STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335799	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNION PLAZA CARE CENTER	33 23 UNION STREET FLUSHING, NY 11354

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview conducted during the recertification and abbreviated survey, the facility did not ensure needed care and services that are in accordance with the resident's preferences, goals for care and professional standards of practice were provided. Specifically, 1). a resident was administered a dose of insulin without a physician's orders [REDACTED]. This was evident for 2 of 9 residents reviewed for Unnecessary Medications out of a sample of 35 residents (Resident # 401-Complaint #NY 392 and Resident # 245) The findings are: 1. Resident #401 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medication Administration Record [REDACTED]. Accident/Incident Report dated 9/14/18 documented that resident was administered [MEDICATION NAME] 7 units at 9:15 PM. There was no documented evidence that the resident had a physician order [REDACTED]. ED Patient Discharge Instructions dated 9/15/2018 documented blood glucose was assessed via meter at 2:19 AM. The blood glucose level was 168 mg/dL. On 9/15/18 at 2:35 AM, a Basic Metabolic Panel (BMP) was done in the hospital, the blood glucose level was 179 mg/dl. Nursing progress notes dated 9/15/18 at 1PM documented a call was received from a Nurse Manager at the hospital indicating the resident is stable to return. There were no episodes of [DIAGNOSES REDACTED] and blood glucose via fingerstick was 168mg/dL. Attempts to contact the Licensed Practical Nurse via telephone for interview were unsuccessful. LPN is no longer employed at the facility. On 3/6/2020 at 11:38 AM, the resident's primary physician (MD #4) was interviewed. MD #4 stated the resident did not have an order for [REDACTED].#4 also stated the resident's daughter requested the resident be transferred to the hospital for evaluation. On 3/6/2020, at 11:50 AM, an interview was conducted with the RN Supervisor (RN #3). RN #3 stated when she reviewed the resident's record, there was no insulin order noted on the Medication Administration Record. 2. Resident # 245 was admitted to facility with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS dated [DATE] documented resident as cognitively intact. Physician order [REDACTED]. Medication Administration Record [REDACTED]. MAR indicated [REDACTED]. Medication was administered to the resident on a daily basis and not every other day as ordered by the physician. On 03/06/20 at 01:34 PM, an interview was conducted via telephone with Licensed Practical Nurse (LPN #2). LPN #2 stated when administering medications, she normally follows the five rights of medication administration and according to the physician's orders [REDACTED]. LPN #2 also she read the order but did not check the scheduling of the order because the wording was correct. LPN #2 further stated she thought she did the correct thing when administering the medication. On 03/05/20 at 02:03 PM an interview was conducted with Licensed Practical Nurse (LPN #3) LPN #3 stated she is the regular medication nurse for the unit and administered this medication to the resident on 2/29/20, 3/1//20, 3/3/20, 3/4/20 and 3/5/20. LPN #3 stated she read the orders and I administered medications as they as it appeared in the MAR. LPN #3 also stated she is not allowed to enter orders but has to confirm orders placed before giving medication. LPN #3 further stated she saw the initial order last week, confirmed the order was for every other day but did not check the schedule of the order because she assumed it was correct as the wording in the order was correct. On 03/05/20 at 12:04 PM, an interview was conducted with Unit Manager (RN #2). RN #2 stated she is responsible for entering and reviewing all orders in the computer. RN #2 stated she received a telephone order from the Medical Doctor (MD) to decrease [MEDICATION NAME] from 20 mg daily to [MEDICATION NAME] 20 mg every other day which was confirmed by MD on 2/27/2020. She then changed the wording to [MEDICATION NAME] 20mg every other day but forgot to change the schedule of the order so that it would show in the MAR indicated [REDACTED]. RN #2 further stated when a new order is entered in the system, two other nurses also confirm that the order is correct. 415.12
F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews conducted during the re-certification survey, the facility did not ensure a resident received and consumed foods in the appropriate form as prescribed by a physician. Specifically, the CNA did not provide the resident the correct consistency diet as prescribed. This was evident for 1 of 3 residents reviewed for Nutrition out of an investigation sample size of 38 residents. (Resident#171) The finding is: The most recent Minimum (MDS) data set [DATE] documented resident has a [DIAGNOSES REDACTED]. On 3/2/2020 at 12:45 PM, resident was observed coughing in the dining room during lunch service. CNA #1 walked over to resident and held a cup of thin water to the resident while she drank. Tray ticket for the resident documented nectar thick liquids. physician's orders [REDACTED]. Speech Language Pathology (SLP) screen dated 2/10/20, SLP evaluation dated 1/6/20, and Nutrition assessment dated [DATE] all documented the resident is prescribed nectar thick fluids. On 3/05/2020 at 2:34 PM, an interview was conducted with LPN#1. LPN#1 stated the trays got switched. One resident gets thin liquids and the other gets nectar thick. Initially the trays were placed in front of the wrong residents. The cups of water were given out to the residents that receive thin liquids. Before the residents started eating, I switched the trays back to the appropriate resident, however I forgot to place the thin water back in front of the resident who receives thin liquids. Then when resident #171 started coughing, the CNA seeing the thin liquids in front of her gave it the resident. On 3/11/2020 at 2:51 PM, an interview was conducted with RN Supervisor #1. RN #1 stated We don't necessarily encourage staff to memorize diet orders since they should always be checking what is on the ticket. This is especially important since residents may be upgraded or downgraded in consistency. We don't have a list or any other documents with diet orders in the dining room, staff relies on the tray tickets. The nurses have access to the diet orders in Sigma which helps us stay up to date on diet changes. At meal times there is always a nurse present. Dispensing of water can be completed by either a CNA or a nurse. On 03/11/2020 at 2:24 PM, an interview was conducted with CNA #1 via telephone. CNA #1 stated when it is mealtime, I look at the tray ticket. If I see a patient with thickened water, I won't give them water and I will tell whoever is giving out the water not to give it the resident. CNA #1 stated she doesn't know why she had given the resident thin liquids because she always follows what is on the tray ticket. 415.14(e)
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 and staff interview conducted during the Recertification survey, the facility did not ensure that an infection prevention and control program was established and maintained a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, oxygen tubing

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) connected to resident from a Bi-pap machine was observed touching the floor and a resident's nasal cannula was found attached to a portable oxygen tank uncovered and touching the floor. This was evident in 1 of 3 residents reviewed for Infections out of sample size of 38 residents. (Resident # 304) The finding is: The undated policy titled Oxygen Therapy documented if oxygen is to be used for greater than 24 hours, the mask and or cannula and humidifier will be replaced weekly. The tubing is to be dated when first used and the 11-7 staff is responsible for setting up the new system. Resident #304 was admitted with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] documented resident with intact cognition and required extensive assistance of staff with Activities of Daily Living. On 03/06/2020 at 11:00 AM, resident was observed in bed asleep with oxygen mask with ongoing treatment. The tubing from the oxygen concentrator was observed touching the floor from the concentrator to the resident. In addition, a wheelchair in the resident's room was observed with an attached oxygen tank and the nasal cannula tubing was coiled around the wheelchair with no cover. The tubing was dated 02/21/2020, indicating the tubing had not been changed for two (2) weeks. Review of the physician's orders [REDACTED]. On 3/06/2020 at 11:20 AM, Registered Nurse (RN) #8 was interviewed. RN # 8 stated she was unsure of the facility policy on changing oxygen tubing and would check and get back to the surveyor. On 3/06/2020 at 11:20 AM, RN # 9 was interviewed. RN #9 stated tubing is changed weekly by the night shift and should be dated. On 03/06/2020 at 3:45 PM, Infection Control Coordinator (ICC) was interviewed. The ICC stated nasal tubing are change weekly and dated and there is a specific staff person assigned to this task. The ICC also stated the resident's family takes the resident out of the room and this may contribute to tubing touching the floor. The ICC further stated re-education and reminders to staff about different practices including tubing of oxygen and catheter is ongoing and family members would be re-educated. 415.19 (a)(1-3)