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Sullivan County Adult Care Center
January 5, 2023 Certification/complaint Survey

Standard Health Citations	9

FF12 483.24(a)(2):ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

REGULATION: §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
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NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review conducted during the Recertification Survey conducted from 12/27/2022 -1/5/2023, the facility did not ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain grooming and personal hygiene for 1 of 3 residents (Resident #63) reviewed for ADL's. Specifically, Resident # 63 did not consistently receive twice a week showers as per the CNA (Certified Nursing Assistant) Accountability and the unit shower schedule. The findings are: The facility Policy and Procedure (P&P) titled Activities of Daily Living (ADL) un dated documented a program of activities of daily living (ADL) is provided to prevent disability and return to a maximum level of independence. The policy further documented the resident self-image should be maintained. In addition, the resident will be offered shower/bed bath based on resident preference and schedule. Assistance will ne provided based on plan of care. Resident #63 was admitted with [DIAGNOSES REDACTED]. The 11/6/22 Quarterly Minimum Data Set (MDS - a resident assessment tool) documented Resident #63 had a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. required extensive physical assist for bed mobility, transfers, dressing, toileting, and personal hygiene. . The 5/16/22 with a revision date of 8/19/22 ADL Comprehensive Care Plan dated 5/16/22 documented assistance with ADLs related to weakness and limited mobility. Resident is dependent on staff daily in meeting ADL needs. Resident was extensive assist of 1 for bathing and showering. The (MONTH) 2022 CNA Accountability form revealed no documented evidence that bathing was provided 11/1/22, 11/4/22, 11/8/22, 11/11/22, 11/15/22, 11/22/22 and 11/25/22. The (MONTH) 2022 CNA Accountability form revealed no documented evidence that bathing was provided on 12/2/22, 12/9/22, 12/13/22, 12/16/22, 12/20/22, 12/23/22, and 12/30/22. During an interview on 1/4/23 at 10:54 AM, CNA #2 stated the facility is short staffed at times so sometimes there is no time to bathe the residents. CNA #2 stated Resident #63 constantly complained about not being bathed and had never refused cares. CNA #2 stated If a CNA was unable to	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 3 residents. 1. The resident was immediately showered as per the resident?ÇÖs preference. 2. All residents have the potential to be affected. All Care plans and CNA tasks were audited for shower schedules to ensure their accuracy based on resident preferences by the DON /Designee. 3. The Policy and Procedure for Resident ADL?ÇÖs (Bathing), and Clinical Documentation was reviewed by the DON on 1/23/2023. The CNA assignments will be audited by the DON/ Designee to ensure that the residents?ÇÖ preference for bathing is included and accurate based on resident preference. Clinical staff will be re-in-serviced on the policy and procedure and CNA assignments. 4. Clinical nurse managers will conduct audits of all residents bathing preferences and CNA documentation completion weekly x4 weeks to ensure that assistance is being provided in accordance with resident preferences. an order for [REDACTED]. Audit and observation results will be presented by nursing administration at the monthly QAPI meetings for three months and at the discretion of the QAPI team thereafter. 5. Completion Date and Responsible Person: 3/5/2023 Director of Nursing/ designee.

complete an assigned task, they should communicate with the next shift and the unit manager so that the task can be reassigned. During an interview on 1/4/23 at 11:22 AM, Licensed Practical Nurse (LPN #1) stated residents should get bathed twice a week at the very least. LPN #1 stated most residents on the unit were alert and would communicate with nursing staff if a care wasn't provided. LPN # 1 stated the Registered Nurses (RNs) were responsible for checking the Electronic Medical Record (EMR) to ensure CNAs have documented accordingly. During an interview on 1/5/22 at 1:33 PM, the Director of Nursing (DON) stated they were aware of omissions on the CNA accountability documentation as it has been a facility wide issue. The DON stated some CNA have reported they don't have time or are unable to stay late to get the documentation done. The DON stated the staff were aware if they did not document, the task would be considered not completed. 415.12 (a) (3)	

FF12 483.60(i)(1)(2):FOOD PROCUREMENT,STORE/PREPARE/SERVE-SANITARY

REGULATION: §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Scope: Isolated
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Based on observations and interviews conducted during the Recertification Survey from 12/27/22-1/05/23, the facility did not ensure that food was prepared and served in accordance with professional standards for food safety. This was evident during the Kitchen Task observation. Specifically, the cook and 2 food service technicians were observed in the kitchen with their face masks pulled down off their noses and mouths, the cook, who is bearded, was observed without a beard cover, and the Maintenance Assistant was observed in the kitchen without a hair net. The findings are: The undated facility policy titled, Hair Restraint documented that the food service employees are required to have all their hair covered and don a hairnet when preparing and serving food. On 12/27/22 at 09:46 AM during the initial kitchen tour, a bearded cook was observed without a beard cover and had their mask pulled down below their nose and mouth, a food service technician was observed without a hair net and the Food Service Director (FSD) was observed not wearing a face mask. On 12/28/22 at 09:13 AM during the follow-up kitchen tour, 2 food service technicians were observed with their masks pulled down below their noses and mouths, a bearded cook was observed with no beard covering, and the Maintenance Assistant was observed in the kitchen with no hair net. On 1/04/23 at 11:38 AM, an interview was conducted with the cook. The cook stated they were aware that staff should be wearing a beard cover and a face mask, but they had just walked out from the office and were walking over to the stove area. The cook stated they forgot to put the beard cover on and cover their nose and mouth with the mask. On 1/04/23 at 11:41 AM, an interview was conducted with the food service director (FSD). The (FSD) stated they were aware staff should be wearing hair covers and had educated the staff on it in the past. The FSD stated they were aware all staff should wear a face mask when in the facility. 415.14(h)	The facility did not ensure that food was prepared and served in accordance with professional standards for food safety. 1. The Staff in the kitchen were immediately in service on the use of hair nets/ beard nets and face coverings (masks) while in the kitchen. The Staff member without the beard net was immediately educated and required to put on the beard net. The Maintenance Assistant was educated on the use of Hair Nets while in the kitchen. 2. The Policy and procedure for use of hair coverings and face masks while in the kitchen was reviewed and revised by the Administrator on 1/23/2023. 3. Education will be done with all staff by the Staff Development Coordinator/ designee on the requirement of the use of hair coverings and masks. 4. An audit will be performed by the Food Services Director/ Designee on both shifts Daily for 4 weeks to ensure that staff always follow requirements for hair and face coverings while in the kitchen. Random checks will be conducted weekly for the next 2 months to ensure continued compliance. All negative findings will be corrected immediately. 5. The results of the audits and spot checks will be reported to the QAPI committee monthly for three months and at the discretion of the QA team thereafter. 6. Completion Date: 3/5/2023 Responsible for compliance: Food Services Director / Designee

FF12 483.25(c)(1)-(3):INCREASE/PREVENT DECREASE IN ROM/MOBILITY

REGULATION: §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of

motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

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NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, record review, and staff interviews during the Recertification Survey, the facility did not ensure a resident with limited range of motion (ROM) and mobility received appropriate treatment and services to increase range of motion and or to prevent further decrease in range of motion. Specifically, a splint device was not provided to the resident as per physician order. This was evident in 1 of 1 resident (Resident #66) reviewed for ROM care and services. The findings Are: The facility policy and procedure titled Splint, Braces, Casts and Immobilizers (assistive devices) undated documented the following: the facility will access each splint, brace, cast and immobilizer to ensure proper placement fitting, minimal pressure and proper placement and cleaning. Nursing and rehab will collaborate as necessary for resident safety and comfort. Resident #66 was admitted with [DIAGNOSES REDACTED]. The 11/27/22 Quarterly Minimum Data Set (MDS) documented that the resident had severely impaired cognition, required extensive assist of 2 staff for bed mobility and toileting, was totally dependent of 2 staff for transfer and needed extensive assist of 1 staff for eating and had functional impairment on one side of the upper extremities. The 5/18/22 physician's orders [REDACTED]. The 8/22/22 At Risk for Developing Limited Range of Motion (ROM) Care Plan documented resident was at risk for developing limitations in ROM related to immobility-resident with a left arm contracture. Intervention- Apply and remove the splint to the left arm as ordered. Review of the (MONTH) 2022 Treatment Administration Record (TAR) documented Licensed Practical Nurse (LPN #2) signed that the left hand splint was in place for Resident #66 on 12/27/22 during the day shift. Review of the (MONTH) 2023 TAR documented LPN #2 signed that the left hand splint was in place for Resident #66 on 1/4/23 during the day shift. Resident #66 was observed on 12/27/22 at 12:07 PM with their left hand resting in front of their face,and without the placement of the left-hand splint, 12/27/22 at 3:15 PM resting in their geri chair and without the placement of the left hand splint, 01/04/23 at 11:01 AM and 1/04/23 at 3:25 PM resting in bed without the placement of the left hand splint. During an interview on

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The facility did not ensure that a resident with limited range of motion and mobility received appropriate treatment and services to increase range of motion and or to prevent further decrease in range of motion. 1. The resident splint was immediately placed on the resident as ordered. 2. All resident care plans and CNA tasks for residents who have orders for splints have the potential to be affected and were audited by clinical nurse managers. All CNA assignments were updated for any resident needing a splint. The Nurse on the unit will be responsible for checking that the CNA has applied the splint as ordered and will sign off that it has been applied on the TAR. The Policy and Procedure for Splint use, and Clinical Documentation was reviewed by the DON on 1/23/2023. All Clinical staff will be re-in-serviced on the revised policy and procedure and CNA assignment by the Staff Development Coordinator. 3. Clinical nurse managers will conduct audits of all residents with splints CNA documentation and nursing Documentation completion weekly x4 weeks to ensure that splints are applied as per residents?ÇÖ orders. Bi- weekly spot checks of all documentation will be conducted by clinical nurse managers/supervisors to ensure compliance for the next two months. Audit and observation results will be presented by nursing administration at the monthly QAPI meetings for three months and at the discretion of the QAPI team thereafter. 4. Completion Date and Responsible Person: 3/5/2023 Director of Nursing/designee will be responsible for compliance.

1/04/23 at 3:23PM LPN #2 stated the Certified Nursing Assistant (CNA) usually put the resident splint on. LPN # 2 stated they signed off on the TAR that the left hand splint was in place on 12/29/22 and 1/4/23 because they thought it had been put on by the CNA. LPN #2 stated the CNAs are usually good at putting the splints on. LPN #2 stated they would go and put the splint on for the resident. During an interview on 1/4/23 at 2:11PM with the Certified Nurse Assistant, they stated the resident did not always have the left hand splint on. CNA #3 stated on 12/29/22, if the hand splint was not on it may be that the resident may not have been given the splint. CNA #3 stated that the resident was to have the splint on throughout the day and it should only be removed at night or during cares. During an interview on 1/4/23 at 3:23PM with Licensed Practical Nurse, LPN #2 on 01/04/23 they stated the CNAs usually put the plints on the residents. LPN #2 stated they thought the splint was on the resident. 415.12(e)(2)	

FF12 483.80(a)(1)(2)(4)(e)(f):INFECTION PREVENTION & CONTROL

REGULATION: §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

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NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, interviews, and record reviews conducted during a Recertification Survey from 12/27/2022-1/4/2023 the facility did not ensure that an infection prevention and control program was established and maintained to prevent the transmission of a Multi Drug Resistant Organism for 1 of 1 (#47) resident reviewed for Infection Control. Specifically PTA #1 (Physical Therapist Aide) did not use appropriate Personal Protective Equipment (PPE) when providing services for Resident # 47, who had a Multi Drug resistant Organism and was on contact precautions. The findings are: Review of policy and procedure titled Infection Control dated 4/05 and revised 7/22 documented Transmission based precaution will be used in addition to standard precaution for residents with suspected infection and pathogens that can be transmitted by droplet or contact routes. Appropriate PPE (gloves, gowns, masks goggle etc.) will be available outside of the resident room as necessary, in an over the door isolation station or in the drawer bin directly outside the resident room. Resident # 47 was admitted to the facility with [DIAGNOSES REDACTED]. The 12/27/2022 5 Day Minimum Data set (MDS a resident assessment tool) documented Resident #47 had a BIMS (brief interview of mental Status) of 14 (intact cognition) and received extensive assist of 2 staff for bed mobility was totally dependent of 2 staff assist for transfer. The 12/23/2022 Physicians orders documented Contact Precaution related to MDRO colonization every shift start date 12/23/2022 and discontinue date 12/28/2022 The Comprehensive Care Plan titled Resident has contact precautions for MDRO status [REDACTED]. The Hospital discharge instructions dated 12/17/2022 documented the resident needed strict contact isolation due to an MDR organism (Multi Drug Resistant) colonization. The 12/23/2022 Progress note documented Strict Contact Precautions for MDRO(multidrug Resistant Organism) colonization. During observation on 12/27/2022 at 10:50am PTA #1 was at the resident bedside holding their right leg and wearing gloves. PTA #1 was not weraing a gown. The door to the residents room had a Precaution sign. The contact precautions for anyone entering the	F- 0880 ?Çô Infection Prevention and Control I. The following actions were accomplished for those residents found to have been affected by the deficient practice: Resident #47: On 12/28/22, the unit nurse had a discussion with the attending MD regarding the follow-up for MDRO infection and appropriateness of contact precautions. Resident?ÇÖs hospital transfer record does not indicate any supporting documentation for MDRO infection and site. Wound culture was obtained on 12/23/26 and completed on 12/26/22 with negative results. MD ordered to discontinue the contact precautions on 12/28/22. On 1/25/2023, PTA#1 was provided with counselling and re-education by the Director of Nursing (DNS) on the selection and use of PPE for Standard Precaution and Transmission-based precautions and Breaking the Chain of Infection. Education also included the HCP? ÇÖs responsibility related to infection prevention and control protocols. PPE use re-training and competency skill evaluation was conducted on 1/25/2023. II. The following corrective actions will be implemented to identify other residents having the potential to be affected by the same deficient practice: All residents have been identified as potentially being affected by the same practice. On 1/26/23, a full house audit was conducted of all residents with current transmission-based precaution orders to ensure appropriateness and proper implementation of PPE use per facility protocol. The audit included an assessment of physician orders, posting of signage on the door or wall outside the resident room indicating the type of precautions and required PPE use, readily available PPE supplies outside the room, access to hand hygiene supplies, and availability of trash container inside the room and near the exit for discarding PPE after removal. The facility?ÇÖs QAPI Committee and outside Consultant participated in a DP(NAME) QAPI meeting on (MONTH) 24, 2023, to discuss the Infection Control issues identified at F-880 and conducted a Root Cause Analysis. During this meeting, the outside Consultant provided education to the Committee members on Infection Prevention and Control principles and how non-adherence to proper infection control practices resulted in the cited deficient practices. Education also addressed use of a

room indicated staff were to wear a gown and gloves. During an interview with the Physical Therapist Aide #1 on 1/3/2023 at 9:30am they stated they did not see the sign on the door to the resident room. PTA #1 stated they were not wearing a gown because the infection was presumptive as per the Nurse Manager. PTA #1 stated they have had training on infection control during general orientation and about a month ago which covered droplet and contact precaution. During an interview with the Nurse Manager on 1/3/2022 at 10:15am they stated the resident came to the facility from another facility with Contact Precautions related to MDRO. The Nurse Manager stated they were awaiting test results before the order for contact precaution could be discontinued. During an interview with the Director of Nursing (DON) on 1/3/2022 at 10am they stated all staff have to follow the signs on the resident room doors and must wear the proper PPE. The DON stated staff have had inservice on infection control, both annually and when there is an infection outbreak. The DON further stated all staff including the physical therapy staff have received inservice on proper use and donning and doffing of PPE. 415.19(a)(1)

Root Cause Analysis when compliance issues are identified. Based on the Root Cause Analysis that was part of the DP(NAME) QAPI meeting on 1/24/22, the following issues were identified that required corrective actions: ?? The facility?ÇÖs Infection Control policy and procedures for preventing the development and transmission of communicable diseases and infections, including the protocol related to initiating transmission-based precautions and the selection and use of PPE by health care personnel (HCPs) for standard and transmission-based precautions, would benefit review and revisions, if needed, to ensure that policies in compliance with State and Federal guidance, as well as directives from the CDC. ?? All facility staff would benefit from additional education and evaluation of their knowledge and understanding about infection prevention and control practices and protocols related initiating transmission-based precaution, the selection and use of personal protective equipment (PPE) for standards and transmission-based precautions (contact, droplet, airborne and enhanced barrier precautions /isolation) and the general core principles of Infection Prevention and Control (IPC) to prevent the spread of infection. ?? All facility staff providing high and close-contact resident care activities, including performing resident care and/or contact of potentially contaminated areas in the resident?ÇÖs environment who requires transmission-based precaution would benefit from additional training and a competency skill evaluation to ensure their understanding of the correct selection and use of personal protective equipment (PPE) for standard and transmission-based precautions. ?? The facility would benefit from reviewing and revising, as needed, the surveillance process related to the implementation of transmission-based precautions and the correct use of PPE. The facility would benefit from implementation of a system process that includes periodic monitoring of residents on transmission-based precautions and the correct use of PPE following provision of in-service education to ensure correct implementation and compliance with PPE use protocols. ?? There was a need to enhance the supervision and monitoring of PPE use within the facility to ensure infection control practices related to PPE use are following current state and federal guidelines, as well as directives from the CDC. Please refer to corrective actions outlined in Sections II, III and IV of this DP(NAME). III. The following system changes will be implemented

to ensure that the deficient practice does not recur: On 1/24/23, administrative staff and the outside consultant reviewed the policy and procedure for Transmission-based precaution use to ensure compliance with the CDC guidelines for implementation and use of PPE to prevent spread of infection. Revisions were made to include resident placement, transport and education, the selection and use of PPEs and the surveillance process related to the correct use of PPE. Effective 1/25/23, DNS/designee will conduct retraining and competency skill evaluations of all staff related to appropriate PPE selection and use (donning and doffing) prior to entering and exiting the resident?ÇÖs environment, providing close and high contact resident care activities, including performing ?Ç£short tasks?Ç¥ and/or contact of potentially contaminated areas in the resident?ÇÖs environment. Additional competencies will be conducted for those staff who are identified as needing additional education/skills check. This training and competency skill evaluation will continue until all identified staff have participated and completed the required training and competency skill check. This training and competency skill evaluation will be provided during orientation, annually, and on an as needed basis with follow-up monitoring to ensure staff understand these protocols. Beginning 1/26/23, DNS/designee will provide additional education on general infection prevention and control (IPC) practices with a focus on breaking the chain of infection, initiating transmission-based precaution, and the selection and use of personal protective equipment (PPE) for standard and transmission-based precaution. The education will also include the use of PPE when performing ?Ç£short tasks?Ç¥. This education will be provided during orientation and on an as needed basis with follow-up monitoring to ensure staff understand these protocols. Effective 1/26/23, the facility will develop and utilize a surveillance list of all residents with transmission-based precaution orders that will be reviewed and discussed during morning report. The IP/designee will be responsible for completing and updating the surveillance list and providing copies to interdisciplinary care team members and each nursing unit daily and as needed. The DNS, ADON, IP, Unit RM Managers and Nursing Supervisors will monitor for compliance with infection control practices related to implementation of transmission-based precautions and PPE use for standard precautions and transmission-based

precautions during routine and random rounds on the resident units. Findings will be documented on the Infection Control Rounding audit tool. Immediate corrective actions, such as counselling or reeducating staff observed not wearing appropriate PPE and or any breach in the practice, will be implemented as needed. IV. The facility?ÇÖs compliance will be monitored utilizing the following quality assurance system: As per the Directed Plan of Correction, a QAPI Committee meeting co-chaired by Outside Consultant was convened on (MONTH) 24, 2023, to conduct a Root Cause Analysis and examine the deficiency cited at F-880. The facility will develop an audit tool to monitor staff knowledge and compliance with the facility?ÇÖs protocols related to the selection and correct use of PPE for standard precaution and transmission-based precautions. DNS/designee will conduct a direct observation audit of five HCPs assigned to each nursing unit to assess compliance with infection prevention and control practices related to selection and use of PPE for standard precautions and transmission-based precautions. Audits will be conducted weekly for 4 weeks then monthly for 3 months. The audit sample will include staff from all shifts and departments, including Rehabilitation. All findings will be reported to the Administrator, DNS and IP for follow-up actions such as reeducation and/or competency skill check related to correct PPE use. The DNS/designee will audit 10% of all staff members for staff knowledge and understanding of the protocol related to the selection and use of PPE monthly for the next three months and then on a quarterly basis for the next two quarters. Corrective actions such as reeducation will be implemented when indicated. All staff knowledge audit findings will be reported to the Administrator and Director of Nursing. DNS/designee will report PPE use audit findings to the QAPI committee monthly for three (3) months and quarterly for an additional two quarters. At the end of this period, the Committee will determine the need for ongoing monitoring of PPE use and at what frequency. DNS/designee will report staffs?ÇÖ infection control knowledge audit findings to the QAPI Committee monthly for three (3) months and quarterly for an additional two quarters. At the end of this period, the Committee will determine the need for ongoing monitoring and at what frequency. The IP/designee will continue to conduct routine and random Infection Control Rounds and will report findings to the QAPI Committee monthly for

evaluation and follow-up corrective actions such as staff and/or resident re-education. Completion Date: 2/27/23 Responsibility: Director of Nursing

FF12 483.15(d)(1)(2):NOTICE OF BED HOLD POLICY BEFORE/UPON TRNSFR

REGULATION: §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

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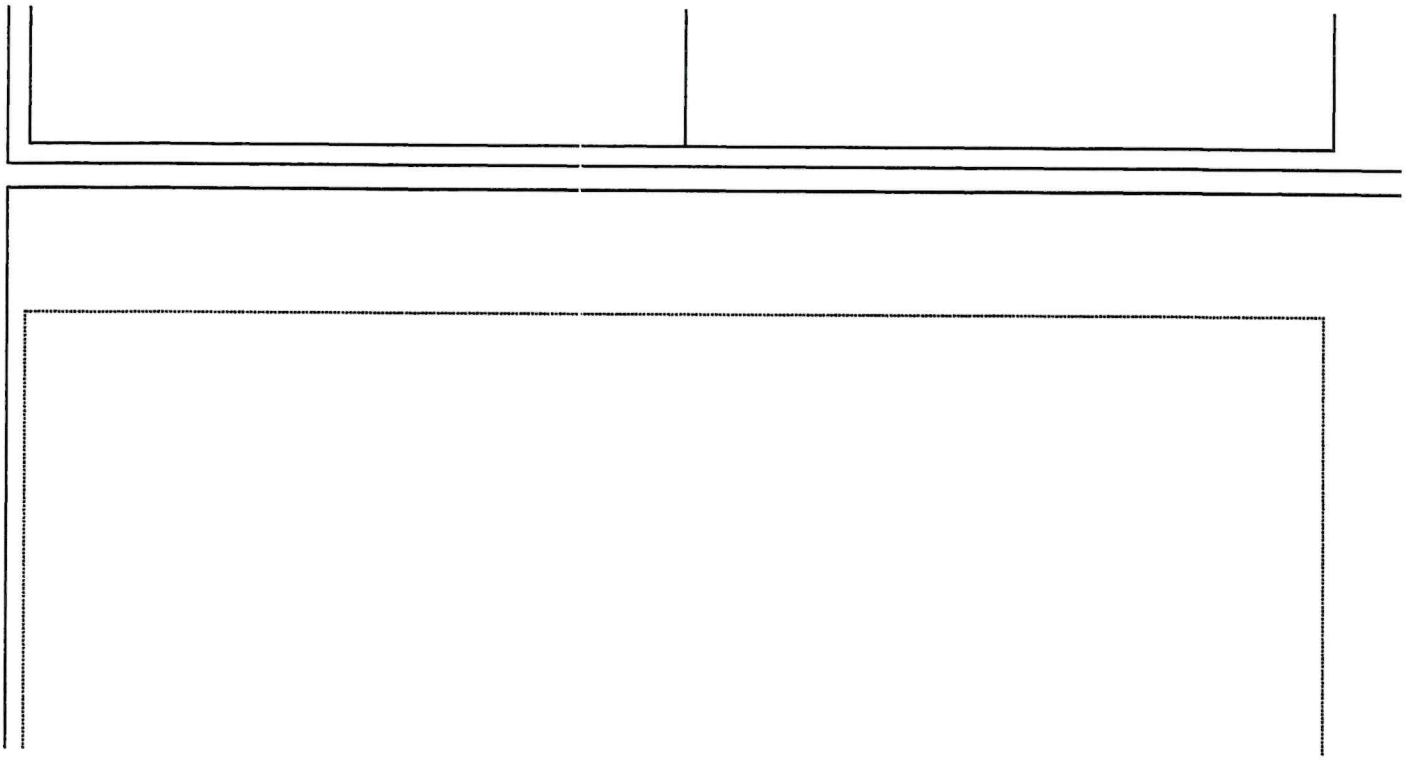

Citation Details

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record review and interview conducted during the Recertification Survey conducted from 12/27/22 to 1/05/2023, the facility did not ensure that a resident's representative was made aware of the facility's bed hold policy before and upon transfer to a hospital for 1 of 3 residents reviewed for Closed Record Review. Specifically, Resident #62 was transferred to the hospital on [DATE] for an evaluation and the facility did not give advance notice of the bed hold policy to the resident/resident's representative prior to the transfer. The findings are: Resident #62 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The 9/19/22 Admission MDS (Minimum Data Set - a resident assessment tool) documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The 12/20/22 Transfer to the Hospital Summary documented the resident was transferred to the hospital and admitted for Acute Kidney Injury,[MEDICAL CONDITION], and COVID. The family was made aware of the transfer to the hospital. A Bed hold was not in place, as the Medicaid residency regulations have not been met. Return anticipated. The 12/18/22 Nurse's Health Status Note documented the resident vomited this morning at 6:00 AM, was lethargic, had a temp of 102.3, COVID test result positive. MD was made aware and wants the resident to be sent to the emergency room (ER) for evaluation. The spouse was made aware. The Transfer/ Discharge Notice sent to to the resident's spouse documented the notice was being issued because the resident was in need of emergent medical attention which could not be provided at the facility. On 12/30/22 at 10:10 AM an interview was conducted with the Supervising Social Worker (SW). The SW stated they were not aware that a bed hold policy notice was to be given to the resident or resident representative when residents were transferred to the hospital. On 12/30/22 at 10:35 AM an interview was conducted with the Caseworker (CW). The CW stated they sent the transfer/discharge notice to the resident's spouse and faxed it to the Ombudsman, but they did not send the bed hold policy to the family. The CW stated they were not aware of such a document On 12/30/22 at 10:45 AM an interview was

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The facility did not ensure that residents or their representatives were provided with advanced notice of the bed hold policy prior to transfer. 1. The bed hold policy was reviewed and revised by the Administrator on 1/23/2023. The admission agreement was reviewed on 1/23/2023 by the Administrator to ensure that the Bed hold policy was included upon admission to the facility. 2. An audit was created for Bed Hold notification of residents/ representatives for all residents?ÇÖ discharges and transfers, to ensure that Bed Hold letter and information is provided in keeping with regulation. 3. Education was provided to the Business office Manager, Social Work Supervisor, Case Manager and Admissions Coordinator on the Bed Hold Policy Revisions by the Administrator. The Business Office Manager will be responsible for auditing all resident transfers and discharges for 90 days to ensure that bed hold letters are provided for all required residents/ representatives. 4. The results of the audit will be presented to the QAPI committee by the business office manager monthly for three months and at the discretion of the QAPI committee thereafter. 5. Completion Date 3/5/2023: It will be the responsibility of the Business Office Manager/designee to ensure compliance.

conducted with the Administrator who stated they were not aware that the bed hold policy was not being sent to the resident/family representative at the tiime of transfers. The Administrator stated they thought Social Work was sending the bed hold policy when residents were transferred to the hospital. The Administrator stated they were aware that a bed hold notice should be given at the time of transfer. On 12/30/22 at 12:30 PM, an interview was conducted with the resident. The resident stated they were not given a bed hold policy when they were transferred, and and their wife did not receive it either. 415.3(h)(4)(i)(a)

FF12 483.60(a)(1)(2):QUALIFIED DIETARY STAFF

REGULATION: §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

Based on interview and record review during the Recertification Survey conducted between 12/27/2022-1/5/2023, the facility failed to employ qualified staff with the appropriate competencies and skills to carry out the function of the food and nutrition services. Specifically, the Diet technician was a full-time employee at the facility, but did not have a certification and the Registered Dietician was remotely employed 8 hours per week and did not report to the facility. The Findings include: The undated facility policy and procedure titled Nutritional assessment documented the Dietician in conjunction with the nursing staff and healthcare professionals will complete a nutritional assessment for each resident upon admission and as indicated by change in condition that places the resident at risk for impaired nutrition. During an interview conducted with the diet technician (DT) on 01/04/23 at 03:36 PM, they stated they are a diet tech with an associate degree. The DT stated they are supervised by the Registered Dietician. The DT stated they completed the nutrition assessments. DT stated they did not currently have any certifications and were not registered. The DT stated the Registered Dietician (RD) did not come to the building and they were able to do the annual assessments and the mini assessment/quarterly without the Registered Dietician. The DT stated the Registered Dietician only did the Nutrition Admission Assessments or Nutrition readmission assessments. During an interview conducted with the Food Service Director (FSD) on 01/04/23 at 11:41 AM, The FSD stated they have never spoken to or met with the registered dietician since they started working at the facility 3.5 months ago. The FSD stated they did not have a Certification in Food Service. During an interview conducted with the Registered Dietician (RD) on 01/05/23 at 10:06 AM, RD stated they were contracted for remote work 8 hours per week by the facility. RD stated they never came to the building. RD stated they completed the Nutritional Admission Assessment on all new residents by either talking to the resident or the healthcare proxy and initiated the admission care plan. RD stated they spoke with the Diet Tech approximately 8 hours a week. RD stated they always ask if there are any concerns and are always told that everything is fine. RD stated they did not attend Care Plan Meetings nor the

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The Facility failed to employ qualified staff with the appropriate competencies and skills to carry out the function of the food and nutrition services. The dietary Technician was not certified, and the Dietician was remote from the facility as a consultant. 1. A Meeting was immediately scheduled with the Food Services Director Diet Tech and Registered Dietician to review residents' dietary needs. 2. The Food services Director meets criteria to oversee the Food services department without the oversight of a registered Dietician as per regulation 483.60(A)(2). He fulfills the requirements of parts C, D and E of this regulation as well as qualifying under civil service law requirements. The Dietician is currently remote she will be required to visit the facility at the least monthly in person or via zoom conference to review any dietary needs or concerns and collaborate with staff and administration in addition to weekly meetings with FSD and the Diet Tech. 3. The Food Services Director and the Registered Dietician will have weekly meetings to collaborate both clinical and dietary concerns to ensure appropriate services are being met. The Dietary Technician will also attend these meetings. The Administrator will be provided copies of these minutes after each weekly meeting and copies will be kept in the FSD office. 4. The minutes of these meetings will be reported to the QAPI Committee by the Food Services Director for three months and quarterly thereafter for 90 days. 5. Completion Date: 3/5/23 Responsible party Food Services Director/ Designee

QAPI. RD stated they were aware that the Diet Tech did not have any Certifications and was aware of the updated requirements for Certification, but was told it was okay for the diet tech to work at this facility without Certification. 10 NYCRR 415.14(a)(1)

FF12 483.60(d)(4)(5):RESIDENT ALLERGIES, PREFERENCES, SUBSTITUTES

REGULATION: §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, record review, and interviews during a Recertification Survey conducted from 1/27/2022-1/4/2023 the facility did not ensure that each resident received, and was provided food that accommodated resident allergies, intolerances, and preferences, for one Resident (#95) of three residents reviewed for nutrition. Specifically, the facility did not ensure Resident #95 who was allergic to pineapple was not given pineapple on their meal tray. The Findings are: The undated and revised 10/2017 Policy and Procedure titled Food and Nutrition Policy documented each resident was provided with a nourishing palatable well-balanced diet that meets their daily nutritional and special dietary needs taking into consideration the preferences of each resident. The resident was admitted with [DIAGNOSES REDACTED]. The 10/26/22 Quarterly Minimum Data Set (MDS) documented the resident had severe cognitive impairment and required setup and supervision for meals and was on a regular diet with chopped meats and thin liquids. The 5/30/22 Physician orders [REDACTED]. The 6/1/2022 and updated 12/28/22 Care Plan titled Altered Nutrition/Hydration Status due to Dementia and Parkinson Disease documented the following interventions assist with meals and the resident had food allergies such as Coconut, Grapes Pineapple and Wine, The resident allery list documented Coconut, Grape, Pineapple, Wine, During a 12/28/22 at 12:05PM observation Resident #95 was sitting with their spouse. The meal ticket documented allergic to pineapples. There were pineapples on the resident meal tray. During a12/28/22 at 12:10PM interview with the residents spouse they stated they did not know what happened if the resident ate pine apple. They stated it was a childhood allergy. During a 12/28/22 at 12:45PM interview with Certified Nursing Assistant (CNA #1) they stated they had handed the resident their meal tray, but were supposed to check the tray for the right diet consistency and allergies. CNA #1 stated on that day they did not check the tray. During a 12/28/22 at 1:00PM interview with the Dietary Aide they stated they were responsible for the desserts on the tray line. The Dietary Aide stated there were residents that were allergic to applesauce and they were supposed to be given apple sauce. The Dietary Aide

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NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY The Facility did not ensure each resident received and was provided food that accommodated resident allergies [REDACTED]. 1. The resident who was identified receiving the item that was listed as an allergy on her ticket immediately had that item removed from her tray. The CNA was immediately educated by the DON. The dietary Staff was immediately educated on reading meal tickets to ensure that the meals are accurate when being sent up. All Clinical staff was educated on the need to Ensure that they are checking the meal ticket prior to serving to a resident. 2. The DON and the Dietary technician completed an audit of all residents allergies [REDACTED]. 3. Audits will be conducted Weekly by the DON/ Designee for 4 weeks of all new admissions to the facility to ensure that all residents allergies [REDACTED]. 4. The Dietary Technician / Designee will conduct weekly audits x4 weeks of all resident meal tickets with listed allergies [REDACTED]. 5. The Food Services Director/ Designee will conduct Daily Audits on at least 2 trays of residents that are listed with allergies [REDACTED]. Random checks will be conducted by the Food Services Director/ Designee going forward weekly for two months to ensure compliance. All negative findings will be immediately corrected. 6. The results of these audits will be presented to the QAPIU Committee for 3 months by the DON/ FSD and Dietary Tech. 7. Completion Date 3/5/2023 Responsible for compliance: FSD/ Designee

stated they had placed the pineapples on the resident tray in error. During a 12/28/22 at 2:10PM interview with the Dietary Technician they stated the dietary aide was in charge of the tray line desserts and were responsible for checking resident allergies and giving the alternative. The Dietary Technician stated the staff had been educated on the residents and process for residents with allergies. During a 12/28/22 at 1:55PM interview with the Food Service Director (FSD) they stated during tray line there are 2 dietary staff that check the trays/meal tickets and the 3rd dietary staff does the final check. The FSD stated inservice with staff regarding tray preparation was verbal and hands on. There is no documentation. During a 12/28/22 at 2:00PM interview with the residents physician they stated the resident had pineapples listed as an allergy on their medical record. The physician stated they did not think the resident would have an anaphylactic reaction. The physician stated the allergy was a child hood allergy and sometimes those allergies are outgrown. 10NYCRR 415.14(d)(4)

FF12 483.20(f)(5); 483.70(i)(1)-(5):RESIDENT RECORDS - IDENTIFIABLE INFORMATION

REGULATION: §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interviews and record review during a Recertification Survey the facility did not ensure that medical records were maintained in accordance with accepted professional standards and practices that were complete and accurately documented for each resident. Specifically, Nursing Staff documented on two occasions in medical record assistive devices were applied to prevent further decrease in range of motion when they were not being provided. This was evident for 1 of 1 resident (Resident #66) reviewed for Positioning and Mobility. The finding is: The facility policy and procedure titled Splint, Braces, Casts and Immobilizers (assistive devices) undated documented the following: the facility will access each splint, brace, cast and immobilizer to ensure proper placement fitting, minimal pressure and proper placement and cleaning. Nursing and rehab will collaborate as necessary for resident safety and comfort. Resident #66 was admitted to the facility with [DIAGNOSES REDACTED]. The 11/27/2022 Quarterly Minimum Data Set (MDS) documented that the resident had severely impaired cognition, required extensive assist of 2 staff for bed mobility and toileting, was totally dependent of 2 staff for transfer, extensive assist of 1 staff for eating and had functional impairment on one side affecting the upper extremities. The 5/18/22 physician's orders [REDACTED]. Review of the (MONTH) 2022 Treatment Administration Record (TAR) documented Licensed Practical Nurse (LPN #2) signed that the left hand splint was in place for resident #66 on 12/27/22 during the day shift. Review of the (MONTH) 2023 TAR documented LPN #2 signed that the left hand splint was in place for resident #66 on 1/4/23 during the day shift. Resident #66 was observed on 12/27/22 at 12:07 PM with their left hand resting in front of their face,and without the placement of the left-hand splint, 12/27/22 at 3:15 PM resting in their geri chair and without the placement of the left hand splint, 01/04/23 at 11:01 AM and 1/04/23 at 3:25PM resting in bed without the placement of the left hand splint. During an interview on 1/04/23 at 3:23PM LPN #2 stated the Certified Nursing Assistant (CNA) usually put the resident splint on. LPN # 2 stated they signed off on the TAR that the left hand splint was in

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The Facility did not ensure that medical records were maintained in accordance with accepted professional standards and practices that were complete and accurately documented for each resident. 1. The nurse was counseled on proper documentation in the medical record by the DON on 1/23/23. 2. All resident care plans and CNA tasks for residents who have orders for splints were audited and verified, and all CNA assignments were updated for splints and accountability. 3. The Policy and Procedure for Clinical Documentation was reviewed by the DON on 1/23/2023. All Nursing staff will be in-serviced on the requirement to ensure that there is accurate documentation in the residents chart by the Staff Development Coordinator/Designee. 4. Clinical nurse managers will conduct audits of all residents with splints for CNA documentation completion weekly x4 weeks to ensure that splints are applied as per residents orders. Random checks of all documentation will be conducted by the DON/ Designee bi-weekly for the next two Months. All negative findings will be corrected Immediately. Audit and observation results will be presented by nursing administration at the monthly QAPI meetings for three months and at the discretion of the QAPI team thereafter. 5. Completion Date and Responsible Person: 3/5/2023 Director of Nursing/Designee will be responsible for compliance.

place on 12/29/22 and 1/4/23 because they thought it had been put on by the CNA. LPN #2 stated the CNAs are usually good at putting the splints on. LPN #2 stated they would go and put the splint on for the resident. 415.22(a) (1-4)

FF12 483.10(a)(1)(2)(b)(1)(2):RESIDENT RIGHTS/EXERCISE OF RIGHTS

REGULATION: §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

Scope: Isolated
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Citation Details

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, record review and interview conducted during Recertification Survey, the facility did not ensure that care was provided in a manner to maintain dignity for 2 of 2 residents (#23 and #72) reviewed for dignity. Specifically, the urinary foley catheter tubing and drainage collection bag for Resident #23 and #72 were not covered with a privacy cover to prevent direct observation by other residents and their families. The findings are: The facility Policy and Procedure (P&P) titled Resident Rights/Dignity dated 10/2022 documented the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of a person-centered care approach. Resident #23 had [DIAGNOSES REDACTED]. The 9/26/22 Quarterly Minimum Data Set (MDS; a resident assessment and screening tool) documented that Resident #23 had severely impaired cognition; was totally dependent of two staff for bed mobility and transfer, dependent of one staff for toileting and had an indwelling urinary catheter in place. Review of the Certified Nursing Assistant (CNA) Care Instructions (a record that provides instructions for CNAs of the type of care to provide the residents) revealed no documented evidence of directions or instructions given to the CNAs on how to maintain privacy of the foley bag. Observation on 12/27/22 at 2:48 PM revealed Resident #23 lying in bed with their foley catheter hanging from the bed, facing the door. The foley catheter was uncovered and visible from the hallway. Observation on 12/29/22 at 12:06 PM revealed Resident #23 was in the hallway sitting in a geri chair with their foley catheter and tubing uncovered. Observation on 01/04/23 at 10:55 AM revealed Resident #23 lying in bed with their foley catheter hanging from the bed, facing the door. The foley catheter was uncovered and visible from the hallway. During an Interview on 1/4/23 at 11:12 AM, Licensed Practical Nurse (LPN #2) stated they make sure the catheter bag has a privacy cover on it when the residents were out of the room. LPN #2 stated they have not seen catheter bags covered when residents were in their room. LPN # 2 stated when residents were out of their room and in the hallway foley bags are supposed to be covered. LPN #2

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The Facility did not ensure that the urinary foley catheter tubing and drainage collection bag was covered with a privacy cover to prevent direct observation by other residents and their families. 1. Urinary Drainage bag covers were immediately provided for affected residents. 2. All other residents with Catheters were audited to ensure that all had drainage bag covers in place. No other residents were identified. 3. The policy and procedure for Urinary Catheter Use and Care was reviewed on 1/23/2023 by the Director of Nursing. CNA assignments were revised to include application of urinary drainage bags cover at all times. Clinical staff will be re-in-serviced on the Foley Catheter policy and procedure and where to find supplies needed in the building. Par levels for urinary drainage bag covers will be established and maintained on all units in the clean utility rooms. 4. Clinical nurse managers will conduct audits of all residents with urinary drainage bags weekly x4 weeks to ensure they are concealed by covers. Ongoing, all residents with urinary drainage bags will be audited 1X weekly for two months and will be conducted by clinical nurse managers/supervisors to ensure compliance. Audit and observation results will be presented by nursing administration at the monthly QAPI meetings for three months and at the discretion of the QAPI team thereafter. 5. Completion Date and Responsible Person: 3/5/2023 Director of Nursing/Designee will be responsible for compliance.

stated they could not give a reason why the privacy bag was uncovered on 12/29/22 at 12:06 PM, when the resident was in the hallway. During an interview on 1/4/23 at 11:38 AM, CNA #4 stated the reason the urinary bag was not covered was because they were waiting on staff to bring the foley catheter privacy covers from central supply. CNA #4 stated the last foley catheter privacy cover was used for another resident. CNA #4 stated there is never enough foley catheter privacy covers on the unit. Resident #72 was admitted into the facility on [DATE] and had [DIAGNOSES REDACTED]. The 11/8/22 Quarterly MDS documented Resident #72 had a Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Resident #38 was totally dependent for toileting. Review of Catheter Comprehensive Care Plan (CCP) dated 11/2/22 documented Resident #72 had a foley catheter as evidenced by [MEDICAL CONDITION] Bladder, Obstructive [MEDICAL CONDITIONS], and strict output due to Diuresis. Interventions included change the foley drainage bag per policy and cover it at all times. On 12/27/22 at 10:10 AM and 12/29/22 at 12:24PM Resident #38 was observed sleeping in their bed. The uncovered foley catheter bag contained urine and was positioned on the right side of the residents bed and visible from the hallway. During an interview on 1/4/23 at 11:05 AM, CNA #2 stated foley catheter privacy covers are kept in the storage room on the unit. If none are available, the nursing staff should call central supply. CNA #2 stated most times the foley catheter privacy covers are not available. At this time CNA #2 went into the unit storage room and confirmed that there were no foley catheter privacy covers available on the unit. CNA #2 stated if the resident is out of the bed, in the hallway, or in public, a foley catheter privacy cover should be used. CNA #2 further stated if the foley catheter bag can be viewed from the room it should be covered. During an interview on 1/4/23 at 11:36 AM, LPN #1 stated if a foley catheter bag can be viewed from the hallway it should be moved upwards and away from public view. LPN #1 stated the best placement for the foley bag is on the opposite side of the bed and away from the door. LPN #1 stated if the foley bag needs to be placed on the door side of the bed, a foley catheter privacy cover should be used. LPN #1 stated If the foley catheter privacy covers are not available on the unit, nursing staff should call central supply and request more 415.5 (a) Surveyor: Mollette-Forrest, Ni

FF12 483.10(i)(1)-(7):SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

REGULATION: §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

Based on observation, interview, and record review conducted during Recertification Survey conducted between 12/27/2022 -1/5/2023, the facility did not ensure that they provided a safe, clean, comfortable, and homelike environment for 1 of 2 residents (Residents #38) reviewed for resident rights. Specifically, the wheelchair armrests of Resident #38 were observed with rips and holes and exposed foam. The findings are: Review of the Policy and Procedure (P&P) titled Equipment/Wheelchair dated 10/22 documented maintenance will be done on equipment/wheelchairs by the Division of Public Work (DPW) or Maintenance Department. The Maintenance Department/DPW will check the daily log on each unit for any request. The policy further documented nursing services will notify the DPW maintenance department and the rehab department of any concerns with wheelchairs. The 12/12/22 Quarterly MDS (Minimal Data Set) documented Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment, required limited assist for bed mobility and physical extensive assist for transfers, toileting, and personal hygiene. The Activities of Daily Living (ADL) Comprehensive Care Plan (CCP) dated 7/5/22 documented Resident #38 needed ADL assist daily related to limited mobility. Interventions included assistive devices used; resident can self-propel and is independent in their wheelchair. Review of the (MONTH) 2022 to (MONTH) 2023 maintenance log book revealed no documented evidence that a request for wheelchair armrest repair was in place for Resident #38. During an observation on 01/03/23 at 11:01 AM, the wheelchair for Resident #38 revealed the right armrest had foam exposed and the left armrest cushion was ripped. At the time of observation Resident # 38 stated they would like a new wheelchair, as their chair has been in this condition for some time. Resident #38 stated they were not aware they could request a new wheelchair or the process for reporting issues. During an interview on 1/5/23 at 10:22 AM, the Director of Nursing (DON) stated nursing will notify the maintenance department when a wheelchair repair is needed. The DON stated if there were a rip or problem with a wheelchair, it should be reported to maintenance. An order should be written in the log book. The DON stated maintenance should check the book daily. The

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The Facility did not ensure that a safe, clean, comfortable, and home like environment was provided for all residents. 1. The Wheelchair arm rest for resident #38 was immediately replaced with a new arm rest. 2. Any resident with a wheelchair has the potential to be affected. Maintenance Department will conduct a house wide audit of all resident wheelchairs by 2/6/2023 to ensure that they are in good repair. All negative findings will be corrected immediately. 3. The policy and procedure for wheelchair maintenance and cleaning was reviewed by the Administrator on 1/23/2023. All Staff will be re-in-serviced on the Wheelchair cleaning and maintenance policy by the Staff Development Coordinator/Designee. The Maintenance Assistant / Designee will conduct Monthly Audits of all resident Wheelchairs for the next 3 months. Any issues noted will be immediately corrected by Maintenance Assistant/ Designee. 4. The Maintenance Assistant/ Assistant Housekeeping Supervisor will be required to report the findings of the audits to the QAPI committee Monthly for 3 months and then at the discretion of the QAPI committee thereafter. 5. Completion date: 3/5/2023 Administrator/designee will be Responsible for compliance.

DON stated Certified Nursing Assistants (CNA) were aware that they should report wheelchairs that are in poor condition to maintenance or the unit nurse and depending on the issue, the wheelchair could be repaired or replaced. During an interview on 1/5/23 at 10:53 AM, CNA #5 stated if a wheelchair was not in good repair, CNAs are supposed to document the issue in the repair log book CNA # 5 stated they can also report directly to maintenance and let the nurse know. CNA # 5 stated If the armrest of a wheelchair is ripped, it should be reported because the armrest can be replaced. During an interview on 1/5/23 at 11:25 AM, the Maintenance Assistant (MA) stated they were not aware that the resident's wheelchair armrests were ripped. The MA stated they check the log book or receive verbal requests from nursing staff and/or residents regarding repair issues. 415.5(h)(2)

FF12 483.35(a)(1)(2):SUFFICIENT NURSING STAFF

REGULATION: §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

Scope: Pattern
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review conducted during the Recertification Survey conducted from 12/27/2022 -1/5/2023, the facility did not ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident population in accordance with resident needs identified in the facility assessment. Specifically, three of four resident care units reviewed for sufficient staff did not consistently have adequate staff to meet the needs of the residents as per the facility staffing minimum. In addition, during a Resident Counsel meeting held on 1/3/23, four residents (#38, 63, 37, and 75) verbalized that staffing was inadequate. The findings are: The facility Policy and Procedure entitled Staffing dated 10/2022 documented the facility provides staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. The policy further documented staffing numbers and the skill requirements of direct care staff determined by the needs of the residents based on each resident's plan of care. Mandate for nursing staff is based on census and acuity and is determined by the DON/Administrator/Designee for the safety and comfort of residents. Review of the undated facility assessment documented the bed capacity, common diagnoses, general care, specific care and practices and acuity level of care required by the resident population. The assessment identified the average number of nursing staff needed per day to provide resident care, and further specified the number of direct care LPN (Licensed Practical Nurse) and CNA (Certified Nurse Aide) staff needed for each shift as follows: 8AM-4PM: LPN - 1-2, CNA: 3-4, 4PM-12AM: LPN - 1, CNA: 2-3, and 12AM-8AM: LPN - 1, CNA: 2-3. Review of the daily staffing nursing sheets from 11/40/22 to 12/30/22 revealed staffing was less than the facility assessed average number needed on 12/9/22- Unit 2: 8AM-4PM 1 CNA and 1 additional CNA worked from 1 PM to 3 PM. 12/10/22- Unit 2: 8AM-4PM 0 LPN, 4PM-12AM 1.5 CNAs and 0 LPN, 12AM-8AM 0 CNA. Unit 3: 8AM-4PM 1 CNA, 4PM-12AM 1 CNA, 12AM-8AM 1 CNA, Unit 4: 12AM-8AM1 CNA

Plan of Correction: ApprovedJanuary 25, 2023

The facility did not ensure that there were adequate nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of the resident. 1. Staffing was immediately reviewed for the next two weeks to ensure that staffing needs were identified for that time period. The Administration Team identifies the anticipated number of staff needed to provide adequate care to residents. These needs are identified and the scheduled is created to ensure adequate staffing levels. In the event of staff call outs the facility will follow the current staffing policy in place for emergency staffing. 2. Weekly Staffing meetings have been implemented to ensure that Administration and Nursing Staffing are in constant communication with each other regarding staffing needs of the facility. The actual daily schedule is reviewed every morning by the Administrator/ Designee. The Facility Assessment was reviewed and revised by the Administrator on 1/23/2023 to ensure that the staffing listed is accurate and adequate to provide for residents needs. The Staffing Policy and Emergency Staffing Policy was reviewed by the DON on 1/23/2023. 3. The facility continues to offer sign on bonuses for new staff as well as pick up shift incentives for current staff to assist with ensuring that the facility is staffed appropriately per the determination of number of needed staff by Nursing Administration. The Facility has implemented a partnership with B(NAME)ES to have clinicals completed by the CAN. 4. The facility also has an agreement with SUNY(NAME)for Nursing students to do clinical rotation at the facility and has created new positions for the students while they complete their certification. The Facility has also partnered with a regional testing site to ensure that all TNA?ÇÖs will have the opportunity to pass their CNA certification so that they may continue to be employed at the facility. The facility continues to encourage our staff in domestic aide positions to attend and complete their CNA training course which they are paid to attend. The Facility offers the opportunity for potential staff to be trained from start to finish as a CNA though the partnership with the regional testing site. The marketer attends various job fairs as well as monitoring postings on all virtual job boards. We have

4PM-12AM 0 LPN, 12/11/22- Unit 2: 8AM-4PM 1 CNA, 0 LPN, 4PM-12AM 1.5 CNA, 0 PLN, 4PM-12AM 1 CNA, Unit 3: 8AM-4PM 1 CNA 4PM-12AM 1 CNA, 4PM-12AM 0 CNA, Unit 4 8AM-4PM 1 CNA 12/13/22-Unit 2: 1 CNA (7 AM to 7 PM), Unit 3 4PM-12AM 1 CNA, 12AM-8PM I CNA, Unit 4: 12AM-8AM 1 CNA, 12/14/22- Unit 3 12AM-8AM 1 CNA 12/22/22 - Unit 2: 12AM-8AM 1 CNA, Unit 4: 12AM-8AM 1 CNA, 12/24/22- Unit 2: 8AM-4PM 1 CNA, 12AM-8PM 1 CNA, Unit 3: 8AM-4PM 1 CNA, 4Pm-12AM 1 CNA, Unit 4: 8AM-4PM 1 CNA, 12/25/22- Unit 2: 8AM-4PM 1 CNA, Unit 3: 8AM-4PM 1.5,CNAs, 0 LPN, Unit 4: 8-4 1 CNA, 4-12 1 CNA, 12-8 1 CNA, 12/26/22- Unit 3: 12AM-8AM 1 CNA, Unit 3: 12AM-8AM 1 CNA, Unit 4: 12AM-8AM 1 CNA and 12/30/22- Unit 2: 12AM-8AM 1 CNA. The (MONTH) 2022 Certified Nursing Assistant (CNA) form had no documented evidence that bathing wes provided for Resident #63 on 12/9/22, 12/13/22 and 12/30/22. During a Resident Council meeting on 1/3/23 at 11:01 AM members expressed concerns about the lack of staff available to provide care to the residents. They stated there was not enough help and there were times when there was only 1 aide for the entire day and on weekends. Staff were constantly being removed to help out on other units leaving no aides on their assigned unit. Members expressed feelings of frustration about their care at the facility. They also stated they feel nothing was being done by administration to address the issue. During an interview on 12/27/22 at 10:56 AM, Relative #1 stated they visited 2 to 3 times a week and had observed a staffing concern. The facility was lacking nurses and aides. Most residents required 2 aides to provide cares and the majority of times there was only 1 aide available. Relative #1 stated weekend staffing was a major concern. During an interview on 12/29/22 at 8:15 AM, Relative #3 stated that there was only 1 CNA on 12/25/22 for unit 3 and the census was 36. On average during the day there may be 2 CNAs or less for that unit. During an interview of 12/29/22 at 9:40 AM, the Relative #2 stated the staffing levels were not good at the facility. On 12/26/22 Resident #7 went to the emergency room (ER) and returned to the facility on [DATE] around 4 AM. When the resident returned to the unit there were no LPN staff on the unit and an LPN from another unit was called to receive the resident. Relative #2 stated there was never enough nurses and CNAs. During an interview on 1/4/23 at 10:54 AM, CNA #2 stated the facility is short staffed, so sometimes there was no time to bathe the

collaborated with(NAME)County in addition to gain their assistance in funneling applicants who are interested in health care to the facility. The facility has taken out radio ads as well as new paper and other virtual ads. The marketer is a regular guest on local radio shows and promotes the facility and its incentives as well as talks about open positions and hiring opportunities. The facility continues to mentor incoming staff who are interested in pursuing a healthcare career and encouraging their growth as well as assisting in their certification and licensure. Referral Bonuses are also in place for current staff members who refer another staff member. 5. The results of the staffing meeting will be reported to the QAPI meeting as well as the current staffing numbers for all clinical staff including new hires for that month, staff that have passed their CNA examination and a review of bonus structure and any additional measures that are determined to be needed to ensure sufficient staff. Daily staffing sheets will be used to audit the hours scheduled and the hours worked at the facility to ensure that the schedule is covered adequately. 6. Completion Date: 3/5/2023 Responsible for Compliance DON/ Designee.

residents and staff were overworked because there was not enough staff to provide all the cares. During an interview on 1/4/23 at 11:22 AM, LPN #1 stated there is a staff shortage and nurses are overwhelmed with ensuring medications are being administered on time. LPN #1 stated CNA documentation for completion of assigned tasks was not checked consistently as a result. During an interview on 1/5/23 at 10:17 AM, the Director of Nursing (DON) stated they believe residents don't always realize there could be staff on break which is why there may not be an aide visible on the unit. The DON stated breaks were staggered to avoid staff not being available on the unit and nurses try to help as much as they can. During an interview on 1/5/23 at 10:09 AM, the Administrator stated staffing level determination was based on resident acuity and resident care levels. The residents' acuity, needs, and [DIAGNOSES REDACTED]. Currently there are 104 residents in house. The administrator was unaware that the current staffing numbers did not meet the facility PAR levels and stated the facility could always use more staff. 415.13(a)(1)(i-iii)

Standard Life Safety Code Citations 7

K307 NFPA 101:COOKING FACILITIES

REGULATION: Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details	Plan of Correction: ApprovedFebruary 9, 2023
2009 17 A Standard for Wet Chemical Extinguishing Systems Chapter 7 Inspection, Maintenance, and Recharging 7.2.5 At least monthly, the date the inspection is performed and the initials of the person performing the inspection shall be recorded. Based on observation and staff interview, the facility did not ensure that the Ansul system (fire suppression system) was inspected in accordance with NFPA 96. Specifically, the inspection tag for the fire-extinguishing system (Ansul) in the kitchen was not signed monthly. The findings are: During the Life Safety recertification survey conducted on 12/29/22 at approximately 1:55 PM, a tour of the kitchen was conducted and it was noted that the monthly inspection tag for the manual activation station for the Ansul system was not signed monthly as evidence of inspections of the system. In an interview with the Director of Housekeeping at the time of the findings, the Director of Housekeeping stated that the monthly tag for the Ansul system will be signed. 2012 NFPA 101: 9.2.3 2009 NFPA 17 A: 7.2.5, 7.3.2* 10 NYCRR 711.2 (a)(1)	Based on observation and staff interview the facility did not ensure that the Ansul System was inspected in accordance with NFPA 96. Specifically, the inspection tag got the fire extinguishing system in the kitchen was not signed monthly. 1. The Director of Maintenance / Designee immediately inspected the Ansul system and signed of the inspection tag. 2. All residents have the potential to e affected by this deficient practice. 3. Education has been completed with the Maintenance Assistant on NFPS 96 requirements that fire suppression systems must be inspected and tags signed monthly by the Director of Maintenance / Designee. The Director of Maintenance will conduct a monthly audit of the Ansul system for 6 months to ensure that the Maintenance Assistant has completed the inspection as required. All negative findings will be corrected immediately. 4. Director of Maintenance/ Designee will report audit findings for the inspection tag on the Ansul system to the QAPI Team for the next three months and at the discretion of the team there after. 5. Completion Date: 3/5/2023 Responsible for compliance: assistant housekeeping supervisor

DEVELOPMENT OF EP POLICIES AND PROCEDURES

REGULATION: §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency

preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.

Scope: Widespread
Severity: Potential to cause minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

Based on documentation review and staff interview, the facility did not ensure policies and procedures were developed based on the facility risk assessment utilizing an all-hazards approach. Specifically, the emergency preparedness plan did not address internal floods. The findings are: Documentation review of the facility's Emergency Preparedness (EP) manual on 12/29/22 at 9:30 AM, revealed that the facility's Hazards Vulnerability Assessment listed floods external and internal. A review of the facility policy and procedure for external floods did not address internal floods. During the Exit conference the same day at approximately 3:50 PM, the Administrator stated that a written policy and procedures for internal floods will be included in the emergency preparedness manuals. 483.73 (a) (1)

Plan of Correction: ApprovedFebruary 13, 2023

Based on observation and staff interviews the facility did not ensure that there was an emergency policy in place for internal flooding 1. An internal flood policy has been created and added to the emergency disaster planning. 2. All residents have the potential to be affected by this deficient practice 3. Staff Development Coordinator / Designee will Inservice all facility staff on the internal flooding policy. The Staff Development Coordinator will keep track of all staff who have completed this training by auditing the education sign in sheets for internal flood training. 4. The results of the audit and progress toward completion of training all staff on the internal flooding policy will be reported to the QAPI Committee Monthly for 3 months, by the Staff Development Coordinator, and at the discretion of the QAPI team thereafter. 5. Completion Date: 3/5/23 Responsible for Compliance: Administrator

K307 NFPA 101:ELECTRICAL SYSTEMS - ESSENTIAL ELECTRIC SYSTE

REGULATION: Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical

panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

Scope: Pattern
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details

2012 NFPA 101: 9.1.3.1 Emergency generators and standby power systems shall be installed, tested , and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. 2010 NFPA 99 6.4.4.1.1.1 Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenance parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 6.4.1.1.10 and 6.4.3.1. 2010 NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.6 Transfer switches shall be operated monthly. 8.4.6.1 The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Based on document review and staff interview, the facility did not ensure that the generator was maintained in accordance with NFPA 99 and NFPA 110. Specifically, 1. The required monthly test of the automatic transfer switch from the standard position to the alternate position was not provided and documentation indicating that the transfer switch was capable of supplying power within the 10 second interval was not provided at time of survey. 2. A remote manual stop station was not provided for the outdoor generator. The findings are: During the Life Safety recertification survey on 12/28/22 and 12/29/22 between the hours of at 10:30 AM and 3:30 PM, the following issues were noted: 1. During the Life Safety recertification survey on 12/29/22 at 10:20 AM, the generator logs were reviewed, and it was noted that the testing information for the automatic transfer switch and the duration time the automatic transfer switch supplied power to the generator, was not included on the generator logs for the monthly load tests or when the generator was exercised weekly. In an interview with the Director of Housekeeping the same day at

Plan of Correction: ApprovedFebruary 15, 2023

1. The Facility has contracted with DPW in order to install a manual shut off switch for the generator elsewhere on the premises outside of the generator room, or housing or prime mover, the switch will be installed no later than 3/5/23. The Generator Monthly generator load test form was immediately updated to require that the individual completing it indicate the amount of time between loss of power and the generators initiation. 2. This deficient practice has the potential to affect all residents. 3. Once installed the Maintenance Director/ Designee will ensure placement and functionality by performing an audit of the installed switch weekly for three months. The Director of Maintenance/ Designee will complete the Monthly Load test form every month and will ensure that the generator comes on within 10 seconds of the loss of power. Any Negative Findings will be reported to the Administration and Corrected Immediately. 4. The findings of the Audit of the Generators ability to come on within 10 seconds of the loss of power and the results of the Switch placement and functionality audit will be reported to QAPI Committee by the Director of Maintenance/ Designee for three months and at the discretion of the QAPI Committee thereafter. 5. Completion Date: 3/5/2023 Responsible for Compliance : Assistant Housekeeping Supervisor

approximately 11:30 AM, the Director of Housekeeping stated the duration time power is transferred to the generator will be included on the generator logs. 2. On 12/29/22 at approximately 2:30 PM, it was noted that a remote manual stop station for the generator was not installed elsewhere on the premises. In an interview with the Director of Housekeeping at the time of the finding, the Director of Housekeeping confirmed that a remote manual station for the generator was not installed elsewhere on the premises. The Director of Housekeeping further stated that the vendor will be contacted. 2012 NFPA 101: 9.1.3.1 2012 NFPA 99: 6.4.4.1.1.1, 2010 NFPA 110: 5.6.5.6*, 8.4.1*,8.4.2, 8.4.6, 8.4.6.1, 8.4.9.2 10 NYCRR 711.2 (a)(1)

EP TESTING REQUIREMENTS

REGULATION: §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency

plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or

prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

Scope: Widespread
Severity: Potential to cause minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details	Plan of Correction: ApprovedFebruary 13, 2023
Based on documentation review and staff interview, the facility did not ensure that the community based, facility based and tabletop drills to test the emergency plan were conducted in accordance with 483.73. Specifically, the facility did not provide after action reports for the drill conducted on 5/16/22 High Winds and a drill for the attendance sheet 3/15/22 labeled Disaster Planning was not provided at time of survey. The findings are: During the Life Safety recertification survey conducted on 12/29/22 at 1:20 PM, documentation review of the facility's Emergency Preparedness drills was conducted and it was noted that the external facility based disaster drill dated 5/16/22 and titled High Winds, did not include an after action report. An additional drill was not provided. Email correspondence regarding collaboration for an Active shooter drill was provided. The email correspondence was dated 11/2022 and the attendance sheet titled disaster planning was dated 3/15/22. However the actual drill for Active shooter was not provided and a facility analysis report was not provided. During the Exit conference at 3:30 PM, the Administrator stated that the email correspondence was the planning for the Active shooter and the drill was conducted on 3/15/22. The Administrator stated after action reports will be included in the drills. 483.73(d)(2)	Based on Observation and staff interviews the facility did not ensure that after action reports were completed for all Drills: 1. After action reports will be completed by Administration after all drills in order to assess a facility need for policy review and to critique the drill/ exercise itself for possible improvements. The Administrator reviewed and revised the Disaster Policy on 2/8/23. The Staff Development Coordinator will educate all staff on the updates to the Disaster Policy. 2. All residents have the potential to be affected by this deficient practice. 3. A drill log was created which includes an audit for After action reports which will now be kept in the Administration office of all Drills and After-action reports. Administrator will audit all drills monthly for the next three months and will report all findings to QAPI Committee. Any negative findings will be immediately corrected. 4. Administration will report all drills and After-Action Report Audits to QAPI Committee Monthly for 3 months and at the discretion of the QAPI Team thereafter. 5. Completion Date 12/29/2022. Responsible for Compliance : Administrator

K307 NFPA 101:FIRE DRILLS

REGULATION: Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7

Scope: Pattern
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details	Plan of Correction: ApprovedFebruary 9, 2023
Based on documentation review and staff interview, the facility did not ensure fire drills were conducted quarterly on each shift in accordance with NFPA 101. Specifically, the first and second quarter fire drill reports for the Evening shift in 2022 and the third quarter fire drill for the Night shift for the year 2022 and the 4th quarter fire drill for the year 2021 were missing and not provided at time of survey. The findings are: During the life safety recertification survey on 12/29/22 at 1:00 PM, the facility's fire drill logs for the past 12 months were reviewed. It was noted that the Evening shift fire drill reports for the 1st and 2nd quarter of 2022, and the 3rd quarter fire drill report for the Night shift for the year 2022 and the 4th quarter fire drill report for the Night shift for the year 2021 were missing. In an interview with the Director of Housekeeping at the time of the findings, the Director of Housekeeping stated that the missing drills were conducted and could not be located. 2012 NFPA 101: 19.7.1.26 10 NYCRR 711.2 (a)(1)	Based on observation and staff interview the facility did not ensure that fire drills were conducted at least quarterly on each shift. 1. Fire Drills will be performed quarterly on all shifts. All shifts will have a fire drill performed for the month of (MONTH) to ensure proper response to fire emergency by the Director of Maintenance/ Designee. 2. All residents have the potential to the affected by this deficient practice. 3. Education will be completed with the Maintenance / Designee that fire drills must be performed on all shifts quarterly. A schedule of fire drills and the shifts that they are to be performed on was created and education provided to the Assistant Maintenance/ Designee , to ensure that a fire drill is scheduled on each shift at least quarterly. The Director of Maintenance/ Designee will be required to sign and date the Schedule of Fire Drills in the Disaster Drill Book after each fire drill and provide a copy of the drill to the Administrator. 4. Fire Drills completed for the month will be reported to the QAPI Committee monthly for three months and then at the discretion of the team there after by the Director of Maintenance/ Designee. 5. Completion Date: 3/5/2023 Responsible for Compliance : Assistant Housekeeping Supervisor

K307 NFPA 101:HAZARDOUS AREAS - ENCLOSURE

REGULATION: Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details	Plan of Correction: ApprovedFebruary 13, 2023
Based on observation and staff interview, the facility did not ensure that the corridor doors to storage areas were installed and maintained in accordance with NFPA 101. Specifically, 1. The corridor doors to storage rooms were not equipped with self -closing devices, 2. The doors to the boiler room was not able to resist the passage of smoke, 3. The oxygen storage room on the loading dock did not positive latch upon self-closing. These issues were noted on 1 of 4 resident units on 1 of 2 resident floors and in the basement. The findings are: During the Life Safety recertification survey on 12/28/22 between the hours of 10:30 AM and 3:00 PM the following issues were noted: On 12/28/22 at approximately 1:00 PM, a tour of Unit 1 located on the first floor was conducted and it was noted that 3 resident rooms on the unit (119, 120 and 121) were turned into storage rooms and the doors to the rooms lacked self - closing devices. In an interview with the Director of Housekeeping at the time of the finding, the Director of Housekeeping stated that self - closing devices will be installed on the doors. At 1:40 PM the same day, a tour of the basement was conducted, and it was noted that the double doors to the boiler room were not able to resist the passage of smoke. The opening between the two doors was noted more than ?? inche wide. In an interview with the Director of Housekeeping at the time of the finding, the Director of Housekeeping stated that an astragal will be installed between the doors to resist the passage of smoke. At 1:45 PM, a tour of the loading dock was conducted, and it was noted that the door to the oxygen storage room did not latch upon self - closing. The door rested on the door frame. In an interview with the Director of Housekeeping at the time of the finding, the Director of Housekeeping stated that the doors to storage rooms are checked quarterly and the door will be repaired. 2012 NFPA 101: 19.3.2.1.3, 7.2.1.8 10 NYCRR 711.2 (a)(1)	Based on observation and staff interview the facility did not ensure that storage areas had self closures on the doors, that the boiler room door resisted the passage of smoked and that the oxygen storage room door was self latching. 1. The door to the oxygen storage room was immediately repaired and it was ensured that it latches on self closure, completed on 1/3/23. The boiler room door was immediately repaired and an astragal installed so that that it resists the passage of smoke by ensuring that the opening is less than ?? inch, completed on 1/3/23. Self closures for the corridor storage rooms were installed on 2 of the 3 doors immediately, the third self closure is on order and will be installed upon delivery by the maintenance department. 2. All residents have the potential to be affected by this deficient practice. 3. Education was completed with the Housekeeping Supervisor and the Maintenance Assistant by the Administrator on the requirements of self closures on the Unit doors, Self closure on the 02 door and the requirement that boiler room door is to resist the passage of smoke. The Director of Maintenance/ Designee will audit the Oxygen Self room latch, the boiler room door for resistance of passage of smoke by ensuring that the opening between the two doors is less than ?? inch, and the corridor storage room self closures are functioning, weekly for the next 3 months. All negative findings will be reported to administration and corrected immediately. The facility will complete a facility wide audit of all doors to ensure all doors, self closures, astragals and other equipment are in place and functioning properly. 4. The Maintenance Director/ Designee will report the findings of the oxygen room door, Boiler room door and Corridor storage doors audits to the QAPI Committee Monthly for three months and at the discretion of the team there after. 5. Completion Date: 3/5/23 Responsible for Compliance: Assistant Housekeeping Supervisor

K307 NFPA 101:SPRINKLER SYSTEM - MAINTENANCE AND TESTING

REGULATION: Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the

Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25

Scope: Pattern
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details	**Plan of Correction: ApprovedFebruary 9, 2023**
2011 NFPA 25: Chapter 14 Obstruction Investigation 14.1* General. This chapter shall provide the minimum requirements for conducting investigations of fire protection system piping for possible sources of materials that could cause pipe blockage. 14.2 Internal Inspection of Piping. 14.2.1 Except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Based on observation, record review and staff interview, the facility did not ensure that the sprinkler system was maintained in accordance with NFPA 25. Specifically, documentation of the 5 year internal pipe inspection report was missing and not provided at time of survey. The findings are: During the Life Safety recertification survey, documentation review of the facility's sprinkler logs were conducted on 12/28/22 at 2:30 PM, and it was noted that the 5 year internal pipe inspection report was missing. During the Exit Conference the same day at approximately 2:50 PM, the Director of Housekeeping stated that the vendor will be scheduled to conduct an internal pipe inspection. 2012 NFPA 101: 9.7.5, 9.7.7, 9.7.8 2011 NFPA 25: 9.3.6, 14.1, 14.2 10 NYCRR 711.2 (a) (1)	Based on observation and staff interview the facility did not ensure that the internal inspection for the facility sprinkler system was maintained in accordance with NFPA 25, specifically the required 5 year inspection was not completed. 1. The facility uses(NAME)Fire Protection to inspect the sprinkler systems. (NAME)Fire Protection was immediately contacted for an appointment to complete the sprinkler inspection. 2. All residents have the potential to be affected by this deficient practice. 3. Education has been completed with the Director of Maintenance/ Designee on the requirement that the Sprinkler system is required to have an internal inspection every 5 years. The Director of Maintenance / Designee will track the date of the next required internal inspection bi annually to ensure that we are in compliance with the 5 year internal inspection regulations. The 5 year inspections will be put on Automatic Scheduling through(NAME)Fire Protection to ensure that the inspections are completed within the 5 year time frame, in addition to the facility keeping records to notify(NAME)Fire Protection when the inspections are due. 4. Upon completion of the inspection the results will be reported to QAPI Committee, the Results of the Audit and ongoing communication between(NAME)Fire and The Facility, to ensure that inspections are scheduled and completed within the required time frame will be reported to the QAPI Team monthly for the next three months and then at the discretion of the QAPI team thereafter. 5. Completion Date: 3/5/2023 Responsible for Compliance: Assistant Housekeeping Supervisor

ZT1N 713-1:STANDARDS OF CONSTRUCTION FOR NEW EXISTING NH

REGULATION: N/A

Scope: Isolated
Severity: Potential to cause more than minimal harm
Citation date: January 5, 2023
Corrected date: March 5, 2023

Citation Details	Plan of Correction: ApprovedFebruary 9, 2023
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 713 -3.10 Physical Therapy Facilities Physical Therapy facilities shall include and comply with the following: (a) Treatment areas shall have space and equipment commensurate with all approved programs including, but not limited to, thermotherapy, diathermy, ultrasound, and hydrotherapy. Provisions shall be made for cubile curtains around each individual treatment area, handwashing facility (ies) (one lavatory or sink may serve more than one cubicle), and facilities for the collection of soiled linen and other material. 713 -3.25 - Electrical requirements (f) The electrical circuit(s) to fixed or portable equipment in hydrotherapy units shall be provided with five milliampere ground fault interrupters. Based on observation and staff interview, the facility did not ensure: 1. A ground fault circuit interrupter (GFCI) outlet was provided for the portable hydrotherapy unit ([MEDICATION NAME]), and 2. Privacy curtains were installed around each individual treatment area. Specifically, the hydrotherapy unit was plugged into the standard outlet and the platform tables for individual treatment lacked privacy curtains. These issues were noted in the large Rehab room. The findings are: During the life safety recertification survey on 12/28/22 at 12:25 PM, a tour of the Physical Therapy gym (previously dining room) was conducted and it was noted that the [MEDICATION NAME] was plugged into a standard electrical receptacle rather than a GFCI outlet. In addition, the platform tables in the room lacked privacy curtains. In an Interview with the Director of Housekeeping at the time of the finding, the Director of Housekeeping stated that the hydrotherapy unit will be plugged into a GFCI outlet and the platform tables may be removed. 10 NYCRR 713-3.10, 3.25 (f) 10 NYCRR 711.2 (a) (1)	Based on observation and interview with staff the facility did not ensure that the hydrotherapy unit was connected to a GFI and that privacy curtains were installed around each treatment area (specifically the platform tables) 1. The Hydrotherapy unit was immediately moved and plugged into a GFCI outlet, the Platform Table was moved back to its original placement and it was ensured that a curtain was present in the area for resident privacy when in use. 2. All residents who utilize the Hydrotherapy Unit while participating in Therapy have the potential to be affected by this deficient practice. 3. Education will be completed with Therapy staff on the requirement that the hydrotherapy unit is to always remain plugged into a GFCI outlet, and that privacy must be provided for all residents when using the platform table. The Director of Therapy/ designee will be responsible and insure that the privacy curtain is in place around the platform table. All negative findings will be corrected immediately. Maintenance will monitor the GFCI outlets in the therapy office weekly for one month then quarterly to ensure it is functionality. All negative findings will be reported to administration and corrected immediately. 4. The Director of Rehab/ designee will be responsible to report the findings of the hydrotherapy and platform bed privacy audit to the QAPI Committee monthly for three months and then at the discretion of the team there after. The Maintenance department will be required to report the GFCI functionality audit to the QAPI Committee monthly for three months and then at the discretion of the team thereafter. 5. Date of Completion 3/5/2023. Responsible for Compliance : Assistant Housekeeping Supervisor