STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335023	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Holly Patterson Extended Care Facility	875 Jerusalem Avenue Uniondale, NY 11553

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/26/2024 and completed on 4/2/2024 the facility did not ensure that each resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of their quality of life. This was identified for two (Resident #134 and Resident#192) of three residents reviewed for dignity. Specifically, during a lunch meal observation on 3/26/2024 two staff members were observed standing over Resident #134 and Resident #192 while they assisted the residents with eating. The findings are: The facility's policy titled, Meal Pass documented to provide dignified care to residents during the meal pass. 1) Resident #134 was admitted with diagnoses that included Cerebral Vascular Accident (stroke), Dementia, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented the Brief Interview for Mental Status score was 11, which indicated the resident had moderately impaired cognition. The resident required setup or clean-up assistance for meals. The Comprehensive Care Plan for Activities of Daily Living initiated on 8/18/2023 and updated on 11/9/2023 documented Resident #134 needed setup or clean-up assistance with eating and was able to feed themself. During the Dining Task observation conducted on Unit 14 during the lunch meal on 3/26/2024 from 12:24 PM to 12:56 PM Resident #134 was observed being fed their yogurt by Certified Nursing Assistant #2, who was standing over the resident. Certified Nursing Assistant #2 was interviewed on 3/26/2024 at 2:16 PM and stated Resident #134 needed encouragement to eat and before they (Certified Nursing Assistant #2) removed the tray they wanted to encourage Resident #134 to eat a little more yogurt. Certified Nursing Assistant #2 stated Resident #134 normally eats independently once the tray is set up. Certified Nursing Assistant #2 stated they should have sat down next to Resident #134 while they assisted the resident with completing their meal. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #4 was interviewed on 3/26/2024 at 2:29 PM. Registered Nurse #4 stated a staff person assisting a resident with their meal should be seated next to the resident. Registered Nurse #4 stated a staff person is expected to sit and interact with the resident in order to maintain the resident's dignity and quality of life. The Director of Nursing Services was interviewed on 3/26/2024 at 3:48 PM. The Director of Nursing Services stated a staff person is expected to sit next to and interact with the resident while assisting with a meal in order to maintain the resident's dignity and quality of life. The Director of Nursing Services stated they reviewed the Meal Pass policy, and the policy did not explicitly indicate that staff should sit next to the resident while assisting with meals. Resident #134 was interviewed on 3/28/2024 at 11:31 AM. Resident #134 stated they were able to eat independently; however, they sometimes felt weak and the staff assisted them with eating. Resident #134 could not recall if the staff normally sat next to them during that time. 2) Resident #192 was admitted to the facility with diagnoses that included Cerebral Vascular Accident (stroke), Dementia, and Left Hemiparesis (weakness). The resident required setup or clean-up assistance for meals. The Comprehensive Care Plan for Activities of Daily Living initiated on 8/30/2023 and updated on 11/23/2023 documented Resident #192 needed setup or clean-up assistance with eating and was able to feed themself. During the Dining Task observation conducted on Unit 14 during the lunch meal on 3/26/2024 from 12:24 PM to 12:56 PM Resident #192 was observed being fed their sherbet by Certified Nursing Assistant #3, who was standing over the resident. Certified Nursing Assistant #3 was interviewed on 3/26/2024 at 2:23 PM. Certified Nursing Assistant #3 stated Resident #192 normally did not require assistance with eating once their meal tray was set up. Certified Nursing Assistant #3 stated Resident #192 does not have use of their left hand but was able to use a utensil in their right hand. Certified Nursing Assistant #3 stated they normally sit next to a resident who requires total assistance with eating but during the lunch meal, they (Certified Nursing Assistant #3) wanted to encourage Resident #192 to eat a little bit more before they (Certified Nursing Assistant #3) removed Resident #192's tray. Certified Nursing Assistant #3 stated they should have been seated next to Resident #192 when they assisted the resident with their sherbet. Certified Nursing Assistant #3 understood it was a dignity concern and they would normally sit next to a resident they were assisting with a full meal. Registered Nurse #4 was interviewed on 3/26/2024 at 2:29 PM. Registered Nurse #4 stated a staff person assisting a resident with their meal should be seated next to the resident. Registered Nurse #4 stated a staff person is expected to sit and interact with the resident in order to maintain the resident's dignity and quality of life. The Director of Nursing Services was interviewed on 3/26/2024 at 3:48 PM. The Director of Nursing Services stated a staff person is expected to sit next to and interact with the resident while assisting with a meal in order to maintain the resident's dignity and quality of life. The Director of Nursing Service stated they reviewed the Meal Pass policy, and the policy does not explicitly indicate that staff should sit next to the resident while assisting with meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #192 was interviewed on 3/28/2024 at 11:38 AM. Resident #192 stated they did not like to be fed because it made them feel worse than they really were. Resident #192 stated their left hand is in a brace due to a stroke and their right hand sometimes shakes. Resident #192 stated on days when their right hand shakes more than normal they required assistance with eating and could not recall if staff sat next to them or stood over them. 10 NYCRR 415.3(d)(1)(i)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/26/2024 and completed on 4/02/2024, the facility did not ensure that each resident received services in the facility with reasonable accommodation of resident needs including ensuring that the resident has a call system within reach and is able to use it if desired. This was identified for one (Resident #233) of one resident reviewed for the Environmental Task. Specifically, Resident #233 was observed lying in a Geri chair in their room on 3/26/2024 at 10:15 AM, 3/26/2024 at 2:39 PM, and on 3/28/2024 at 9:46 AM. The call bell was observed on the floor on each occasion and was not within the resident's reach. The finding is: The facility's policy titled, Call Bells/Call Bell Audit revised in April 2023, documented the call bell must always be accessible to the resident. Resident #233 was admitted with diagnoses that included Cerebral Infarction, Pulmonary Embolism, and Tachycardia. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 00 which indicated the resident had severe cognitive impairment. The Minimum Data Set assessment documented the resident had a range of motion impairment to both upper extremities. The Comprehensive Care Plan for Falls dated 2/28/2024 documented to keep the call bell within the resident's reach. The Comprehensive Care Plan for Potential for Injuries dated 3/07/2024 documented to place the call bell within reach of the resident. During an observation on Unit 21 on 3/26/2024 at 10:15 AM and again on 03/26/2024 at 2:39 PM, Resident #233 was lying in a [NAME] chair in their bedroom with no call bell within their reach. The call bell was observed on the floor on both occasions. Resident #233 was not able to be interviewed. On 03/27/2023 at 11:03 Certified Nursing Assistant #5 was observed finishing their care with Resident #233 and placing the call bell on her blanket within reach. During an observation on 3/28/2024 at 9:46 AM the surveyor walked with Registered Nurse #1, the Charge Nurse, into Resident#233's room. The resident was resting in their bed. The curtain was drawn halfway around the bed and the resident was not visible from the room door. The call bell was on the floor. Registered Nurse #1, the Charge Nurse, cleaned and placed the call bell in the resident's hand. Registered Nurse #1 asked the resident if they could press the call bell. The resident stated Yes but did not press the call bell. On 3/27/2024 at 11:04 AM, Certified Nursing Assistant#5 was interviewed and stated that every resident must always have access to a call bell. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #1 was interviewed on 3/28/2024 at 9:46 AM and stated Resident #233 sometimes uses the call bell. Registered Nurse #1 stated the call bell should be accessible to the resident when the resident is in their room. The Director of Rehabilitation Services was interviewed on 3/29/2024 at 8:47 AM and stated that Resident #233 receives occupational and speech-language pathology services. Resident #233 will be evaluated today for the ability to use the call bell. Licensed Practical Nurse #4 was interviewed on 3/29/2024 at 10:00 AM and stated Resident #233 was evaluated today by an Occupational Therapist and the resident was unable to use a call bell and therefore now will be monitored frequently. Once the physician's order to monitor the resident is obtained the Certified Nursing Aide Accountability record will be updated to reflect the enhanced monitoring schedule. The Director of Nursing Services was interviewed on 4/01/2024 at 8:29 AM and stated if the residents cannot use the call bell, they should be evaluated for an alternate means to alert staff if they need assistance. The use of a tap bell is an alternative to the regular call bell. For those residents who cannot use any call bell, the call bell will still be kept within reach for the resident and any of the resident's visitors. The Director of Nursing Services further stated that staff should monitor those residents who cannot use the call bell system and Resident #233 should have been assessed upon admission for their ability to use the call bell system. 10 NYCRR 415.5 Euro(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on record review and interviews during the Recertification Survey initiated on 3/26/2024 and completed on 4/2/2024, the facility did not ensure a person-centered comprehensive care plan was reviewed and revised to address each resident's needs. This was identified for one (Resident #252) of one resident reviewed for care planning care area out of 40 total sampled residents. Specifically, there was no documented evidence that the comprehensive care plans for Resident #252 were reviewed and revised upon the quarterly Minimum Data Set assessment dated [DATE]. The finding is: The facility's policy and procedure titled, Care Planning last reviewed 2/2024, documented to ensure the accurate and timely completion of the Minimum Data Set, Care Area Assessment, and Comprehensive Care Plan for all residents. Procedure 1.0.3 documented the care plan will be reviewed and revised to reflect the resident's current condition per policy and regulation. Procedure 1.0.11 documented it is the responsibility of the clinical team to ensure that care plans are updated according to specified time frames and the resident response to goals, interventions, and changes in condition must be updated as well. Resident #252 was admitted diagnosis of Cerebral Infarction. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact. The resident required setup assistance for eating and bed mobility, and supervision for toileting and transfer. The resident participated in the assessment. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact. The resident required setup assistance for eating and bed mobility, and supervision for toileting and transfer. The resident participated in the assessment. A record review revealed multiple Comprehensive Care Plans (such as, but not limited to dementia, dental, vision, communication, and pain) with an onset date of 8/4/2023, last revised 10/27/2023, were not reviewed and/or revised in accordance with the Minimum Data Set assessment schedule. There was no documented evidence that the comprehensive care plans were reviewed and/or revised when the quarterly Minimum Data Set assessment was completed on 1/19/2024. Registered Nurse #11 was interviewed on 4/1/2024 at 9:55 AM and stated that all Registered Nurses and Nursing Supervisors, on any shift can initiate, update, and review care plans. Registered Nurse Supervisor #6 was interviewed on 4/1/2024 at 10:04 AM and stated that any Registered Nurse on the unit can update a care plan. The Director of Nursing Services will also assign some nurses familiar with the process to review and revise the care plans. Registered Nurse Supervisor #6 stated that care plans are updated every time there is a change in the resident's condition, such as a medical order; and reviewed and revised quarterly, with the Minimum Data Set schedule. Registered Nurse Supervisor #6 stated nursing supervisors are responsible for ensuring that residents' care plans are initiated and updated timely. Registered Nurse Supervisor #6 stated they were not aware that the care plans for Resident #252 were not updated when the quarterly Minimum Data Set assessment was completed on 1/19/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Registered Nurse Minimum Data Set Coordinator was interviewed on 4/1/2024 at 2:41 PM and stated that they complete the Minimum Data Set assessments but have nothing to do with the care plans. The Registered Nurse Minimum Data Set Coordinator further stated that the Director of Nursing Services assigns the Nursing Supervisors to initiate and update the care plans in accordance with the Minimum Data Set schedule. The Director of Nursing Services was interviewed on 4/1/2024 at 2:46 PM and stated that the Nurse Manager and Nursing Supervisors are responsible to review and update residents' care plans. The care plans are supposed to be updated whenever there is a change in the resident's condition or when a change in the resident's treatment plan occurs such as new physician orders, etc. The Director of Nursing Services stated that if there are no changes in the resident's plan of care then the staff are supposed to review the care plans in accordance with the Minimum Data Set schedule. The Director of Nursing Services stated that the care plans for Resident #252 should have been updated with the 1/19/2024 Minimum Data Set assessment schedule. 10 NYCCR 415.11(c)(2)(i-iii)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on record review and staff interviews during the Recertification and Abbreviated Survey (Complaint #NY00314085) initiated on 3/26/2024 and completed on 4/2/2024, the facility did not ensure that each resident's environment remains free of accident hazards as is possible. This was identified for two (Resident #42 and #159) of eight residents reviewed for accidents. Specifically, 1) on 4/4/2023 Resident #42 fell out of the mechanical lift when the mechanical lift sling pad loops got detached from the mechanical lift's sling bar hook. The mechanical lift used for the resident's transfer was missing the safety latches (clips), which were supposed to hold the mechanical lift sling pad loops in place, on the mechanical lift's sling bar hook. Certified Nursing Assistant #14, who was assisting with the resident's transfer, was aware of the missing safety latches and continued with transferring the resident from the bed to the wheelchair. Subsequently, the resident was transferred to the hospital and was diagnosed with a Right Humerus (upper arm bone) Fracture. 2) Additionally, Resident #159 was observed on 3/26/2024 with one medication capsule (Neurontin 100 milligrams) in a medication cup on their overbed table with no staff member in the vicinity. The resident was not assessed to self-administer their medication and did not have a physician's order to self-administer medications. This resulted in actual harm to Resident #42 that is not Immediate Jeopardy. The findings are: 1) Resident #42 was admitted with diagnoses that included Cerebral Vascular Accident with Right Hemiplegia (paralysis of one side of the body), and Osteoarthritis (degenerative joint disease). The annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 11 which indicated the resident had moderately impaired cognition. The resident had no behavior problems and required extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. The facility policy and procedure dated 10/11/2023 for Management of Essential Equipment Malfunction documented to replace and sequester the malfunctioning equipment without interruption to patient care. In the event of malfunctioning of a medical device and or injuries sustained to a patient caused by equipment, the device must be sequestered, labeled with an appropriate tag describing the malfunction, and sent to the Medical Electronics Department. The facility policy and procedure for Application and Use of Transfer Sling revised 10/2022 documented that at least two staff members are needed to transfer a resident using a mechanical lift, the nursing staff will ensure resident safety during transfer procedures and inspect the (mechanical lift) for functionality prior to use for safety. The undated instruction manual for the mechanical lift, under the safety instruction section, documented that before lifting always make sure that accessories are not damaged, the lifting accessory is correctly attached to the lift; the latches are intact; missing or damaged latches must always be replaced; and that the sling's strap (pad) loops are correctly connected to the sling bar hooks when the sling straps are stretched up but before the patient is lifted from the underlying surface. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Comprehensive Care Plan for activities of daily living dated 2/23/2023 documented interventions that included but were not limited to provide total assistance of two staff members for transfers via a mechanical lift. A Comprehensive Care Plan for falls dated 2/23/2023 documented interventions included but were not limited to transfer the resident out of bed to a wheelchair via a mechanical lift. A review of the Certified Nursing Accountability Record dated 3/2023 documented the resident required the use of a mechanical lift and two staff members for transfers. A nursing progress note dated 4/4/2023 documented the resident was alert, verbally responsive, and able to make needs known. The resident sustained a fall during the transfer and complained of right shoulder pain. The resident's physician was notified and visited the resident. Tylenol (pain medication) 1000 milligrams was administered as per the physician's order. The resident was transferred to the hospital for further evaluation. A medical progress note dated 4/4/2023 documented the resident fell during transfer and complained of right arm and right shoulder pain. There was a decreased passive range of motion causing severe pain. Tylenol Extra Strength was ordered for pain and the resident was sent to the emergency room for further evaluation. A physician's order dated 4/4/2023 documented to administer Tylenol 500 milligram, give 2 tablets by mouth one time only for right shoulder pain. A physician's order dated 4/4/2023 at 12:52 PM documented to transfer the resident to the emergency room , Status Post fall. The Hospital Radiology Report dated 4/4/2023 documented a fracture of the right humerus. The Hospital Orthopedic Consult and Recommendation dated 4/4/2023 documented the Computerized Tomography (CT) scan of the right shoulder showed there was a right humerus fracture. The plan included no weight bearing to the right upper extremity; to place a sling to the right upper extremity; and pain control. The Accident and Incident Report dated 4/4/2023 documented that at 11:15 AM the resident sustained a fall during transfer and the resident was transferred to the emergency room for complaint of pain to the right shoulder and right elbow. The resident was unable to describe the occurrence and stated, I fell . A nursing admission note dated 4/6/2023 at 2:00 PM documented the resident was readmitted to the facility status post fall with diagnoses of humerus fracture and Urinary Tract Infection (UTI). The resident had a right arm sling status post fracture and required extensive assistance for all activities of daily living and three staff members' assistance with the mechanical lift transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Accident and Incident Summary dated 4/10/2023 documented a demonstration of the procedure which was performed with the two involved Certified Nursing Assistants shortly after the occurrence revealed a missing metal closure clip (latch) on the right hook of the mechanical lift. The mechanical lift was removed from the unit for further inspection and repair. The team analyzed the root causes of the event; any equipment with missing parts or malfunctioning should have been removed from the unit and reported immediately for maintenance; there was a need to reinforce with staff to ensure the attachment of mechanical lift pad loops onto the hooks and that the staff is using the right size sling. A Work Order Sheet dated 4/13/2023 documented that a full service was completed for the Unit 24 Electrical Patient Lift (mechanical lift) and both missing safety clips were replaced for the sling bar. Registered Nurse #11, who was on duty on 4/4/2023 and responded to the accident, was interviewed on 3/28/2024 at 9:14 AM. Registered Nurse #11 stated they were outside a resident's room when they heard Certified Nursing Assistant #15 calling for assistance. Registered Nurse #11 stated they ran to the room and observed Resident #42 on the floor between the legs of the mechanical lift. Registered Nurse #11 stated they assessed the resident who complained of right arm pain and was transferred to the hospital. Registered Nurse #11 stated they spoke with Certified Nursing Assistant #14 and Certified Nursing Assistant #15, who reported the right side of the safety latch was missing from the mechanical lift sling bar where the mechanical lift sling pad loops came off. Registered Nurse #11 stated maintenance was called, and the mechanical lift sling bar hook was fixed. Registered Nurse #11 was re-interviewed on 4/1/2024 at 9:17 AM and stated they were not aware the safety latches were missing from the sling bar until after Resident #42 fell from the mechanical lift. Registered Nurse #11 stated Certified Nursing Assistants were responsible for checking the mechanical lift before they used the machine and if a problem was identified they were to report the issue to the unit nurses immediately. Registered Nurse #11 stated a sticker should be placed on the machine indicating the machine is out of order and the mechanical lift is then removed from the unit. Registered Nurse #11 stated when they were examining the mechanical lift, they observed that one of the safety latches were missing. Registered Nurse #11 stated they could not recall if the safety latch was missing on both sides. An attempt to call Certified Nursing Assistant #15 on 3/27/2024 at 3:07 PM was made; however, the staff member was out of the country on vacation and would not be available until 4/3/2024 as reported by the Director of Nursing Services. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A re-enactment observed by the surveyor was completed on 3/28/2024 at 8:15 AM with Certified Nursing Assistant #14 who had assisted with Resident #42's transfer on 4/4/2023. Certified Nursing Assistant #14 demonstrated that they were on one side of Resident #42 and the assigned Certified Nursing Assistant #15 was on the other side of Resident #42. Certified Nursing Assistant #14 stated they attached the mechanical lift sling pad loops to the hook of the mechanical lift sling bar on their side and the assigned Certified Nursing Assistant #15 attached the mechanical lift sling pad loops on their side. Certified Nursing Assistant #14 stated that assigned Certified Nursing Assistant #15 was controlling the mechanical lift and lifted the resident off the bed without a problem. Certified Nursing Assistant #14 stated just before Certified Nursing Assistant #15 began to lower the resident onto the wheelchair, they (Certified Nursing Assistant #14) observed that one of the mechanical lift sling pad loops came off the mechanical lift sling bar hook, and the resident slid out of the mechanical lift sling pad onto the floor between the legs of the mechanical lift. Certified Nursing Assistant #14 stated the safety latch was missing from the right side of the mechanical lift sling bar and that the safety latch keeps the mechanical lift sling pad loops in place and prevents the mechanical lift sling pad loops from coming off the hook. Certified Nursing Assistant #14 was interviewed on 3/28/2024 at 8:34 AM and stated during Resident #42's mechanical lift transfer on 4/4/2023, when Certified Nursing Assistant #14 was hooking up the mechanical lift sling pad loops, they noticed the safety latch was missing; however, continued using the mechanical lift. Certified Nursing Assistant #14 stated they did not switch the mechanical lift because the second mechanical lift available on the unit was in use. A subsequent interview was conducted with Certified Nursing Assistant #14 on 4/1/2024 at 9:10 AM. Certified Nursing Assistant #14 stated both safety latches on the mechanical sling bar were missing for a long time and they have been using the mechanical lift without the safety latches. Certified Nursing Assistant #14 could not recall how long the safety latches on the mechanical lift had been missing. Certified Nursing Assistant #15's written statement, dated 4/4/2023, documented that while transferring Resident #42 with the mechanical lift, they noticed one of the loops (right top one) fell off. Certified Nursing Assistant #14 and Certified Nursing Assistant #15 tried their best to lower the patient. An interview was conducted on 3/28/2024 at 10:19 AM with the Medical Electronic Technician (maintenance employee) who was responsible for servicing the mechanical lift and other medical equipment. The Medical Electronic Technician stated the mechanical lift that was used for Resident #42 was last serviced on 7/1/2022. All the mechanical lifts are checked annually and as needed. The Medical Electronic Technician stated after the resident's fall, they were informed by the Director of Environmental Services that the safety clips were missing. The Medical Electronic Technician stated when they checked the mechanical lift sling bar, both safety clips were missing and on 4/13/2023 both safety clips were replaced. The Medical Electronic Technician stated they were not notified of the missing safety latches prior to the resident's fall. The Medical Electronic Technician stated if the nursing staff observed missing parts or that the machine was not functioning properly, nursing staff were supposed to email their department (Medical Electronic) The Medical Electronic Technician stated that the safety latch on the mechanical lift functions to keep the mechanical lift sling pad loops from slipping off of the mechanical lift sling bar hooks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with Resident #42's physician, who was on duty on 4/4/2023, was conducted on 4/1/2024 at 9:52 AM. The physician stated they assessed Resident #42 after the resident fell from the mechanical lift on 4/4/2023. The physician stated that the resident complained of severe pain to the right arm and was sent to the emergency room . The physician stated the pain in the resident's right arm was related to a fracture which was directly related to the fall from the mechanical lift. The Registered Nurse Risk Manager was interviewed on 4/1/2024 at 10:16 AM and stated on 4/4/2023 they were on the resident's unit and when they got to the resident's room the resident was already back in bed; however, the mechanical lift was still in the resident's room. The Registered Nurse Risk Manager stated the safety latch on the right side of the sling bar hook was missing. The Registered Nurse Risk Manager stated that Certified Nursing Assistant #14 and Certified Nursing Assistant #15 informed them the mechanical lift safety latch was missing prior to the use of the mechanical lift for Resident #42. The Registered Nurse Risk Manager stated the staff should not have used the mechanical lift as the safety latch was missing. The Registered Nurse Risk Manager stated the staff should have immediately reported the faulty mechanical lift issue to the charge nurse. The Inservice Coordinator was interviewed on 4/1/2024 at 10:45 AM and stated all Certified Nursing Assistants receive training on the use of the mechanical lift transfer and then a competency is completed at least yearly, and as needed. The Inservice Coordinator stated if the Certified Nursing Assistants observe any malfunction that prevents the machine from functioning as designed, then the Certified Nursing Assistants should report the malfunction to the unit Registered Nurse in charge or the Supervisor. The Inservice Coordinator stated the staff should not have used the mechanical lift to transfer Resident #42 if the safety latch was missing. The Director of Nursing Services was interviewed on 4/1/2024 at 11:36 AM and stated they expected the staff to inspect the equipment before use and if there was something wrong with the equipment, or if the equipment was broken, the staff should have reported the issue to the unit nurses, and the equipment should have been immediately removed from the unit. The Director of Nursing Services stated the staff should not have used the mechanical lift knowing the safety latch was missing. The Director of Nursing Services stated Resident #42 sustained a fracture due to a fall from the mechanical lift. The Director of Nursing Services stated after the Registered Nurse Risk Manager completed the investigation, the mechanical lift was taken out of service on 4/4/2023. 44963 2) Resident #159 was admitted with diagnoses that included Peripheral Autonomic Neuropathy (when there is damage to the nerves that control automatic body functions this can affect the blood pressure or temperature control), End Stage Renal Disease, and Seizures. The Annual Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 3 which indicated severely impaired cognition. The Minimum Data Set assessment documented the resident was usually able to understand others. The facility's policy titled, Medication Administration last reviewed 3/2024 documented that medications are never left at the bedside. The unit nurse must watch the resident take the medications. Directly Observed Therapy is required by the nurse when administering medication. Visualization of the oral cavity by a resident's tongue sweep after the resident has taken a dose of medication is required to verify that it (the medication) has been swallowed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A physician's order dated 10/8/2023 documented to administer Neurontin 100 milligram (mg), 1 capsule by mouth three times a day for Peripheral Autonomic Neuropathy. A Seizure Activity Comprehensive Care Plan dated 2/21/2024 documented the resident has potential for seizure activity related to Seizure disorder. Interventions included but were not limited to administer anticonvulsant(s) as per the physician's order. Resident #159 was interviewed on 3/26/2024 at 2:30 PM. Resident #159 was observed in bed and alert. A medication cup containing one white dry capsule was observed on the resident's overbed table within the resident's reach. Resident #159 was unable to name the medication and did not know how long the medicine had been there on the overbed table. There was no staff member present in the resident's room. The medication was observed in Resident #159's room accompanied by Registered Nurse #7 at 2:35 PM. Registered Nurse #7 stated that the medication in the cup was a Neurontin 100 milligram capsule that they (Registered Nurse #7) had administered to Resident #159 approximately ten minutes ago. Registered Nurse #7 stated they observed Resident #159 put the medicine in their (Resident #159) mouth. Registered Nurse #7 stated they were then called away to see another resident on the unit and left the resident with the empty medication cup and their nutrition supplement. Registered Nurse #7 stated they assumed the resident had swallowed the medicine but did not ask the resident to open their mouth to check. Licensed Practical Nurse #6 was interviewed on 3/28/2024 at 1:39 PM. Licensed Practical Nurse #6 stated that they were the regularly assigned day (7:00 AM-3:00 PM) shift nurse on the unit where Resident #159 resided; however, they did not work on that unit on 3/26/2024. Licensed Practical Nurse #6 stated they regularly administered medications and Resident #159 required a lot of encouragement to take their (Resident #159) medication. Licensed Practical Nurse #6 stated they have never observed Resident #159 with any noncompliant behaviors. Licensed Practical Nurse #6 stated Resident #159 cannot take medications on their own and there was no reason for the medication to be left unattended with the resident. Registered Nurse #8 was interviewed on 3/29/2024 at 1:44 PM and stated that they were the regularly assigned evening (3:00 PM-11:00 PM) shift nurse on the unit where Resident #159 resided. Registered Nurse #8 stated they regularly administered medications to Resident #159 who required verbal prompts to take their medications. Registered Nurse #8 stated they have never observed Resident #159 with any noncompliant behaviors. Registered Nurse #8 stated Resident #159 cannot take medications on their own and the nurses should not leave any medicine with the resident unless the resident was assessed for self-administration. The Director of Nursing Services was interviewed on 3/29/2024 at 3:12 PM and stated that the nurse who administered medications to Resident #159 should have ensured the medications were swallowed by the resident. The Director of Nursing Services stated that Resident #159 was not allowed to self-administer their medication and therefore the medication should not have been left unattended by Resident #159's bedside. 10 NYCRR 415.12(h)(1)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/26/2024 and completed on 4/2/2024, the facility did not ensure that a resident who is fed by enteral means receives the appropriate treatment, care, and services to prevent complications of enteral feeding. This was identified for one (Resident #184) of three residents reviewed for Tube Feeding. Specifically, on 3/26/2024 at 10:30 AM and 3/27/2024 at 8:00 AM Resident #184's tube feeding bottle was observed hanging on a feeding tube stand without a label including the resident's name, and the time the tube feeding was initiated. The finding is: The facility's Policy and Procedure titled; Enteral Tube Feeding last revised 10/2023 documented that the tube feeding preparation will be administered as per the physician's order to meet the nutritional needs of the resident. The feeding bottle must be labeled with the resident's name and the administrating nurse's initial, date, and time of administration. Resident #184 was admitted with diagnoses that included Respiratory Failure, Osteomyelitis (bone infection), and Type II Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] documented that the resident's Brief Interview for Mental Status (BIMS) score was 99 which indicated the resident had severely impaired cognition. Resident #184 required one-person assistance with all Activities of Daily Living (ADL). The Minimum Data Set documented the resident required a feeding tube to meet the total calories per day. The Comprehensive Care Plan (CCP) for tube feeding dated 1/9/2024 documented interventions to assess for patency and proper placement of the tube, and ensure the head of the bed is elevated at 45 degrees during feeding and one-hour post feeding. The Physician's order dated 2/20/2024 documented to administer Jevity 1.5 Cal (a fiber-fortified, high-nitrogen liquid tube feeding formula, suitable for supplemental or sole source of nutrition) at 95 milliliters per hour continuously. Water flush of 120 milliliters before and after each feeding. During an observation on 3/26/2024 at 10:30 AM, Resident #184 had an enteral feeding bottle hanging from the feeding tube stand. The enteral bottle did not have a label that indicated the resident's name, the time feeding was started, and the feeding directions as prescribed by the physician. In a subsequent observation on 3/27/2024 at 8:00 AM, Resident #184 had an enteral feeding bottle hanging from the feeding tube stand. The enteral bottle did not have a label that indicated the resident's name, the time feeding was started, and the feeding directions as prescribed by the physician. Licensed Practical Nurse #1 was interviewed on 3/27/2024 at 8:00 AM and stated they did not notice that Resident #184 did not have a label on their enteral feeding bottle. Licensed Practical Nurse #1 stated they should have checked the bottle to ensure a label was in place. Resident #184 receives continuous feeding and they (Licensed Practical Nurse #1) were concentrating on the medication administration and forgot to check the enteral feeding label. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #5 was interviewed on 3/28/2024 at 2:03 PM and stated that they always check the label on the enteral bottle before administering the enteral feeding. All enteral feeding bottles are received from the kitchen. The nurses are responsible for ensuring that labels on the enteral feeding bottles are in place with the correct name of the resident and the amount to be administered as per the Physician's order. The Director of Nutrition and Food Services was interviewed on 4/1/2024 at 8:00 AM and stated that the process of labeling for all enteral bottles starts from the kitchen. Once they receive the order for enteral feeding, one of the nutritionists will provide a label with the resident's name, room number, direction for enteral feeding, date, and the name of the Physician who ordered the enteral feeding. All enteral feeding bottles are supplied to each resident unit with the correct label. The kitchen staff delivers the enteral bottles early in the morning. The Director of Nutrition and Food Services stated they did not know why Resident #184's enteral feeding bottle was not labeled. The Director of Nursing Services was interviewed on 4/1/2024 at 8:19 AM and stated that all nurses must follow the protocol for Tube Feeding which includes labeling the tube feeding bottle with the resident's name, and the direction for enteral feeding administration as per the physician's orders. The Director of Nursing services stated they expected the nurses to ensure that the enteral bottle had a proper label before starting the enteral feeding. 10 NYCRR 415.12(g)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/26/2024 and completed on 4/2/2024, the facility did not ensure that drug records were in order and accounted for all controlled drugs. This was identified on three (Unit 21, Unit 22, and Unit 31) of 13 nursing units. Specifically, during the medication storage task observations on Unit 21, Unit 22, and Unit 31, the Controlled Substance Administration Record form was not reconciled to reflect the available controlled medications in the medication blister pack for Resident #35 (Unit 21), Resident #221 (Unit 22) and for Resident #7 (Unit 31). The finding is: The facility's policy titled, Medication: Controlled Substances, revised 3/2024, documented that immediately after a medication dose is administered the licensed nurse administering the drug enters all of the following information on the controlled substance administration record: date/time of administration, dose/amount administered, and the signature of the nurse administering the drug. 1) Resident #35 was admitted with diagnoses including Diabetes Mellitus, Anxiety Disorder, and Depression. The 1/8/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A physician's order effective 3/8/2024 documented to administer Klonopin (Clonazepam-a controlled substance used to treat anxiety) 1-milligram tablet, one tablet by mouth two times a day, for diagnosis of Anxiety Disorder. During an observation of Unit 21's medication cart on 3/26/2024 at 1:16 PM, Resident #35's Controlled Substance Administration Record form for Clonazepam documented that 55 tablets of Clonazepam were remaining; however, the blister pack for Clonazepam only had 24 tablets. Registered Nurse #1 was present during the observation. Registered Nurse #1 was interviewed on 3/26/2024 immediately after the observation and stated that there were 30 additional tablets available, in storage, in the medication room. Registered Nurse #1 stated they gave one tablet of Clonazepam to Resident #35 at 10:00 AM but did not document in the Controlled Substance Administration Record form that the dose was administered because the unit was busy. Registered Nurse #1 stated they should have documented and reconciled the Controlled Substance Administration Record as soon as they removed the controlled substance from the blister pack. 2) Resident #221 was admitted with diagnoses including Diabetes Mellitus, Cerebral Palsy, and Seizure Disorder. The 1/18/2024 Minimum Data Set assessment documented no Brief Interview for Mental Status due to the resident's severely impaired cognitive skills for daily decision-making. A physician's order dated 3/11/2024 documented to administer Vimpat (Lacosamide- controlled substance used to treat seizures) 100 milligrams tablet; give one tablet via gastrostomy tube two times a day, for diagnosis of Seizures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Unit 22's medication cart on 3/26/2024 at 1:25 PM Resident #221's Controlled Substance Administration Record form for Lacosamide (Vimpat) documented that 34 tablets were remaining; however, the blister pack for Lacosamide only had three tablets. Licensed Practical Nurse #2 was present during the observation. Licensed Practical Nurse #2 was interviewed on 3/26/2024 immediately after the observation and stated there were 30 additional tablets in storage in the medication room. Licensed Practical Nurse #2 stated they gave one Lacosamide tablet to Resident #221 at 10:00 AM. Licensed Practical Nurse #2 stated normally they document on the Controlled Substance Administration Record form immediately after the medication is administered; however, today the unit was busy and they were not feeling well. 3) Resident #7 was admitted with diagnoses including Diabetes Mellitus, Seizure Disorder, and Schizophrenia. The 2/15/2024 Minimum Data Set assessment documented no Brief Interview for Mental Status score due to the resident's moderately impaired cognitive skills for daily decision-making. A physician's order dated 3/19/2024 documented to administer Xcopri (a controlled substance used to treat seizures) 100 milligrams tablet; give one tablet by mouth per day, for diagnosis of Seizures. During an observation of Unit 31's medication cart on 3/26/2024 at 2:07 PM, Resident #7's Controlled Substance Administration Record form for Xcopri documented that eight tablets were remaining; however, the blister pack for Xcopri only had seven tablets. Registered Nurse #2 was present during the observation. Registered Nurse #2 stated they administered one Xcopri tablet to Resident #7 at 10:00 AM. Registered Nurse #2 stated they have been getting calls from residents and have been busy and that is why they (Registered Nurse #2) did not document on the Controlled Substance Administration Record form when they removed the controlled medication from the blister pack for administration. The Registered Nurse Inservice Coordinator was interviewed on 3/27/2024 at 10:26 AM and stated all medications have to be signed for when they are administered, not just narcotics or controlled substances. The Registered Nurse Inservice Coordinator stated whenever a narcotic or controlled substance is removed from a blister pack, the Controlled Substance Administration Record form has to be updated and the controlled substance count of the blister pack has to be confirmed. The Director of Nursing Services was interviewed on 3/27/2024 at 1:52 PM and stated signing the Controlled Substance Administration Record form has to be done immediately after a medication is administered because reconciliation of the Controlled Substance Administration Record is necessary to keep track of controlled substances. 10 NYCRR 415.18(b)(1)(2)(3)

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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** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/26/2024 and completed on 4/2/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for four (Residents #151, #64, #374, and #282) of seven residents reviewed for Infection Control. Specifically, during observation of the four-bedded room shared by Resident #151, Resident #64, Resident #374, and Resident #282, a Special Droplet/Contact Precaution sign was observed outside the door. The precaution sign included instructions for the use of Personal Protective Equipment (PPE) including gloves, mask, gown, and a face shield or goggles. Certified Nursing Assistant #6 was observed taking vital signs (blood pressure, pulse rate, and oxygen saturation level) for Resident #151 inside the room wearing gloves and a surgical mask. Certified Nursing Assistant #6 was not wearing a gown and a face shield or goggles as indicated on the precaution sign. The finding is: The facility's policy titled Infection Prevention and Control: Transmission-Based Precautions revised on 2/9/2024 documented that transmission-based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Special Precautions are combined Droplet and Contact precautions used for residents with confirmed or suspected COVID-19 and with high-risk exposures; may also be used on the unit when an outbreak occurs when both COVID-19, influenza, or Respiratory Syncytial Virus (RSV) infections are co-circulating on the unit or in the facility. A fit-tested National Institute for Occupational Safety and Health (NIOSH) approved N95 (Non-Oil 95 percent efficiency mask) or higher-level Respiratory Respirator for healthcare personnel who must enter the room is required upon entry into the resident room. Doff (take off)/discard) when exiting the room to contain pathogens and perform hand hygiene. The policy documented that Multidrug-Resistant Organisms contaminate the skin and immediate environment of residents who are dependent upon assistance for activities of daily living, ventilator dependent, have indwelling medical devices, wounds, and frequent soiling. The use of gowns and gloves for specific care activities for such residents reduces contamination and subsequent transmission to other residents. -Resident #151 was admitted with diagnoses including Acute Respiratory Failure with Hypoxia, Traumatic Brain Injury, and Sepsis. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of four which indicated the resident had severely impaired cognition. A Comprehensive Care Plan dated 1/20/2023 for Actual and Potential Infection as evidenced by Extended Spectrum Beta Lactamase (ESBL - a type of bacteria that is resistant to some antibiotics) in the urine and Vancomycin-Resistant Enterococci (VRE-bacteria that is resistant to some powerful antibiotics) in the rectum included intervention to monitor vital signs as needed, laboratory monitoring, and physician evaluation as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) dated 1/26/2024 for Actual/Potential for Infection of COVID-19 virus/Influenza/Respiratory Syncytial Virus/ Pneumococcal documented interventions that included monitoring signs and symptoms of infection such as congestion, fever, chills, body aches, and shortness of breath. Practice social distancing. Encourage fluids via a Gastrostomy Tube (GT). Proper handwashing and maintaining precautions as ordered. A physician's order dated 4/27/2023 documented to place the resident on Contact Isolation (Precautions) secondary to Multidrug-Resistant organism (MDRO). There were no current physician's orders for Contact precautions. A Nursing Progress Note dated 3/24/2024 during the 11:00 PM-7:00 AM shift documented that Resident # 151 developed a temperature of 102.5 degrees Fahrenheit, and Tylenol (fever-reducing medication) was administered. A rapid COVID-19 test was completed with a negative result. -Resident #64 was admitted with diagnoses including Nontraumatic Intracerebral Hemorrhage, Type II Diabetes and Hypertension. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A Physician's Order dated 7/22/2023 documented to place the resident on Contact Isolation secondary to Multi-Drug Resistant Organism (MDRO). There were no current physician's orders for Contact precautions. A Comprehensive Care Plan dated 11/28/2023 for Multi-Drug Resistant Organism (MDRO) Colonization in the rectum, sputum, and nares (nose), documented interventions that included vital signs and laboratory orders as per the physician. -Resident # 374 was admitted with diagnoses including Malignant Neoplasm of the tongue, Gastrostomy (G Tube) Status, and Dysphagia (difficulty swallowing). A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. A Comprehensive Care Plan (CCP) dated 1/4/2024 for Multi-Drug Resistant Organism (MDRO) documented interventions that included vital signs monitoring, laboratory orders, and a physician's evaluation as needed. A physician's Order dated 1/4/2024 documented to place the resident on Contact isolation secondary to Multi-Drug Resistant Organism (MDRO). There were no current physician's orders for Contact precautions. A Comprehensive Care Plan dated 1/26/2024 for Actual potential for infection, COVID-19, Influenza, and Respiratory Syncytial Virus documented interventions that included social distancing, medications as per order, proper handwashing, and monitoring for signs and symptoms of infection such as fever, chills, body aches, shortness of breath. -Resident #282 was admitted with diagnoses including Respiratory Failure, Quadriplegia, and Sepsis. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for a Mental Status score of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) dated 9/6/2023 for Multi-Drug Resistant Organism (MDRO) in urine and rectum, documented interventions that included monitoring for signs and symptoms of infection. Ensure good hygiene and observe frequent hand washing. A physician order dated 12/19/2023 documented to place the resident on Contact Isolation secondary to Multi-Drug Resistant Organisms (MDRO). There were no current physician's orders for Contact precautions. During an observation on 3/27/2024 at 8:00 AM on Unit 22, Certified Nursing Assistant #6 was observed inside the residents' room that was occupied by Resident #151, Resident #64, Resident # 374, and Resident #282. Certified Nursing Assistant #6 obtained Resident #151's blood pressure, pulse, and oxygen saturation level then exited the room. Certified Nursing Assistant #6 was observed wearing gloves and a surgical mask; Certified Nursing Assistant #6 was not wearing a gown and was not wearing a face shield or goggles. A sign posted outside the room read Special Droplet/Contact Precautions. The sign included instructions for the use of specific Personal Protective Equipment (PPE) for all visitors, doctors, and staff which included, wearing a face mask, eye protection (face shield or goggles), a gown, and gloves. When doing aerosolizing procedures, N95 mask with eye protection or higher is required. Use patient-dedicated or disposable equipment. Clean and disinfect shared equipment. Certified Nursing Assistant #6 was interviewed on 3/27/2024 at 8:40 AM and stated that they were in the residents' room to check Resident #151's vital signs. Certified Nursing Assistant #6 stated they were wearing gloves and a surgical mask in the room. Certified Nursing Assistant #6 stated while they were in the room they cleaned the blood pressure machine after using the machine for each resident. Certified Nursing Assistant #6 stated they did not check the sign posted outside the door, they did not pay attention because they were focused on completing their task. Certified Nursing Assistant #6 stated they were aware that the unit had different isolation precautions and they should have checked the sign and the instructions for the use of proper Personal Protective Equipment (PPE) before entering the resident rooms. The Infection Preventionist was interviewed on 3/27/2024 at 9:00 AM and stated that the signage posted outside the resident's room is to alert the staff about proper Personal Protective Equipment (PPE) use before entering the room. Resident #151, Resident #64, Resident #374, and Resident #282 were on contact precautions because of a history of Multi-Drug Resident Organism infection. The Residents were placed on enhanced droplet-contact precautions secondary to possible COVID-19 infection exposure; however, the test results came back negative and the residents were put back on contact precautions again. The expectation is for all staff and visitors to follow the correct Personal Protective Equipment use as indicated on the precaution sign that is posted outside the resident's room. A subsequent observation of the Residents (#151, #64, #374, and #282) room was conducted on 3/28/2024 at 9:00 AM. The sign posted outside the room read, Contact Isolation which included instructions for the use of a gown, gloves, an eye shield, and a surgical mask. The Director of Nursing Services was interviewed on 4/1/2024 at 9:37 AM and stated that all staff must follow infection control protocols. These protocols are in place to keep the residents and staff safe. All changes are communicated to each unit to ensure that all infection control standards are followed. The Director of Nursing Services stated that Certified Nursing Assistant #6 should have followed the correct Personal Protective Equipment indicated on the signage that is posted outside the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335023	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Holly Patterson Extended Care Facility	875 Jerusalem Avenue Uniondale, NY 11553

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.19(a)(1-3)