STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335719	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QUANTUM REHABILITATION AND NURSING L L C	63 OAKCREST AVENUE MIDDLE ISLAND, NY 11953

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 0580
 	
Level of harm - Minimal harm or potential for actual harm
 	
Residents Affected - Few
	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.
	NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
	Based on interview and record review, during the COVID-19 Focused Infection Control Survey (Complaint # NY 364) the facility did not ensure that 1 (Resident #3) of 3 resident representatives was immediately notified of a significant change in the resident's physical condition. Specifically, Resident #3's Health Care Proxy (HCP) was not notified that Resident #3 was tested for COVID-19 due to symptoms on 4/24/20 and was diagnosed with [REDACTED]. The finding is: The facility Notification of Significant Changes in Resident's Medical Status policy dated 8/2019 documented that the facility shall consult with the resident, if competent, and notify the designated representative of any significant changes in the resident's condition and/or status. Significant changes include a need to alter treatment significantly and deterioration in health status. Resident #3 was admitted to the facility with the [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #3 had a Brief Interview for Mental Status (BIMS) Score of 4, indicating severely impaired cognition. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The Physician's Note dated 4/24/20 at 10:53 AM documented Resident #3 was in bed with fever and prescribed Tylenol (fever reducer medication), Isolation Precautions, and Monitoring for temperature, cough, shortness of breath and lethargy. The Nursing Progress Note dated 4/25/2020 at 6:13 AM. The Registered Nurse (RN) Supervisor #1 documented that she performed the COVID-19 nasal test and would continue to monitor Resident #1. The Nursing Progress Note dated 4/27/20 at 1:15 AM documented that Resident #3 was positive COVID-19. The Nursing Progress Note dated 4/27/2020 at 11:01 AM documented that the Unit Manager received the Nurse Practitioner's orders for positive COVID-19 Status which included Tylenol 650 milligrams (mg), every 6 hours for 3 days, [MEDICATION NAME] (antibiotics) 250mg twice a day for 4 days, and continued the Isolation Precautions. The Nursing Progress Note dated 4/30/20 at 6:34 PM documented that RN Supervisor #2 spoke with Resident #3's Representative and notified that the physician ordered intravenous (IV) fluid and IV antibiotics. The family member (HCP) for Resident #3 was interviewed on 5/8/20 at 9:47 AM and stated that the HCP was never informed that Resident #3 was sick, tested for COVID-19, and confirmed positive COVID-19 on 4/27/20. On 4/30/20, the family member received a phone call from the Suffolk County Department of Health and was informed that Resident #3 was positive COVID19. The family member then called the facility and spoke with Unit Manager #1 who informed her that the family member was on the list to be called on 4/27/20 but Unit Manager #1 did not get a chance to make the call. Unit Manager #1 was interviewed on 5/8/20 at 10:38 AM. Unit Manager #1 stated that if a resident is sick, tested for COVID-19, and confirmed positive COVID-19, the next of kin is called by a nurse on the same day. She stated that she generates a list of calls to make when a change of status occurs and thinks she told the Wellness nurse to make the call for Resident #3 on 4/27/20. She stated that the call should be documented in the Nursing progress notes. RN Supervisor #2 was interviewed on 5/8/20 at 12:30 PM. RN Supervisor #2 stated that she received a call from Resident #3's HCP on 4/30/20. She stated that Resident #3's HCP was upset that she got a call from the Department of Health stating that Resident #3 was positive COVID-19. She confirmed Resident #3 was positive COVID-19 and updated the HCP on the medications that were being administered. She stated that same day notifications are expected when residents have a new infection, require IV fluids and antibiotics. The Wellness Nurse was interviewed on 5/8/20 at 1:29 PM. The Wellness Nurse stated that Unit Manager #1 did not instruct her to reach out to Resident # 3's HCP on 4/27/20. The Director of Nursing Services (DNS) was interviewed on 5/8/20 at 2:53 PM. The DNS stated that any change in the resident condition has to be communicated with the designated representatives of the affected residents. She stated that it was the Unit Manager's responsibility to contact the HCP.
	415.3(e)(2)(ii)(b)

F 0836 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during the COVID-19 Focused Infection Control Survey (Complaint # NY 364), the facility did not ensure that it was in compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility did not comply with New York State Executive Order (EO) 202.18, and ensure that residents' family members and their next of kin were notified of either a single confirmed infection of COVID-19 or COVID-19 death within 24 hours from the date of occurrence for three of three residents reviewed The findings are: The Executive Order #202.18 dated [DATE] documented the following: Any skilled nursing facility, nursing home, or adult care facility licensed and regulated by the Commissioner of Health shall notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death. The family notification policy dated [DATE] documented that the facility will notify residents and the residents family members or next of kin for all residents if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test or death, if that resident/family member/next of kin chooses to be notified via telephone call or email. Information related to communication is shown on the facility website. Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #1 had a Brief Interview for Mental Status (BIMS) Score of 2 indicating severely impaired cognition. Resident #2 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #2 had a Brief Interview for Mental Status (BIMS) Score of 14 indicating intact cognition. Resident #3 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #3 had a Brief Interview for Mental Status (BIMS) Score of 4 indicating severely impaired cognition. There was no documented evidence of communication regarding facility COVID-19 updates to the representatives of Resident #1, Resident #2, and Resident #3 from [DATE]-[DATE]. The facility website entitled Family Communication Letter documented the facility does not want to add to the insurmountable stress loved ones are already under. The facility goal is to communicate effectively within the boundaries of the requirements while maintaining our resident's right to privacy and allowing you to make the choice of the information you receive. We will provide the necessary information that satisfies the Department of Health (DOH) communication as well as your desire for this information, should you want to hear it. An untitled log documented Residents Notified and Family Notified of positive COVID-19 case via call on [DATE], COVID-19 Death on [DATE], and COVID-19 Death on [DATE]. The document did not indicate

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 0836 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) which residents and families were notified. The document did not indicate who made the phone call. The facility COVID-19 Death listing documented 7 in-facility deaths from [DATE] to [DATE]. The facility COVID-19 New Case listing documented 39 new cases of positive COVID-19 in the facility from [DATE] to [DATE]. The Family Member for Resident #1 was interviewed on [DATE] at 2:39 PM. Resident #1's family member stated that she was never informed of any new COVID-19 cases in the facility and was not aware that it was in the facility until she was notified that her mother was tested for COVID-19 on [DATE]. The administrator did not answer her questions regarding the number of new cases or deaths in the facility. Resident #1's family member stated that she did not receive a letter from the facility in [DATE]. The family member for Resident #2 was interviewed on [DATE] at 3:05 PM. Resident #2's family member stated that the facility has not contacted him to give updates on new facility COVID-19 cases or deaths. He stated that he was not offered to opt into any regular communication regarding the facility's status with new COVID-19 cases and deaths. Resident #2's family member stated that he did not receive a letter from the facility in [DATE]. He stated that he was not aware that the facility had a website. He stated that he is interested in receiving all facility notifications. The family member for Resident #3 was interviewed on [DATE] at 9:47 AM. She stated that the facility has not contacted her regarding new cases of COVID-19 and COVID-19 related deaths in the facility. Resident #3's family member stated that she did not receive a letter from the facility in [DATE]. She stated that she called the Administrator on [DATE] to address her grievance regarding a lack of communication from the facility. She stated that the Administrator told her that he was thinking of starting an email and took her email address. She stated that she never received any emails since he noted her email address. The Wellness Nurse was interviewed on [DATE] at 1:29 PM and stated she was instructed to make phone calls on [DATE]. Any communication before [DATE] was done by the Administrator. She stated that the contact list provided to her to make the phone calls did not include all families. She stated that on [DATE] she finalized a list of family representatives who wanted to be notified. The list provided documented Resident #1's family member wanted to be contacted and Resident #2's and Resident #3's family members did not want to be contacted. She stated that she did not make the calls to the family members for Resident #2 and Resident #3. She could not account for the discrepancy. The Wellness Nurse that she did not start documenting the phone calls until [DATE]. The administrator was interviewed on [DATE] at 3:58 PM. He stated that the facility was mandated to inform residents and resident representatives of new cases of COVID-19 and COVID-19 Deaths within 24 hours. The Administrator stated that he was contacted by some families and residents who wished to not receive the information and decided to make the notifications elective for all families. He stated that the facility sent out a letter on [DATE] addressing the COVID-19 family notifications policy. Families were directed to contact himself and the Wellness Nurse regarding COVID-19 information. The Administrator stated that he also placed the letter on the website and that all families are told about the website upon admission. The administrator stated that he handed over the responsibility to notify families to the Wellness Nurse on [DATE] and he began to document calls made on the log he provided. He stated that the call log is not resident specific and does not reflect each of resident representatives who elected to be notified. He stated that there was phone outreach by his team to all the families to establish their choice in being contacted regarding COVID-19 notifications. He stated that the list of residents and representatives who elected to be notified was finalized on [DATE]. 400.2