STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335050	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARY MANNING WALSH NURSING HOME CO INC	1339 YORK AVENUE NEW YORK, NY 10021

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

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification survey, the facility did not ensure that a resident and the resident's representative was notified of a hospital transfer in writing. Specifically, a resident that was hospitalized was not provided with a notice of transfer/discharge as soon as practicable once the transfer occurred. This was evident for 1 of 2 residents reviewed for hospitalization (Resident #207). The findings are: A facility policy and procedure related to Involuntary Transfer/Discharge, dated 10/16/18, documented that when a resident is temporarily transferred on an emergency basis to an acute care setting, a Notice of Transfer may be provided as soon as practicable to the resident or resident's representative. Resident #207 was diagnosed with [REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented that the resident is cognitively intact. An Admission, Discharge, Transfer (ADT) Activity Detail Report for Resident #207 documented that the resident was hosptalized on [DATE] and readmitted to the facility on [DATE]. The resident was also hosptalized on [DATE] and readmitted to the facility on [DATE]. Nursing Notes dated 1/2/20 documented that the resident was transferred to the hospital due to respiratory distress. The resident's daughter was present during the resident's transfer. Nursing notes dated 1/28/20 documented that the resident was readmitted to the facility. A SBAR Communication Form dated 2/25/20 documented that the resident's condition has worsened and that she was being transferred to an acute care hospital. There was no documentation reflecting that the resident or resident's representative was provided with a notice of transfer and discharge. The Director of Social Work (DSW) was interviewed on 03/05/20 at 02:24 PM. She stated that she is not responsible for sending the notice of transfer/discharge to the resident or family member when a resident is transferred to the hospital. She believes that it is the Administrator's responsibility. She is responsible for providing these notices to residents who have planned discharges to the community. An interview was conducted with the Administrator on 03/05/20 at 03:21 PM. He stated that he does send monthly lists to the Ombudsman's office containing the names of residents that have been hospitalized or discharged home. He is aware that notices of transfer/discharge need to be provided to residents or their representatives when they are hospitalized , but the facility has not been providing these notices in these instances. The DSW provides the notices of transfer/discharge to the residents when they have a planned discharge to the community, but there is not anyone assigned to do so when they are hospitalized . This notice makes the resident and their representative aware of their rights upon discharge. 415.3(h)(1)(iii)(a-c)
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F625 Resident #207 hospitalization Based on record review and interviews conducted during the recertification survey, the facility did not ensure that a resident was provided with a notice of bed hold policy within 24 hours of emergency transport to the hospital. Specifically, a resident that was hosptalized on [DATE] and 2/25/20 did not receive a bed hold letter. This was evident for 1 of 2 residents reviewed in the area of hospitalization . (Resident #207) The findings are: A facility policy and procedure related to Bed hold and Return to Facility was revised on 7/15/19 and documented that a resident and representative will be provided with bed hold information before a hospital transfer. Resident #207 was diagnosed with [REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented that the resident is cognitively intact. An Admission, Discharge, Transfer (ADT) Activity Detail Report for Resident #207 documented that the resident was hosptalized on [DATE] and readmitted to the facility on [DATE]. The resident was also hosptalized on [DATE] and readmitted to the facility on [DATE]. Nursing Notes dated 1/2/20 documented that the resident was transferred to the hospital due to respiratory distress. The resident's daughter was present during the resident's transfer. Nursing notes dated 1/28/20 documented that the resident was readmitted to the facility. A SBAR Communication Form dated 2/25/20 documented that the resident's condition has worsened and that she was being transferred to an acute care hospital. There was no documentation that the resident was provided with a notice of bed hold when tranferred to the hospital. An interview was conducted with the Director of Admissions (DOA) on 03/05/20 at 02:33 PM. The DOA stated that she did not provide Resident #207 or her family member with a bed hold letter, and she did not call them to inform them of the bed hold policy after the resident had been hospitalized . If the DOA discusses this with a resident's family member by phone, she usually makes a note of it in her billing system; however, she does not have any notes regarding any conversations that took place with the family of this resident. The bed hold letter is supposed to go with the resident when they are transferred to the hospital and is included with the medical records that are sent to the hospital. The nursing staff on the resident's unit are responsible for sending them. An interview was conducted with Registered Nurse (RN) #4 on 03/05/20 at 12:21 PM. RN #4 is the Nurse Manager of the resident's unit and stated that it is the responsibility of the nurse on duty at the time of transfer to send a bed hold notice with the resident when they are transferred to the hospital. There is a binder on the unit with the bed hold policy and blank letters for the nurses to use. This was not done on the last two hosptializations for Resident #207 on 1/2/20 and 2/25/20. It was most likely not provided because due to the urgency of the transfer to the hospital, the nurse responsible must have forgotten. On 03/05/20 at 12:39 PM, an interview was conducted with RN #5, the RN that was responsible for coordinating the resident's discharge to the hospital on [DATE]. RN #5 stated that there is a bed hold letter that is supposed to be sent with the resident while they are being transferred to the hospital. RN #5 was previously unaware of this policy. The facility administration just recently informed her that she is responsible for sending the bed hold letter with the resident. 415.3(h)(4)(i)(a)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification survey, the facility did not ensure that all drugs and biologicals were kept in locked compartments. Specifically, there was no staff present when an unopened vial of [MEDICATION NAME] was observed to be on an overbed table in a resident's room. This was evident for 1 of

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

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 10 units reviewed for Medication Storage. (Unit #10)) The findings are: A facility policy and procedure related to Storage of Medication was revised on 3/5/20 and documented that drugs shall be stored in cabinets, drawers, and arts or automatic dispensing systems. On 03/02/20 at 07:17 AM, the resident's room [ROOM NUMBER] was entered, and an unopened vial of [MEDICATION NAME] 500 was observed on the overbed table next to the resident's bed. The pink top had not been removed and there was a small amount of clear liquid in the vial. The resident was lying in bed, in and out of sleep, and it was a private room. Identifying markings on the [MEDICATION NAME] vial: Batch - CHN 6/EXP - SEP 2021, N 16. Resident #502 had a [DIAGNOSES REDACTED]. physician's orders [REDACTED]. This order was discontinued and changed on 3/3/20 to [MEDICATION NAME] ([MEDICATION NAME]) unit/mL injection every 12 hours. A Comprehensive Care Plan (CCP) related anticoagulation therapy was initiated on 2/16/20 and documented that the resident uses [MEDICATION NAME]. Medications are to be administered as ordered. A Minimum Data Set ((MDS) dated [DATE] documented that the resident is cognitively intact and received 6 days of an anticoagulant. The Medication Administration Record [REDACTED]. A Medical Doctor (MD) progress note dated 3/3/20 documented that the resident was refusing the [MEDICATION NAME] mini dose every 8 hours and that it will be changed to every 12 hours with patient in agreement. An interview was conducted with the Registered Nurse (RN) #1/Medication Nurse for the 7 AM to 3 PM shift on 03/02/20 at 07:19 AM. After the RN #1 observed the [MEDICATION NAME] vial in the room of Resident #502, the RN stated that it must have been left by the nurse from the previous shift. The resident is due to receive [MEDICATION NAME] at 6 AM but had refused that morning. The medication is not supposed to be left in the resident's room. RN #1 did not have a chance to do her rounds as of yet and did not see it. On 03/05/20 at 10:46 AM, an interview was conducted with the medication nurse that worked at 6 AM on 3/2/20, RN #3. She stated that she is an agency nurse and does not usually work on the resident's unit. She became nervous when she heard that the New York State Department of Health had entered the building and made an oversight by leaving the [MEDICATION NAME] vial in the resident's room. Medication, including those in vials, should never be left unattended in a resident's room. If the resident refuses the medication, it should be brought back to the medication cart. An interview was conducted with the nurse manager for the resident's unit, RN #2, on 03/06/20 at 09:08 AM. The medication should not have been left in the resident's room at all. The nurse was inserviced on not ever leaving medications at the bedside. If the resident refuses the medication, then the medication nurse is to take it back, put it back in the original packaging, and lock it in the medication cart. The MD is then notified, and the nursing supervisor is made aware so that the resident can receive further counseling. The nursing staff are then responsible for documenting the refusal in a nursing note and on the MAR. 415.18(e)(1-4)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews during the recertification survey the facility did not maintain infection control practices to help prevent the development and transmission of communicable diseases and infections. Specifically, 1) oxygen tubing was observed lying on the floor while connected to a resident; and, 2) a catheter drainage bag was observed to be on the floor. This was evident for 1 out of 2 residents observed for Respiratory care (Resident #507) and 1 out of 4 residents observed for catheter care (Resident #89). The findings are: 1) A facility policy and procedure related to Oxygen Therapy was reviewed 2/24/20 and documented that the nasal cannula is to be changed when soiled. On 03/02/20 at 11:15 AM, Resident #507 was observed lying in bed with a nasal cannula attached to her nose and oxygen flowing from a concentrator. The tubing connecting the concentrator to the nasal cannula was observed to be on the floor under a floor mat that was next to the resident's bed. At 11:17 AM, the Nurse Manager for the unit, Registered Nurse (RN) #4, and RN #6 were observed in the room coming from the behind the privacy curtain for the resident's roommate. They walked past Resident #507 and the oxygen tubing that was on the floor, did not address the oxygen tubing, and exited the room. Resident #507 was diagnosed with [REDACTED]. physician's orders [REDACTED]. There is no Minimum Data Set completed as of yet due to resident being admitted on [DATE]. A Comprehensive Care Plan (CCP) related to Respiratory: Infective airway clearance/oxygen/[DIAGNOSES REDACTED]. Interventions included that the oxygen therapy is to be provided according to Physician Order. The resident's treatment Administration Record (TAR) for March 2020 documented that the resident is receiving the oxygen therapy according to Physician Orders. On 03/02/20 at 11:22 AM, RN #6 was brought to the resident's room to observe the oxygen tubing on the floor. She stated that the oxygen tubing was not supposed to be on the floor due to infection control concerns. She picked up the tubing with bare hands, attached the tubing to the bed rail on the resident's bed, and then grabbed pair of gloves. After donning gloves, the RN made sure that the nasal cannula was securely in the resident's nose and proceeded to leave the room. She stated that she had worked in the facility for 2 years and has received infection control inservices, but those inservices were not specific to caring for oxygen tubing. On 03/06/20 at 10:06 AM, an interview was conducted with RN #4. She stated that is oxygen tubing is observed to be on the floor, the tubing needs to be replaced. This is the facility policy in order to maintain infection control. 2) The facility policy titled, Supra Pubic Catheter Care revised dated 12/7/19 documents: Procedure- 9. Urine collection bag and tubing off the floor at all times. Resident #89 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/02/20 at 7:46 AM during the initial pool process the resident was observed lying in bed. The suprapubic urinary drainage bag was observed hanging off the side rail of the right side of the bed and resting on the floor. The Annual Minimum Data Set (MDS) 3.0 dated 5/19 documented the resident is totally dependent on staff for all activities of daily living including transfers, toilet use and personal hygiene. The resident was documented as using a suprapubic catheter. Current Physician order [REDACTED]. Monitor urine output q shift. Suprapubic tube- cleanse suprapubic site with NS, pat dry and cover with dry protective dressing. Change SPC dressing daily. Suprapubic catheter - change bed side drainage bag weekly and as needed. Suprapubic catheter- change monthly and prn at Urologist. The Care Plan for Elimination-updated 3/3/20 - documents: Indwelling/external suprapubic catheter- documents: alteration in elimination as evidenced by urine retention, Prostrate hypertrophy, diabetes. Goal - Resident will remain free of infection. Interventions- Determine medical need for indwelling external catheter. Insure tubing is free of kinks and below level of bladder. Maintain adequate fluid intake. Secure catheter to upper leg with leg and. Indwelling catheter washed with soap and water. Empty drainage bag every shift. Change straight drainage bag with catheter change as per MD order or as needed. Change leg bag once per week. Observe for signs and symptoms of infection. If leg bag is used cleanse tip with alcohol and keep cap soaking in alcohol when not in use. Assess for pain. Provide pain medication as ordered. Assess for complication such as obstruction, urethral erosion, bladder spasm, hematuria, leakage around the catheter. On 3/02/20 at 7:49 AM Registered Nurse (RN) Supervisor #1 was interviewed and stated, I see the Foley catheter drainage bag for this resident is resting on the floor It also does not have a dignity bag covering it. It should not be like this. The drainage bag should not be hitting the floor. The drainage bag should be hanging from the bed above the floor and not touching the floor. It should also be covered inside a blue dignity bag. It is the Certified Nursing Assistants (CNA) responsibility as well as the nurses to check and make sure the drainage bag is not touching the floor. This is an infection control issue. I will tell the CNA to change the drainage bag to a new one and lace it into a dignity bag. On 3/02/20 at 8:07 AM CNA #1 was interviewed and stated, I see the Foley catheter drainage bag is touching the floor. I started my shift today at 7AM. I did not come into this room until now. When I start my shift, I check the rooms. There was another CNA assigned to this room and they called out, so they extended my assignment to this room. The drainage bag should be at least 2 inches off the floor. I see it is touching the floor and attached to a black strap that is loose. The proper way is the drainage bag should be hanging at least 2 inches above the floor. It should be attached to the non -movable part of the bed frame and covered with a dignity bag. This drainage bag is not covered with a dignity bag. It is the CNA responsibility to check and make sure the drainage bag is not touching the floor and is inside a dignity bag. The overnight CNA should have checked before they went home. Bacteria could contaminate the drainage bag. This is an infection control issue. On 3/06/20 at 12:11 PM the Director of Nursing (DON) was interviewed and stated, I heard from the Unit Manager that you saw a Foley catheter drainage bag touching the floor. For a resident who has a Foley or suprapubic catheter the urinary drainage bag should not be touching the floor. The proper way it should be is that it should be below the bladder of the resident. It should be attached to a section underneath the bed I would say the metal rail. The drainage bag should be covered with a dignity bag. The bag should be at least 2 inches above the floor and not touching the floor. It is the responsibility of both the CNA's and the floor nurses to make sure the catheter drainage bags are not touching the floor. If the drainage bag is touching the floor it is possible that the spigot will get contaminated and may travel to the resident if there is a backflow and could contribute to a possible infection. This is an infection control issue. When I first heard about this issue, I told my supervisors to monitor that the residents who have catheter drainage bags are not touching the floor. We told the supervisors to educate the staff and walk the units and

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) ensure the drainage bags are not touching the floor. 415.19(b)(1)