milligrams/Deciliters and the fingerstick was 60 milligrams/Deciliters. The Physician Assistant recommended changing the intravenous fluid to Dextrose 5% at 70 cubic centimeters (cc) per hour. The Physician's order dated 9/5/2024 documented to administer Dextrose 5% in water intravenous (IV) solution at 70 cubic centimeters (cc) per hour every shift for Hypoglycemia (low blood sugar). Resident # 58 was observed sleeping in bed on 9/6/2024 at 10:50 AM. The resident was observed with a 1000 cubic centimeter capacity Dextrose 5% intravenous solution bag at the bedside with 650 cubic centimeters of fluid remaining. The intravenous solution was being infused into the resident's left arm. The flow meter dial on the intravenous tubing was set at 50 cubic centimeters/hour. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was again observed on 9/6/2024 at 11:47 AM with Licensed Practical Nurse #10. The resident was receiving Dextrose 5% solution intravenously in their left arm. Licensed Practical Nurse #10 confirmed the infusion flow rate was set at 50 cubic centimeters/hour. Licensed Practical Nurse #10 was immediately interviewed after the observation on 9/6/2024 and stated they checked Resident #58's infusion setup at the start of their shift (7:00 AM-3:00 PM) today (9/6/2024) and noticed the flow rate was at 50 cubic centimeters/hour. Licensed Practical Nurse #10 stated that Resident #58 had received Normal Saline intravenously at 50 cubic centimeters/hour the last few days, and they did not realize the Dextrose 5% solution was ordered at 70 cubic centimeters/hour. Licensed Practical Nurse #10 stated that intravenous fluids should be administered as per the physician's order and they should have checked to ensure that the Dextrose 5% solution infusion rate was set at 70 cubic centimeters/hour. Licensed Practical Nurse #12 was interviewed on 9/6/2024 at 3:22 PM and stated they worked the evening shift (3:00 PM - 11:00 PM) on 9/5/2024 and reviewed Resident #58's order for Dextrose 5% solution. Licensed Practical Nurse #12 stated they started Resident #58's Dextrose 5% intravenous solution at 70 cubic centimeters/hour. Licensed Practical Nurse #12 stated the same bag was still infusing at 70 cubic centimeters/hour at the end of their shift and they did not change the setting. Licensed Practical Nurse #12 stated that the nurse must follow the Physician's order and administer intravenous fluids at the rate ordered. Licensed Practical Nurse #13 was interviewed on 9/10/2024 at 12:47 PM and stated they worked the night shift (11:00 PM - 7:00 AM) on 9/5/2024 and saw that Resident #58 was receiving intravenous fluids; however, did not recall the flow rate. Resident #58's Attending Physician #2 was interviewed on 9/10/2024 at 12:04 PM. Physician #2 stated they expected Resident #58 to receive their Dextrose 5% solution as prescribed. Physician #2 stated that Dextrose 5% solution was ordered to treat Hypoglycemia; therefore, an incorrect infusion rate would potentially reduce the actual amount of sugar delivered to the resident and delay the time to resolve Resident #58's Hypoglycemic episode. The Director of Nursing Service was interviewed on 9/10/2024 at 2:31 PM and stated that nursing staff should check the Physician's order before administrating any medication including intravenous fluids and administer the correct amount of intravenous fluid as per the Physician's orders. 10 NYCRR 415.12(k)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on observation, record review, and interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure that drugs and biologicals were labeled in accordance with currently accepted professional principles. This was identified for one (Unit 3 South medication cart) of six medication carts reviewed during the Medication Storage Task. Specifically, the Unit 3 South medication cart was observed with one opened Basaglar 100 units per milliliter insulin pen for Resident #21 and one opened Lantus 100 milliliters per unit insulin pen for Resident #97. Both insulin pens did not have a date indicating when the pens were first opened for use. The finding is: Resident #21 was admitted with a diagnosis of Type 2 Diabetes Mellitus with Unspecified Complications. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 9, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented the resident received insulin injections during the assessment period. A physician's order dated 12/13/2023 documented to administer Basaglar (a long-lasting insulin) 100 units per milliliter insulin pen, 20 units subcutaneously (an injection in between the skin and muscle tissue) at bedtime for Type 2 Diabetes Mellitus with Unspecified Complications. Resident #97 was admitted with a diagnosis of Type 2 Diabetes Mellitus with Unspecified Complications. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident received insulin injections during the assessment period. A physician's order dated 6/25/2024 documented to administer Lantus (long-lasting insulin) 100 milliliters per unit insulin pen, 15 units subcutaneously once a day for Diabetes Mellitus. An observation of the Unit 3 South medication cart was conducted with Licensed Practical Nurse #15 on 9/10/2024 at 12:31 PM. One opened Basaglar insulin pen for Resident #21 and one opened Lantus insulin pen for Resident #97 were observed in the medication cart without an open date documented on both insulin pens. Licensed Practical Nurse #15 was interviewed on 9/10/2024 at 12:38 PM and stated the insulin pens did not have a date indicating when the pens were first opened for use. Licensed Practical Nurse #15 stated all nurses are responsible for ensuring that the medications are appropriately labeled. Licensed Practical Nurse #11, the nurse manager, was interviewed on 9/10/2024 at 1:45 PM and stated the staff can not determine when the medication should be discarded if there was no date indicating when the insulin pens were first opened. The insulin pens should be discarded after 28 days after the opening date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pharmacist #1 was interviewed on 9/10/2024 at 3:16 PM and stated both the Lantus insulin pen and Basaglar insulin pen should be discarded 28 days after opening because the medication (insulin) can lose effectiveness 28 days after opening. The Director of Nursing Services was interviewed on 9/11/2024 at 1:28 PM and stated insulin pens should be discarded 28 days after an insulin pen is opened. An open date should have been documented on the insulin pens for both Resident #21 and Resident #97 so that staff can determine when to discard the pens. 10 NYCRR 415.18 (d)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not ensure each resident received food that accommodated the resident's allergies, intolerances, and preferences. This was identified for one (Resident #27) of three residents reviewed for Nutrition. Specifically, Resident #27 had a Physician's Order that documented allergies to artificial sweeteners; however, Resident #27 was served sugar-free snack puddings and reduced-calorie syrup with artificial sweeteners. The finding is: The facility's policy and procedure titled Allergies, last revised on 8/2023 documented that upon admission, the admitting nurse shall review if the resident has any known drug and food allergies/sensitivities to prevent anaphylaxis and allergic reaction. The admitting nurse obtains information on admission if the resident is allergic to drugs or any specific food items and notifies the dietary department if the resident is allergic to certain foods. Resident#27 was admitted with diagnoses that included Acute and Chronic Respiratory Failure, Heart Failure, and Pneumonia. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #27 had intact cognition. A Physician's Order dated 6/24/2024 documented an order for no artificial sweeteners. A Comprehensive Care Plan (CCP) titled Allergies, dated 9/23/2022 and last revised on 7/22/2024 documented interventions that included identifying the resident's allergies and documenting them in the medical record. Communicate resident allergies with dietary services. During an observation on 9/4/2024 at 11:21 AM, four sugar-free puddings and one reduced-calorie syrup were found on Resident #27's overbed table. Resident #27 had their meal tickets dated 8/26/2024 for breakfast, lunch, and dinner. The meal ticket indicated that the resident has allergies to Artificial sweeteners. The Nutrition and Ingredients for the Snack Pack Sugar-Free Pudding Cups included artificial flavors, and sucralose (an artificial sweetener and sugar substitute). The Nutrition and Ingredients for the Reduced Calorie Syrup one-ounce packet included saccharin (non-nutritive artificial sweeteners). Resident #27 was interviewed on 9/6/2024 at 10:22 AM. The Food Service Director was present during the interview. Resident #27 stated the four sugar-free snack puddings and one reduced-calorie syrup came with their meal tray on 8/26/2024. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Food Service Director was interviewed on 9/6/2024 at 10:23 AM and stated the sugar-free snack puddings and reduced-calorie syrup found in Resident #27's room were from the kitchen. The Food Service Director stated that one of the dietary aides must have mistakenly put the snack puddings and syrup on the resident's tray. Dietary Aide #1 was interviewed on 9/9/2024 at 10:45 AM and stated during the tray line, they were responsible for checking the items in the meal tray were accurate. Dietary Aide #1 stated they double-check the meal ticket for any food allergies. Dietary Aide #1 stated they thought that artificial sweeteners were only present in the sugar packets and did not know that artificial sweeteners could also be part of the ingredients in the sugar-free snack pudding and reduced calorie syrup. The Director of Nursing Services was interviewed on 9/9/2024 at 11:21 AM and stated that Resident #27's meal tray should have been thoroughly checked for accuracy by the kitchen staff. The Director of Nursing Service stated the kitchen staff should be knowledgeable about artificial sweeteners including possible food that contained artificial sweeteners. Registered Dietitian #2 was interviewed on 9/10/2024 at 8:32 AM and stated the kitchen was responsible for all the trays that go out to the residents. Registered Dietitian #2 stated the unit staff should have checked the trays for accuracy before giving them to the residents, especially to those who had food allergies. 10 NYCRR 415.14(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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/4/2024 and completed on 9/11/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for two (Resident #214 and Resident #546) of four residents reviewed for Transmission-Based Precaution (TBP). Specifically, Resident #214 had a physician's order for contact precaution for Methicillin-Resistant Staphylococcus Aureus (MRSA-bacterium that is resistant to some antibiotics) in the sputum (mucus). 1) On 9/4/2024, Physical Therapist #1 was observed entering Resident #214's room without wearing appropriate Personal Protective Equipment and pushed the resident's wheelchair to transport Resident #214 from their room to the Rehabilitation Room. Physical therapist #1 did not perform hand hygiene after transporting Resident #214. 2) On 9/5/2024 during the medication pass observation, Licensed Practical Nurse #7 was observed declogging (removing blockage or obstruction) Resident #214's Gastrostomy Tube (GT-feeding tube). After the procedure, Licensed Practical Nurse #7 did not change their gloves, did not perform hand hygiene, and administered Resident #214's eye drops to both eyes. 3) Resident #546 was admitted to the facility from the hospital with recommendations to be placed on contact precautions due to an infection to both heel wounds. There was no physician's order for contact precautions until 9/4/2024, six days after the resident was admitted . On 9/4/2024, Licensed Practical Nurse #4 was observed entering the resident's room without performing hand hygiene and without wearing proper Personal Protective Equipment. The finding is: The facility's policy and procedure titled Precautions Infection Control, last revised on 8/2023 documented that the facility will use Transmission-Based Isolation Precautions which include Contact Precautions consisting of wearing gloves when entering the room. Gloves are to be removed and discarded before leaving the room. Gowns are indicated if soiling is likely or if contact with the resident or handling of items in the room is expected. Perform hand hygiene. After confirmation of isolation precautions, the Infection Preventionist or designee will post the appropriate isolation precaution sign and provide an isolation station. The resident must remain in their room and all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). The facility's policy and procedure titled, Medication Administration, last revised on 8/2023 documented before administering eye medication, wash hands and apply clean disposable gloves. Use a separate tissue for each eye and allow 5 to 15 minutes to elapse before administering the second medication. Dispose of gloves and wash hands after administering eye drops or ointment. Resident #214 was admitted with diagnoses including Acute and Chronic Respiratory Failure, Type 2 Diabetes Mellitus, and Non-Traumatic Intracerebral Hemorrhage (brain bleed). An Admission Minimum Data Set (MDS) assessment dated [DATE] documented no Brief Interview for Mental Status (BIMS) score as Resident #214 had severely impaired cognitive skills for daily decision making. The Minimum Data Set (MDS) assessment documented the resident was on special treatment for isolation or quarantine for active infectious diseases including Methicillin-Resistant Staphylococcus Aureus and had a feeding tube. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335839	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Comprehensive Care Plan (CCP) dated 8/3/2024 titled Contact Precautions, documented interventions that included to place the contact precaution signage on the door indicating to put on Personal Protective Equipments including a Gown and gloves during high contact with the affected source (the resident). A physician's order dated 8/5/2024 and renewed on 8/13/2024 documented Contact Precautions in place related to Methicillin-Resistant Staphylococcus Aureus in the sputum. A physician's order dated 8/5/2024 documented Hydroxypropyl Methycell Ophthalmic solution, one drop to both eyes every 8 hours. 1) During an observation on 9/4/2024 at 10:55 AM, Resident #214 was sitting in their recliner when Physical Therapist #1 entered the room without wearing any Personal Protective Equipment (PPE) and proceeded to wheel Resident #214 to the Rehabilitation Room. The Physical Therapist did not perform any hand hygiene after they wheeled the resident to the Rehabilitation Room. Physical Therapist #1 then started working on their computer. A signage posted outside Resident #214's door read Contact Precautions. The signage included instructions for the Personal Protective Equipment (PPE) gloves and gowns. Hand hygiene. Limit transport of residents to medically necessary purposes. Ensure that infected or colonized areas of the resident's body are contained and covered. Use disposable noncritical patient-care equipment or implement patient-dedicated use of such equipment. Physical Therapist #1 was interviewed on 9/4/2024 at 11:00 AM and stated they did not know the resident was on contact precautions and read the sign outside the resident's door. Physical Therapist #1 stated they thought that Personal Protective Equipment (PPE) was for high-contact care only. Physical Therapist #1 stated they transported Resident #214 for their scheduled Rehabilitation Therapy session, and they did not think to wear a gown, or gloves prior to transporting the resident. Physical Therapist#1 stated that Resident #214 wore a mask during Rehabilitation Therapy sessions and the staff that worked with Resident #214 would always wear a gown and gloves. Physical Therapist #1 stated they should have read and followed the Personal Protective Equipment (PPE) requirements including hand hygiene. The Infection Preventionist was interviewed on 9/4/2024 at 4:38 PM and stated the contact isolation sign was posted outside Resident #214's room for guidance to staff and visitors. The Infection Preventionist stated they expected all staff and visitors to follow the required Personal Protective Equipment indicated on the signage. The Infection Preventionist stated Physical Therapist #1 should have used the required PPE (Personal Protective Equipment) and should have washed their hands after they brought the resident to the Rehabilitation Room. The Director of Nursing Service was interviewed on 9/10/2024 at 12:17 PM and stated Physical Therapist #1 should have followed the correct Personal Protective Equipment (PPE) and performed hand hygiene. 2) During the medication administration observation on 9/5/2024 at 8:28 AM, Licensed Practical Nurse #7 (Medication Nurse) was observed entering Resident #214's room wearing a gown, a mask, and gloves. Licensed Practical Nurse #7 unclogged the Gastrostomy Tube (GT) by squeezing and rolling the tube with their thumb and forefinger numerous times. Licensed Practical Nurse #7 did not change the gloves and did not wash their hands after the procedure and then administered eye drops to the resident's eyes using the same gloves. (continued on next page)

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	335839	A. Building B. Wing	09/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #7 was interviewed on 9/5/2024 at 8:35 AM and stated they should have changed their gloves and performed hand hygiene after they unclogged the Gastrostomy Tube (GT), and before they administered the eye drops. Licensed Practical Nurse #7 stated they were nervous during the medication observation and forgot to change their gloves and wash their hands. The Infection Preventionist was interviewed on 9/9/2024 at 9:39 AM and stated that Licensed Practical Nurse #7 should have changed their gloves and performed hand hygiene before administering the eye drops. The Director of Nursing Service was interviewed on 9/9/2024 at 10:43 AM and stated Licensed Practical Nurse #7 should have changed their gloves and performed hand hygiene before administering the eye drops. 50423 3) Resident #546 was admitted with diagnoses including Encephalopathy, Acute Kidney Failure, and Moderate Protein-Calorie Malnutrition. There were no Minimum Data Set assessments completed because Resident #546 was recently admitted . A Social Work Progress Note dated 8/29/2024 documented a Brief Interview for a Mental Status score of 6, indicating the resident had severe cognitive impairment. A Comprehensive Care Plan for Right and Left Lateral Heel (Trauma) dated 8/28/2024 and revised on 9/4/2024 documented interventions including but not limited to contact precautions, administering treatment as per physician's order, and following measures to prevent contamination of the wound such as hand hygiene. A nursing progress note dated 8/28/2024 documented Resident #546 was on contact precautions from the hospital due to rare Enterobacter Cloacae complex (a group of infectious bacteria) and moderate Staphylococcus Aureus to the wounds on bilateral heels. A physician's order dated 9/4/2024 documented the implementation of contact precautions. During an observation on 9/4/2024 at 2:13 PM, Resident #546 was observed sitting in their wheelchair in the unit hallway, outside of their room. A sign was observed posted outside of Resident #546's door which documented to perform hand hygiene and apply gloves and gown before entering the room. Licensed Practical Nurse #4 (the nurse manager) pushed the resident's wheelchair to transport the resident into their room. Licensed Practical Nurse #4 did not perform hand hygiene prior to entering or when exiting the resident's room. Additionally, Licensed Practical Nurse #4 did not put on gloves or a gown prior to entering the resident's room. Licensed Practical Nurse #4 was interviewed immediately following the observation and they stated they did not have to wear gloves and gown when entering the resident's room unless there was direct contact with the resident. Licensed Practical Nurse #4 stated the infectious areas of the resident's body were covered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #4 was re-interviewed on 9/5/2024 at 10:50 AM and stated they should have put on gloves and a gown and washed their hands prior to entering Resident #546's room. It is expected that they perform hand hygiene prior to entering and upon exiting a resident's room who was on contact precautions. Licensed Practical Nurse #4 further stated the physician's order for contact precautions for Resident #546 should have been in place since admission and it was an oversight. The Infection Preventionist was interviewed on 9/9/2024 at 9:47 AM and stated Licensed Practical Nurse #4 should have put on appropriate Personal Protective Equipment for contact precautions prior to entering Resident #546's room and should have performed hand hygiene prior to entering the room and exiting the room. The Infection Preventionist stated there should have been a physician's order for contact precautions in place from admission. The Director of Nursing Services was interviewed on 9/10/2024 at 2:37 PM and stated Licensed Practical Nurse #4 should have put on appropriate Personal Protective Equipment before entering Resident #546's room and should have performed hand hygiene before entering the room and exiting the room. The Infection Preventionist stated there should have been a physician's order for contact precautions in place from admission. 10 NYCRR 415.19(a)(1-3) 10 NYCRR 415.19(b)(4)