

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>335829</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/30/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL MALOTZ SKILLED NURSING PAVILLION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 ODELL AVENUE YONKERS, NY 10701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	<p><b>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical record and staff interview conducted during the standard survey, the facility did not ensure that services provided met professional standards of nursing practice. Specifically, a physician's order for Floor Ambulation Program was not implemented by the nursing staff. This was evident for 1 of 24 sampled residents (Residents #9).</p> <p>This resulted in no actual harm with a potential for more than minimal harm.</p> <p>The findings are:</p> <p>Resident #9 has diagnoses of cerebro vascular accident (stroke) and depression. The resident was hospitalized and treated for a urinary tract infection from 12/29/07 -1/09/08. A review of the Interim Physician's Orders Form revealed a telephone order on 1/10/08 to a physical therapist for a "PT Evaluation..." A review of the Physical Therapy Progress Notes dated 1/10/08 revealed that the resident was not a candidate for skilled physical therapy. However, there was a recommendation for "a floor ambulatory program with wheelchair follow with rolling walker for 75 - 100 feet with contact guarding to be incorporated into daily care".</p> <p>A further review of the Interim Physician's Orders Form revealed a telephone order from the</p>	F 281		3/25/08

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 281	Continued From page 1 physician on 1/10/08 for the above ambulation program. A review of the Aides Assignment/Accountability Record from 1/10/08 - 1/30/08 revealed no instructions that this was to be done, nor was there any documented evidence in the nursing notes that this had been attempted.  In an interview with the Registered Nurse/Unit Manager (RN) on 1/29/08 at 12:00PM she confirmed that there were no instructions for the Certified Nurse Aides (CNA) to do this activity and further confirmed that this had not been done. The RN stated that this was an oversight and it would be addressed.	F 281			
F 314 SS=D	415.11(c)(3)(i) 483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility did not ensure that the plan of care was implemented regarding turning and positioning for a resident whose mobility was limited due to a pelvic fracture to help prevent the development of pressure sores. This was evident for 1 of 5 one residents (Resident #2) reviewed for pressure	F 314		3/25/08	

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F 314	<p>Continued From page 2 sores.</p> <p>This resulted in the potential for more than minimal harm.</p> <p>Findings are:</p> <p>Resident #2 is an alert, 81 year old female admitted to the facility on 12/20/07. The resident has diagnoses including osteoporosis, diabetes mellitus and status post pelvic fracture.</p> <p>Review of the Braden Risk Assessment for Pressure Sores dated 12/20/07 revealed that the resident was assessed as being at low risk for developing a pressure sore relating to being occasionally moist and very limited mobility. The Nursing Admission Assessment dated 12/20/07 indicated that the resident's skin upon admission to the facility was intact.</p> <p>The initial comprehensive care plan for "skin integrity" developed on admission, 12/20/07, revealed that the resident was at risk for pressure sores secondary to medical diagnoses (to include diabetes and a pelvic fracture), decline in activities of daily living and incontinence. The interventions to prevent skin breakdown included a turning a positioning program and pressure relief devices for the bed and chair.</p> <p>According to a nurse's progress note on 12/28/07, a Certified Nurse's Aide (CNA) while performing morning cares on that date for the resident noticed that a pressure sore had developed on the resident's sacrum. This nurse's note stated that the ulcer had some black necrotic tissue and was about 1 cm long. However, when the resident was seen on wound rounds on that same</p>	F 314			

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F 314	Continued From page 3 day the pressure sore was assessed as a Stage III and with a measurement of 5.0 cm in length by 1.0 cm in width. (The resident refused to allow her to be observed by the survey team.)  Although the comprehensive care plan noted that the resident should be placed on a turning and positioning program, a review of the December 2007 CNA Assignment/Accountability Record (CNA/AR) revealed no instruction to the CNAs to turn and position the resident. It was not until after the development of the pressure sore that the CNA/AR for January 2008 revealed that the resident was placed on a turning and positioning program.  The Nursing Supervisor on the first floor unit was interviewed on 1/30/08 at 1:00PM regarding the resident's development of this pressure sore. During this interview, he stated that the resident's pressure sore was the result of pressure on the sacrum.  A day staff CNA in an interview on 1/30/08 at 2:00 PM stated that she had provided care to the resident the first week of the resident's admission. This CNA also stated that the resident was usually out of bed and in her wheelchair during most of the day and had a cushion in her wheelchair. She also stated that it would have been necessary to turn and position the resident in bed because of her inability to move independently.	F 314			
F 318 SS=D	415.12(c)(1) 483.25(e)(2) RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318		3/25/08	

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F 318	<p>Continued From page 4</p> <p>with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility did not ensure that a bedfast resident with existing contractures and limited range of motion to bilateral hands/wrists was provided, in accordance with the Comprehensive Plan of Care (CCP), passive range of motion exercises to help prevent further decrease in the range of motion to those joints of the hands/wrists. This was evident for 1 out of 4 residents reviewed for range of motion (Resident #7).</p> <p>This resulted in no harm with potential for more than minimal harm.</p> <p>The findings are:</p> <p>Resident #7 was admitted to the facility on 6/18/07 with diagnoses including diabetes mellitus, seizure disorder, anoxic brain injury (brain disorder resulting from lack of oxygen) resulting from hypoglycemic coma with respiratory failure and medical conditions including a tracheostomy (opening in the throat) with ventilator dependence for breathing and a gastrostomy tube (feeding tube).</p> <p>A review of the MDS (an assessment tool) for June 2007, September 2007 and December 2007 revealed that the resident had been assessed as</p>	F 318		

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F 318	<p>Continued From page 5</p> <p>being severely impaired cognitively, totally dependent on others for all activities of daily living , and was non-ambulatory.</p> <p>A review of the Nurses Notes and Physician Progress Notes for September 2007 through January 2008 revealed that this resident had been experiencing increasing restlessness with constant body movements, periods of physical agitation and combativeness towards staff during cares. According to the 9/8/08 CCPs on resident behavior and restraints the resident was at risk for inadvertently dislodging the tracheostomy tube and attached ventilator tubing due to the residents hands grabbing at and knocking into these devices, potentially causing a medical emergency for this resident's respiratory status.</p> <p>The CCP for problem behavior dated 9/8/07 also indicated that bilateral mitten restraints to the hands were required to assist in preventing the resident from pulling out the tracheostomy apparatus and attached ventilator tubing, as well as the gastrostomy tube in her abdomen. This CCP indicated that these mittens should be removed from both hands every 2 hours and passive range of motion (PROM) was to be provided at those times.</p> <p>Observations on 1/28/08 and 1/29/08 in the AM and PM hours through 1/30/08 in the AM hours respectively, revealed no evidence that the resident's mittens had been removed every 2 hours with passive range of motion (PROM) exercises implemented as was directed in the CCP.</p> <p>Observations on 1/29/08 and 1/30/08 at approximately 11:15 AM revealed the resident</p>	F 318			

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F 318	Continued From page 6 receiving morning cares, a bed bath on 1/29/08 and a shower on 1/30/08 done by 2 CNAs (certified nursing assistants) who regularly provided care for this resident. During this observed bed bath it was noted that the CNA only moved the joints of the fingers/wrists to both hands just enough to wash them with the cloth but did not perform PROM exercises. An interview on 1/29/08 at 11:40 AM with the CNA assigned to care for the resident revealed that this was the first time since her shift had started that day at 7:00 AM that she had removed the mittens. This was done to wash the resident's hands.  A review of the Nurse Aides Assignment/Accountability Record for January 2008 did not reflect that this task had been assigned to the CNA as a procedure that was required to be performed for the resident on a daily basis every 2 hours.  An interview on 1/29/08 at 11:50 AM with the Registered Nurse Unit Manager confirmed that the resident's mittens should be removed every 2 hours with PROM exercises performed and that this was to be done by the CNA assigned to the resident. The RN Manager acknowledged that this information was not reflected on the Nurse Aides Assignment/Accountability Record so that the CNA assigned to the resident would be aware that every 2 hours removal of the hand mittens and PROM was to be done for this resident.	F 318		
F 371 SS=E	415.12 (e) (2) 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and	F 371		3/25/08

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F 371	<p>Continued From page 7</p> <p>serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility did not ensure that refrigerated, high protein, commercially prepared foods would be safe for consumption. This had the potential for more than minimal harm.</p> <p>The findings are:</p> <p>On 1/28/08 at about 9:30 AM during the initial tour of the kitchen the following commercially prepared items were observed opened and undated:</p> <ul style="list-style-type: none"> <li>- Egg salad in a container of about one half gallon, of which over 75 percent was unused</li> <li>- A partially used container of chicken salad with a delivery date of 1/12/08 and an expiration date of 1/28/08</li> <li>- A container of tuna salad with no delivery date and an expiration date of 1/28/08</li> <li>- A gallon container of seafood salad with no delivery date and an expiration date of 2/14/08.</li> </ul> <p>At the time this observation was made the diet technician (DT), who accompanied the surveyor on the tour of the kitchen, was asked about the facility's policy on dating these items to reflect their "open" dates. (The opening of these containers has the potential of reducing the shelf life of the contents.) The DT stated that these items should be discarded 7 days after their "open" date. However, at that time the DT could</p>	F 371			

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F 371	Continued From page 8 not determine when these items should be discarded since no open dates were available.	F 371			
F 441 SS=E	415.14(h) 483.65(a) INFECTION CONTROL  The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.  This REQUIREMENT is not met as evidenced by: Based on observations, review of employee health records and staff interviews conducted during the standard survey, it was determined that the facility did not ensure an effective infection control program designed to prevent the development and transmission of infections. Specifically: 1. Handwashing by a nurse when indicated, was not performed during the medication pass observed for a non-sampled resident. 2. Infection control techniques to promote healing and prevent cross-contamination	F 441		3/25/08	

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F 441	<p>Continued From page 9</p> <p>were not implemented, evidenced during a wound dressing change for Resident #10. 3. Evidence is lacking that 6 of 9 employees were educated and/or offered the influenza vaccine and that 9 of 9 employees were educated regarding the benefits of the pneumococcal vaccine and were given the opportunity to accept or reject this vaccine. This was evident during the review of these employees health records.</p> <p>This resulted in no actual harm with the potential for more than minimal harm.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. During the medication pass on the unit on the first floor on 1/29/08 at 9:05AM the Licensed Practical Nurse (LPN) was observed to check the identification band on a non-sampled resident's arm and, after helping the resident to remove her arm from her sweater, monitored the resident's blood pressure using the communal blood pressure machine. Without decontaminating her hands, the LPN then retrieved 5 medications to give to the resident, potentially contaminating the medication cart.</li> </ol> <p>While taking the medications the resident accidentally dropped a tablet on the floor. The LPN then picked up the tablet and proceeded to the medication cart. Without sanitizing her hands the LPN pulled out the resident's medication again potentially contaminating the medication cart.</p> <p>The LPN was interviewed at this time and stated that she thought that she had sanitized her hands after monitoring the resident's blood pressure. When asked about picking up the medication</p>	F 441			

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F 441	<p>Continued From page 10</p> <p>from the floor, the LPN acknowledged that she should have sanitized her hands before taking the medication from the cart.</p> <p>According to Centers for Disease Control (CDC) hands should be decontaminated after contact with a patient's intact skin (e.g. when taking a pulse or blood pressure).</p> <p>2. Resident #10 has ulcers at base of the left great toe, the second and fourth toes and the left foot toe base. During a wound dressing change for the resident on 1/29/08 at 11:40AM the Registered Nurse (RN) was observed to wash her hands and apply gloves before removing the soiled dressing from the resident's foot. Then using the same contaminated gloves the RN used 4 x 4 gauze pads soaked in normal saline to cleanse all the ulcers, potentially cross-contaminating all the ulcers. The RN then dabbed all the ulcers with the same dry gauze pads, again potentially cross-contaminating the different ulcers.</p> <p>The RN was interviewed at this time and acknowledged that she did not change her gloves or wash her hands after removing the soiled dressing. (This is not in accordance with facility policy.) She also acknowledged that all the ulcers had been touched with the same gauze during the cleansing and drying of the ulcers.</p> <p>CDC recommendations are to decontaminate hands after contact with soiled dressings and after removing gloves.</p> <p>3. The facility's infection control policy includes the education of all employees on the the benefit of receiving the influenza and pneumococcal</p>	F 441		

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F 441	Continued From page 11 vaccine and giving all the staff the option to accept or refuse these vaccines. A review of health records of nine employee health records who worked at the facility December 2007 and January 2008 revealed there was no documentation of education and/or evidence of employees being offered the pneumococcal vaccine. Additionally, of the nine records reviewed only 3 of these employees had documented evidence that they were educated and offered the influenza vaccine.  In an interview with the administrator on 1/30/08 at 4:00 PM, she stated that the employee health department was not able to verify or produce documented evidence that these employees were either educated and/or received or declined the pneumococcal or influenza vaccine.	F 441		
F 465 SS=C	415.19(a)(1-3) 483.70(h) OTHER ENVIRONMENTAL CONDITIONS  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure that a safe and comfortable environment is provided for residents and staff in that 7 of 11 night lights in residents rooms tested on two of two nursing units did not work and three of six ducts inspected on two of two nursing units were in the "closed" position.  This resulted in no actual harm with potential for	F 465		3/25/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>335829</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/30/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL MALOTZ SKILLED NURSING PAVILLION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>120 ODELL AVENUE YONKERS, NY 10701</b>		
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F 465	<p>Continued From page 12 minimal harm.</p> <p>Findings are (not all-inclusive):</p> <p>On 1/30/08 between 12:05 PM and 2:45 PM during environmental and life safety rounds the following conditions were observed:</p> <ol style="list-style-type: none"> <li>1. When tested night lights in resident rooms did not work. Examples include Room #231; 230; 226; 228; 127; 106, and 107.</li> <li>2. Ducts passing through the smoke barrier walls were found to be in the " closed " position when they should have been opened. This would prevent the circulation of air. Examples include: <ol style="list-style-type: none"> <li>a. Duct above the smoke barrier door - 2nd floor "High" side.</li> <li>b. Duct above the smoke barrier door - 1st floor "High" side.</li> <li>c. Duct above the smoke barrier door - 1st floor "Low" side.</li> </ol> </li> </ol> <p>In an intterview on 1/30/08 at 2:15 PM, the Director of Housekeeping acknowledged these observations.</p> <p>10NYCRR 415.29</p>	F 465			

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K 000	INITIAL COMMENTS	K 000		
K 062 SS=C	<p>42 CFR 483.70(a): The facility must meet the applicable provisions of The 2000 Edition of The Life Safety Code (LSC) of The National Fire Protection Association (NFPA).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: 2000 NFPA 101 Life Safety Code Chapter 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.1 Automatic Sprinklers. 9.7.1.1- Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>1999 NFPA 13, Standard for Installation of Sprinkler Systems Chapter 12 System Inspection, Testing, and Maintenance 12-1 General. A sprinkler system installed in accordance with this standard shall be properly</p>	K 062		2/29/08

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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K 062	<p>Continued From page 1</p> <p>inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.</p> <p>1998 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems</p> <p>Chapter 2 Sprinkler Systems 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>1999 NFPA 25 Chapter 2-2.1.1 Sprinklers - Sprinklers shall be inspected from the floor level annually.</p> <p>Chapter 9 Valves, Valve Components, and Trim 9-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Based on record review and interview, the facility did not ensure that the required automatic sprinkler system is continuously maintained in reliable operating condition in that the system is only inspected once a year instead of quarterly as per NFPA 25.</p>	K 062			

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K 062	<p>Continued From page 2</p> <p>This resulted in no actual harm with potential for minimal harm.</p> <p>REPEAT DEFICIENCY</p> <p>Findings are:</p> <p>On 1/30/08 at 11:30 AM, during record review it was determined that although the sprinkler system was scheduled to be inspected on a quarterly basis, the system was only inspected once since 6/12/07.</p> <p>Review of the Plan of Correction (POC) for K-062 deficiency cited during the 04/12/07 survey, revealed that quarterly inspection of the sprinkler system would be conducted. As stated above, the sprinkler system was not tested quarterly and no documentation was provided showing that the POC was followed.</p> <p>In an interview on 1/30/08 at 12:30 PM, the Administrator acknowledged this observation and produced documentation indicating that it was an oversight due to administrative and personnel changes.</p> <p>2000 NFPA 101; 19.3.5, 9.7.1 1999 NFPA 13; 12-1 1998 NFPA 25; 2-1 10 NYCRR 711.2 NYCRR 415.29</p>	K 062			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 335829	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 4/1/2008
<b>Name of Facility</b> MICHAEL MALOTZ SKILLED NURSING PAVILLION		<b>Street Address, City, State, Zip Code</b> 120 ODELL AVENUE YONKERS, NY 10701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC _____	Correction Completed <u>03/25/2008</u>	ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed <u>03/25/2008</u>	ID Prefix <u>F0318</u> Reg. # <u>483.25(e)(2)</u> LSC _____	Correction Completed <u>03/25/2008</u>
ID Prefix <u>F0371</u> Reg. # <u>483.35(i)(2)</u> LSC _____	Correction Completed <u>03/25/2008</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65(a)</u> LSC _____	Correction Completed <u>03/25/2008</u>	ID Prefix <u>F0465</u> Reg. # <u>483.70(h)</u> LSC _____	Correction Completed <u>03/25/2008</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 1/30/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

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ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <b>K0062</b>	Correction Completed <b>03/25/2008</b>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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