STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335024	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACH TERRACE CARE CENTER	640 WEST BROADWAY LONG BEACH, NY 11561

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey the facility did not ensure that care was provided in accordance with each resident's comprehensive care plan for one (Resident #34) of four residents reviewed for medication administration. Specifically, during the medication pass observation on [DATE], for Resident #34, the Licensed Practical Nurse (LPN) administered Calcitonin nasal spray (a medication to treat [MEDICAL CONDITION]), two puffs, in each of the resident's nostrils; Although, the physician's orders [REDACTED]. In addition, the administration directions on the pharmacy label on the calcitonin spray were unclear. The finding is: The facility's policy titled Medication Administration using the E-MAR, dated 2/23/17, documented the Nurse is responsible to read the order and compare the order to the blisterpack and report any discrepancies. Resident #34 has [DIAGNOSES REDACTED]. The 12/13/19 Quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 2, indicating the resident had severe cognitive impairment. A physician's orders [REDACTED]. On [DATE] at 9:15 AM during the medication administration pass observation, for Resident #34, the LPN Medication Nurse administered two sprays of the [MEDICATION NAME] Nasal Spray to each of the resident's nostrils. The LPN Medication Nurse was interviewed on [DATE] at 12:41 PM. The LPN stated he sprayed the medication into both of Resident #34's nostrils. The LPN reviewed the Medication Administration Record [REDACTED]. The LPN reviewed the pharmacy label on the spray. The label documented one spray nasal every two days and one spray nasal every two days dated 2/16/20. The Registered Nurse (RN) Unit Supervisor was interviewed on [DATE] at 12:48 PM and stated she reviewed the physician's orders [REDACTED]. The RN stated the pharmacy label on the spray needed to be clarified. A Pharmacist from the facility's Pharmacy was interviewed on 3/5/20 at 9:31 AM and stated the label documentation of one spray nasal every two days and one spray nasal every two days was how the order was originally provided on 1/29/2018. The Pharmacist stated that pharmacy does not have a differentiation between the right and left nostril and that the facility had to provide clarification. The Director of Nursing Services (DNS) was interviewed on 3/5/20 at 10:02 AM and stated she would call the Pharmacy to clarify the label because the physician's orders [REDACTED].
F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview during the Recertification Survey, the facility did ensure that each resident's total program of care, including medications and treatments was reviewed at each visit. This was identified for two (Resident #61 and Resident #135) of four residents reviewed for Nutrition. Specifically, 1) Resident #61 had a 7.2% significant weight loss over a one week hospitalization and 2) Resident #135 had a 5.4% significant weight loss in a one month time period which was not addressed by the Attending Physician. There was no Physician's evaluation when a change in the resident's nutritional status was identified to address the medical and nutritional issues related to the significant weight loss. The findings are: The Significant Weight Changes and Charting Weight Changes policy, dated 1/[DATE]9, documented that if a resident has had a significant weight change, the chart will be updated and appropriate measures will be taken. The Registered Dietitian will complete a significant weight change form and a copy will be sent to the Director of Nursing Services (DNS), Minimum Data Set (MDS) Coordinator, and Attending (Primary) Physician. 1) Resident #61 has [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented the resident was rarely/never understood and could sometimes understand. The MDS also documented that the resident had severely impaired cognitive skills for daily decision making with both long and short term memory problems. Review of the resident's Admission/Discharge/Transfer (ADT) in the Electronic Medical Record (EMR) revealed the resident was hospitalized from [DATE] to [DATE]. Review of the resident's weight history revealed: 11/5/19 weight of 116.7 lbs (pounds) 11/11/19 weight of 117.0 lbs 11/20/19 weight of 117.9 lbs 11/27/19 weight of 118.9 lbs 12/5/19 weight of 118.7 lb 12/13/19 weight of 110.1 lbs (reflecting a significant weight loss of 7.2% over hospitalization) 12/19/19 weight of 110.6 lbs 12/27/19 weight of 110.9 lbs Review of the physician progress notes [REDACTED]. None of these notes addressed the resident's significant weight loss. The resident's Primary Physician/Medical Director was interviewed on [DATE] at 11:45 AM and stated he usually does not address a resident's weight loss over a hospitalization because he does not know what happened to them while they were in the hospital. The Primary Physician also stated that the Registered Dietitian (RD) usually alerts him of any significant weight losses or gains with a special form that is sent to the Physicians. The Primary Physician stated that when he receives the form, he documents the weight change. The Primary Physician stated that if there was no note written, then he did not receive a form. The RD was interviewed on [DATE] at 12:15 PM and stated that the Significant Weight Change Evaluation Form is a communication tool she uses, a way to alert the Physician of a significant weight change, gain or loss, seen in a resident. The RD stated that she did not fill out a form in December when the resident returned from the hospital with a significant weight loss. The RD stated that she normally would do this, but did not know why she had not. The DNS was interviewed on [DATE] at 12:45 PM and stated the Significant Weight Change Evaluation Form was instituted to make the doctors aware of significant weight changes in the facility so the doctors could address them. 2) Resident #135 has [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented the resident was sometimes understood and could sometimes understand. The resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severely impaired cognitive skills for daily decision making. Review of the resident's weight history revealed: 10/5/19 weight of 113.4 lbs (pounds) 10/1[DATE]9 weight of 113.2 lbs 10/19/19 weight of 113.3 lbs 10/27/19 weight of 109.8 lbs 11/5/19 weight of 107.5 lb 11/11/19 weight of 107.1 lbs (reflecting a significant weight loss of 5.4% over one month) 11/20/19 weight of 106.7 lbs 11/27/19 weight of 107.0 lbs Review of the physician progress notes [REDACTED]. None of these notes addressed the resident's significant weight loss. The Primary Physician/Medical Director was interviewed on [DATE] at 1:15 PM and stated if the Registered Dietitian (RD) documented a significant weight loss, she should automatically fill out a Significant Weight Change Evaluation Form. The RD was interviewed on [DATE] at 1:25 PM and stated that she must have forgotten to fill out the Significant Weight Change Evaluation Form. The Director of Nursing Services (DNS) was interviewed on [DATE] at 1:35 PM and stated she did not know why the RD did not fill out a Significant Weight Change Evaluation Form, but she should have. 415.15(b)(2)(ii)

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.