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	09/30/2025

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 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. Based on observation, record review, and interviews during the Recertification Survey and Abbreviated Survey (#769417) initiated on 09/23/2025 and completed on 09/30/2025, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents. This was identified for one (1) (Resident #314) of four (4) residents reviewed for accidents. Specifically, Resident #314 required two (2) staff persons for transfers as per the Physician's order and their plan of care. On 01/10/2025, Certified Nursing Assistant #8 transferred Resident #314 from the wheelchair to the bed without a second staff member. During the transfer, Resident #314 hit their left leg on the metal bed frame and sustained a fractured tibia and fibula (lower leg bones). This resulted in actual harm to Resident #314, that was not Immediate Jeopardy.The finding is:The facility's policy titled Activities of Daily Living, dated March 2023, documented to ensure residents receive appropriate assistance with Activities of Daily Living to maintain or improve their quality of life, independence, dignity, and safety, and promote maximum level of function. Trained staff will provide the level of assistance required to maintain or improve residents' quality of life and promote the maximum level of function. Maintain safety at all times.The facility's policy titled Certified Nursing Assistant Accountability Record, dated March 2023, documented the Certified Nursing Assistant Accountability Record is the plan of care utilized by Certified Nursing Assistants to provide direct care for the residents. The Certified Nursing Assistant Accountability Record needs to be checked before providing care to the residents.Resident #314 was admitted with diagnoses including muscle weakness, lack of coordination, and osteoarthritis (a common joint disease that causes pain, stiffness, and loss of mobility). The 12/28/2024 Annual Minimum Data Set (a resident assessment tool) documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The resident was dependent (helper did all the effort the resident did none of the effort to complete the activity or, the assistance of two (2) or more helpers was required for the resident to complete the activities) on staff members for transfer to and from a bed to a chair or wheelchair.A Physician's order dated 12/18/2024 documented out of bed to wheelchair with the assistance of two (2) people.The 12/18/2024 Physical Therapy Screen documented the resident had left lower extremity contracture (Equinovarus deformity-the foot is turned inward and downward). Resident #314 required the assistance of two (2) persons for out of bed transfers. The resident was placed on skilled rehabilitation therapy due to a decline in functional transfers and balance.The Fall Risk Potential for Injury Accident/Incident Comprehensive Care Plan effective 01/07/2025, documented that Resident #314 required two (2) person assistance for out of bed to wheelchair transfer.The January 2025 Certified Nursing Assistant Accountability Record documented Resident #314 required two (2) people for out of bed transfers and required substantial maximal assistance (helper lifts and holds trunk or limbs and provides more than half the effort) for chair/bed-to-chair transfer. The Accident and Incident Report dated 01/10/2025 documented the resident complained that during transfer to bed, their leg touched the bed frame, and they had big pain on their left shin, and they were unable to move their leg as the pain was very sharp. The Physician was notified after the resident was assessed and pain medication was administered.A written statement from Certified (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing Assistant #8 dated 01/10/2025, documented that when they were transferring the resident to bed, the resident stated they hit the right leg on the bed.A Post Incident Root Cause Investigation, dated 01/10/2025, documented that all preventive measures were in place, including two (2) [persons] for transfers. The document did not include any contributing factors or corrective preventive actions. The Nurse Manager/Supervisor's summary of investigation, documented by Registered Nurse #7 indicated the resident was assessed for complaints of pain to the left lower leg. No signs of redness or any injury were noted.The Situation, Background, Assessment, and Recommendation (SBAR) form, completed by Licensed Practical Nurse #3, dated 01/10/2025 at 7:10 PM, documented that Resident #314 had left shin pain when transferred to bed. The Physician was notified, and an order for a pain reliever was obtained.A Physician's order (following the incident) dated 01/10/2025 documented Ibuprofen (pain medication) 200 milligram tablet, give two (2) tablets two (2) times a day as needed for unspecified pain and an order for X-ray of the left lower leg.The Situation, Background, Assessment, and Recommendation (SBAR) form dated 01/11/2025 at 8:30 PM documented Resident #314 complained of left leg pain, was unable to move the leg, and was screaming. An X-ray of the left leg was completed, which indicated a fracture of the fibula (lower leg bone). The Physician ordered to transfer the resident to the emergency room for evaluation.The portable X-ray report dated 01/11/2025, documented an acute fracture (sudden break of a bone that occurs as a result of trauma) of the fibula (lower leg bone). The X-ray showed osteopenia (lower than normal bone mineral density) and osteoporosis (a condition that causes bones to become weak and brittle).A Physician's order dated 01/11/2025 documented to transfer the resident to the Emergency Room.The Accident and Incident Investigation summary report, completed on 01/14/2025, documented on 01/10/2025 at around 5:00 PM, Resident #314 complained of left leg pain after being transferred from a wheelchair to the bed. The resident stated their leg contacted the bed frame during the transfer. The portable X-ray of the left lower leg was completed on 01/11/2025 at the facility, which revealed an acute fracture of the left fibula. The Physician was made aware of the X-ray results and ordered the resident to be sent to the emergency room for further evaluation, where the resident was diagnosed with left tibia and fibula (lower leg bones) fractures. The investigation summary documented that Certified Nursing Assistant #8 reported that they were aware the resident required two-person assistance for transfers and lifted Resident #314 by themselves. Certified Nursing Assistant #8 also admitted that they did not check the Certified Nursing Assistant Accountability Record before providing care.The Hospital discharge documents dated 01/12/2025 confirmed additional X-rays of Resident #314's left leg were taken in the Emergency Room. The impression was a minimally displaced fracture of the tibia and fibula (lower leg bones). The hospital recommended non-weight bearing to the left lower extremity; the resident refused surgical intervention, and a knee immobilizer was placed with instructions to follow up with the orthopedic clinic.A Physician's order dated 01/13/2025 documented out of bed to wheelchair via a mechanical lift.During an observation and interview on 09/24/2025 at 9:30 AM, Resident #314 stated on 01/10/2025, only one (1) aide transferred them to the bed, and no other nurse was in the room during the transfer. Resident #314 stated that during the transfer, they hit their leg on the bed and started screaming in pain. Resident #314 stated they had to go to the hospital and got a brace for the leg.During an interview on 09/24/2025 at 11:53 AM, Rehabilitation Department Director #1 stated prior to the incident on 01/10/2025, Resident #314 required two (2) persons for transfer from one surface to another. After the incident, Resident #314's transfer status changed to mechanical lift because the resident was unable to bear weight on the left leg.Multiple attempts were made to call Certified Nursing Assistant #8; however, they were unavailable for the interview. During an interview on 09/24/2025 at 3:05 PM, Licensed Practical Nurse #3 stated on 01/10/2025, Resident #314 called them and stated they wanted to go back to bed; the resident required two (2) staff members for transfers. Licensed Practical Nurse #3 stated they told Certified Nursing Assistant #8 that Resident #314 wanted to go back to bed. Licensed Practical Nurse #3 stated they did not see Certified Nursing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Assistant #8 go into Resident #314's room and did not assist with the transfer. Licensed Practical Nurse #3 stated at approximately 5:00 PM, they heard Resident #314 screaming in pain, and they went to the resident's room. The resident was in bed and complained that Certified Nursing Assistant #8 swung the resident into bed, and the resident's leg hit against the bed frame. Licensed Practical Nurse #3 stated they notified Registered Nurse Supervisor #7. During an interview on 09/25/2025 at 9:15 AM, Registered Nurse Supervisor #7 stated after Licensed Practical Nurse #3 notified them regarding Resident #314's complaint of pain to the left leg, Registered Nurse Supervisor #7 assessed the resident. There were no obvious signs of injury, such as swelling, bruising, or skin breaks. The resident reported they had pain after Certified Nursing Assistant #8 transferred the resident to bed. The Physician was notified, and an investigation was initiated.During an interview on 09/25/2025 at 9:25 AM, Registered Nurse Risk Manager #1 stated they conducted the investigation and concluded that the resident required two (2)person assistance for transfer. Certified Nursing Assistant #8 transferred Resident #314 by themselves and did not follow the resident's plan of care, creating an unsafe transfer.During an interview on 09/25/2025 at 11:10 AM, the Director of Nursing Services stated Certified Nursing Assistant #8 did not review the resident's accountability record before providing care. Certified Nursing Assistant #8 did not follow the resident's plan of care and transferred the resident by themselves, therefore, creating an unsafe transfer. Certified Nursing Assistant #8 was terminated from employment at the facility.During an interview on 09/25/2025 at 11:25 AM, the Medical Director (who is Resident #314's primary Physician) stated the resident had an order to utilize two (2) persons for transfers as recommended by the Rehabilitation Department. The Medical Director stated the Certified Nursing Assistants should follow the transfer orders and the resident's plan of care.10 NYCRR 415.12(h)(1)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews during the Recertification Survey initiated on 09/23/2025 and completed on 09/30/2025, the facility did not ensure that the interdisciplinary team had determined that self-administration of medications was clinically appropriate for each resident. This was identified for one (1) (Resident #94) of eleven residents reviewed for Accidents. Specifically, Resident #94 was self-administering their inhaler medications. The facility staff was aware of the resident's self-administration of the inhalers; however, there was no documented assessment to determine if the resident could safely self-administer their medication. Additionally, Resident #94 did not have a physician's order to self-administer their medications. :The finding isThe facility's policy titled Medication Administration, last reviewed on 03/2024, documented that Residents may self-administer their own medications only if the attending clinician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. The medications are stored in a locked area in their room.Resident #94 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Bronchitis (inflammation of the bronchial tubes, the airways that carry air to and from the lungs), and Colon Cancer. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #94 had intact cognition Resident #94 had an active diagnosis of Chronic Obstructive Pulmonary Disease and did not receive any respiratory treatment. A Physician's Order dated 09/15/2025 documented Advair HFA (medication to treat Asthma and Chronic Obstructive Pulmonary Disease) eight (8) grams 230 per 21 inhaler, two (2) puffs per inhalation by mouth twice a day. A Physician's Order dated 09/15/2025 documented Spiriva (bronchodilator)18 micrograms Handihaler two (2) puffs per inhalation per one capsule by mouth once a day. A review of Resident #94's electronic medical record revealed that Resident #94 did not have a Physician's order to self-administer their own medications. A review of Resident #94's electronic medical record revealed that Resident #94 did not have a self-administration assessment. A Comprehensive Care Plan dated 05/31/2025 titled, Respiratory Distress related to Chronic Obstructive Pulmonary Disorder documented interventions including administering treatments and medications as ordered by the Physician, monitoring for effectiveness, observing adverse drug reactions, and notifying the Physician of any abnormal findings. During an observation on 09/23/2025 at 11:00 AM, Resident #94 was sitting in a wheelchair in their room. An unlabeled box of Spiriva Handihaler was resting on top of Resident #94's nightstand. An unlabeled Advair HFA inhaler was on top of Resident #94's bed. During an interview on 09/23/2025 at 11:02 AM, Resident #94 stated that they administer their own inhalers. Resident #94 stated they know their medications and are aware of when to take them. Resident #94 stated that the Nursing staff were aware that they (Resident #94) had the inhalers in their room. Resident #94 stated that the Nurses administer all their medications except for the inhalers.During an interview on 09/23/2025 at 11:15 AM, Licensed Practical Nurse #2, Medication Nurse, stated that Resident #94 was alert and oriented and was capable of self-medicating their inhalers. Licensed Practical Nurse #2 stated they were not sure if an assessment was completed for Resident #94's self-administration of medication. Licensed Practical Nurse #2 stated they did not know the inhalers were not stored in a locked cabinet in the resident's room. During an interview on 09/24/2025 at 12:20 PM, Registered Nurse #6, Charge Nurse, stated they were not aware that Resident #94 had their inhalers in their room and was administering their own inhalers. Registered Nurse #6 stated that if a resident wanted to self-administer their medications, the Attending Physician should have been notified to assess the resident for the capacity to safely self-administer the medications.During an interview on 09/26/2025 at 8:23 AM, the Director of Nursing Services stated that Nursing staff should have ensured the resident was assessed and had a physician's order to self-administer their medication, and that the medications were stored according (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the facility policy. During an interview on 09/30/2025 at 10:24 AM, the Attending Physician #1 stated that Resident #94 was alert and oriented and was capable of administering their inhalers. Attending Physician #1 stated that Resident #94 had a follow-up with a pulmonologist, and an education was provided on how to administer their inhalers. Attending Physician #1 stated that they were not aware that an evaluation was needed for the resident to be able to self-administer their medication; otherwise, they would have completed the evaluation. 10 NYCRR 415.3(f)(1)(vi)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during the Recertification Survey and Abbreviated Surveys (Complaint #769423 and Complaint #2580693) initiated on 09/23/2025 and completed on 09/30/2025, the facility did not ensure the residents had the right to be free from abuse. This was identified for four (4) (Resident #183, Resident #26, Resident # 184, and Resident #90) of five (5) residents reviewed for Abuse. Specifically, 1) on 02/24/2025, Resident #183, with intact cognition, while fighting over a privacy curtain, hit Resident #26, with severely impaired cognition, in the face, resulting in Resident #26 having a swollen lip, and 2) Resident #90 had a physical and verbal altercation with Resident #184 on 08/03/2025 at 01:25 PM. Resident #90 accused Resident #184 of stealing their money. Later, the same day at 08:45 PM, Resident #184 was found on the floor and reported that Resident #90 had hit them in the face with the television remote to retrieve their money.The findings are: The facility's policy titled Resident Abuse, dated 07/13/2021 and last revised on 05/20/2025, documented to ensure that every resident is free from abuse and that their rights are respected and dignity maintained. The term abuse shall mean the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The term physical abuse includes, but is not limited to, hitting, slapping, pinching, kicking, and shoving. Abuse can occur between one resident to another resident, between a staff member to a resident, and/or between a family/visitor to a resident. 1) Resident #183 has diagnoses including Hypertension (high blood pressure) and Schizophrenia (a serious mental health condition that affects how people think, feel, and behave). The admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The Minimum Data Set (MDS) assessment also documented that Resident #183 did not exhibit any behaviors. A Comprehensive Care Plan titled High risk for abuse dated 01/23/2025 and last updated 07/19/2025 documented the goal as: Resident will not experience any form of abuse over 90 days. The interventions included, but were not limited to monitor for changes in mood and behavior, observe for signs of abuse, and educate the resident to report issues/concerns. The Resident Accident/Incident Report dated 02/24/2025 for Resident #183 documented the resident's description of the occurrence as: Resident #26 threw a shoe at them over an argument involving the (privacy) curtain (which separates their beds), and they responded by hitting them (Resident #26) in their face. Resident #26 has diagnoses including Diabetes Mellitus and Bipolar Disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severely impaired cognitive skills for daily decision making with long- and short-term memory problems. The Minimum Data Set (MDS) assessment also documented that Resident #26 did not exhibit any behaviors. A Comprehensive Care Plan titled High risk for abuse – Cognitive impairment, easily annoyed, history of touching female staff inappropriately dated 06/10/2024 and last updated 02/24/2025, documented interventions including but not limited to: monitor for changes in mood and behavior, and observe for signs of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Accident/Incident Report dated 02/24/2025 for Resident #26 documented the resident's description of the occurrence as: Resident #183, their roommate, hit them. Resident #26 was unable to describe what triggered the incident. The Resident Information Follow-Up report dated 02/24/2025 documented there was reasonable cause to believe that abuse, neglect, or mistreatment occurred. The report documented Resident #26 was alert but severely confused. Resident #26 stated in the initial interview that Resident #183 hit them in the face, but was unable to explain any further. The report also documented Resident #183 was alert and oriented and stated that Resident #26 disturbed their sleep by pulling and playing with the (privacy) curtain located at Resident #183's bedpost and one in between their beds. When Resident #183 stopped Resident #26 by taking the curtain away, Resident #26 hit Resident #183 with a shoe, and Resident #183 hit Resident #26 back in the face. During an interview on 09/23/2025 at 2:15, Resident #183 stated they remembered the incident that occurred on 02/24/2025 PM between them and Resident #26. Resident #183 stated that Resident #26 kept bothering them when they were sleeping and kept waking them up by pulling their (privacy) curtain back. Resident #183 stated the noise woke them up, and Resident #26 also kept bumping into their bed. Resident #183 stated they wanted to stop Resident #26 and pulled back the (privacy) curtain, but Resident #26 kept tugging at it. Resident #183 stated Resident #26 then took a swing at them, hitting them in the face, and then they hit Resident #26 back in the face. During an interview on 09/24/2025 at 12:30 PM, Resident #26 stated they did not recall a fight in February 2025 and have not fought with anyone in the facility. Resident #26 stated they had an issue with the (privacy) curtain with a roommate, but that roommate has not returned to their room. Resident #26 denied being punched or hitting their roommate. During an interview on 09/26/2025 at 12:15 PM, Certified Nursing Assistant #3, who was assigned to Resident #26 on 02/24/2025, stated they were informed by the Nurse regarding the resident to resident altercation between Resident #26 and Resident #183. Certified Nursing Assistant #3 stated that after the altercation, Resident #183 was moved to another room. Certified Nursing Assistant #3 stated they had not seen anything because they were caring for another resident at the time During an interview on 09/26/2025 at 2:50 PM, Licensed Practical Nurse #1 stated 02/24/2025, they found Resident #26 with a swollen lip, and they informed Registered Nurse #2. Licensed Practical Nurse #1 stated they went to Resident #183 to ask what happened, and Resident #183 refused to speak with them. During an interview on 09/29/2025 at 10:15 AM, Certified Nursing Assistant #4, who was assigned to Resident #183 on 02/24/2025, stated they were informed by the Nurse that Resident #183 and Resident #26 were fighting over the bed (privacy) curtain and Resident #183 had hit Resident #26, giving them a swollen lip. Certified Nursing Assistant #4 stated they had not seen the fight actually happen. During an interview on 09/29/2025 at 10:35 AM, Registered Nurse #2, the Registered Nurse Nursing Supervisor who had completed the Accident/Incident Reports on 02/24/2025, stated Resident #183 told them they had an argument with Resident #26 over the (privacy) curtain. Resident #26 threw a shoe at them, and Resident #183 then hit Resident #26 in their face. During an interview on 09/29/2025 at 1:50 PM, Registered Nurse Risk Manager #1 stated the incident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between Resident #183 and Resident #26 was considered abuse because Resident #183 knew what they were doing when they hit Resident #26. During an interview on 09/30/2025 at 8:50 AM, the Director of Nursing Services stated the incident between Resident #183 and Resident #26 on 02/24/2025 was abuse because Resident #183, with intact cognition, hit Resident #26, who was confused. During an interview on 09/30/2025 at 11:00 AM, the Administrator stated the altercation between Resident #183 and Resident #26 on 02/24/2025 was an incident of abuse because Resident #183 was alert and knew what they were doing. Both residents were separated, and Resident #183 was moved to another room. 2) Resident #90 was admitted with diagnoses of Dementia, Hyperlipidemia, and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated Resident #90 had severe cognitive impairment. The Quarterly Minimum Data Set assessment documented that Resident #90 did not exhibit any behaviors. A Comprehensive Care Plan titled No Behavior Problem/Concerns Exhibited, dated 01/10/2025, documented interventions including monitoring changes in cognition, mood, and behavior, and redirecting the resident as appropriate. The care plan was revised on 04/04/2025, indicating the resident accused the staff at times. On 08/03/2025, the Resident accused peers of holding their money. The resident tapped on the peer's shoulders and arms. Nursing staff educated the resident and advised them to keep calm when discussing a matter with another resident and to report to the nurse in charge. One (1) to one (1) visual rounds every half hour were initiated. Resident #184 was admitted to the facility with diagnoses of Fracture of the Left Femur (leg bone), Diabetes Mellitus, and Hypertension. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #184 had intact cognition. The Minimum Data Set documented that Resident #184 did not exhibit any behaviors. A Comprehensive Care Plan titled High Risk for Abuse, dated 07/03/2025 and updated on 08/03/2025, with interventions including observing changes in mood and behavior, observing for signs of abuse, and educating the resident to report issues/concerns. The Resident Accident/Incident Report dated 08/03/2025 for Resident #90 documented that Resident # 90 and Resident #184 were involved in an argument in the hallway on the unit at 01:25 PM. Resident #90 was tapping Resident #184 on their (Resident #184) shoulders and arms. Resident #90 thought that Resident #184 was trying to keep their (Resident #90) money. Staff separated both residents very quickly and took Resident #90 back to their room. Both residents were placed on half-hour visual rounds for three (3) days. The Accident and Incident report dated 08/03/2025 for Resident #184 documented a statement from Resident #184 indicating Resident #90 thought they (Resident #90) gave them (Resident #184) money ($800) to hold. Resident #184 was assessed and did not sustain any injury. A separate Resident Accident/Incident Report dated 08/03/2025 for Resident #90 documented that at 08:45 PM, Registered Nurse #8 reported observing Resident #184 on the floor in their room. Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#184 stated that Resident #90 hit them (Resident #184) in the face with a television remote control. Resident #90 was interviewed and was unable to describe the occurrence. Both residents were separated immediately to prevent further escalation. Resident #90 was transferred to the hospital for further evaluation with psychiatry and will be relocated upon returning to the facility. A separate Resident Accident/Incident Report dated 08/03/2025 for Resident #184 documented a statement from Resident #184 indicating that Resident #90 came to their (Resident #184) room and hit them with a television remote control. Resident #184 was found on the floor by Registered Nurse # 8 with nose bleeding. Upon assessment, Resident #184 sustained injury to the head, face, and left pinky fingers. Resident #184 was transferred to the hospital for Computed Tomography (CT) of the head, spine, and face, and an X-ray of the left 5th digit to rule out fracture. The investigation summary of both incidents concluded there was cause to believe abuse related to resident-to-resident had occurred. A review of documents titled Visual Observation Rounds from 08/03/2025 to 08/05/2025 indicated Resident #90 was observed at a 30-minute interval by Certified Nursing Assistant #10 between 08:00 PM-09:00 PM on 08/03/2025, and Resident #90 was seen in the hallway between 08:30 PM to 09:00 PM. A review of documents titled Visual Observation Rounds from 08/03/2025 to 08/05/2025 indicated Resident #184 was observed at a 30-minute interval. Resident #184 was seen in their room between 08:30 PM to 09:00 PM on 08/03/2025. During an interview on 09/23/2025 at 10:54 AM, Resident #90 stated their family members gave them money for their birthday, and they handed the money to another resident for safekeeping when they were going to take a shower. Resident #90 could not recall the name of the resident. Resident #90 stated that after returning from the shower, they asked the other resident (Resident #184) for their money, and the other resident refused to return the money. Resident #90 stated they got very upset and hit the other resident (Resident #184) in the forehead with a television remote. During an interview on 09/24/2025 at 03:08 PM, Resident #184 stated they were hit by another resident (could not recall the name). Resident #184 denied pain or being fearful for their safety at this time. During an interview on 09/29/2025 at 11:00 AM, Certified Nursing Assistant #10 stated they were assigned to care for Resident #184 during the 07:00 AM-03:00 PM shift on 08/03/2025, and there was no prior history of altercation between Resident #184 and Resident #90. On 08/03/2025, Resident #90 was arguing over money with Resident #184 during the morning shift. Resident #90 was observed tapping Resident #184 on the shoulder and was verbally argumentative. Certified Nursing Assistant #10 stated that both residents were placed on half-hourly visual rounds. Certified Nursing Assistant #10 stated they also worked the evening shift (03:00 PM to 11:00 PM) on the same unit on 08/03/2025 and were responsible for checking the residents (Resident #90 and Resident #184) for a visual round between 8:00 PM to 09:00 PM. Certified Nursing Assistant #10 stated both residents were observed during 8:00 PM to 9:00 PM; however, Certified Nursing Assistant #10 could not say what time they last saw both residents. Certified Nursing Assistant #10 stated that at approximately 08:45 PM, they were putting away a mechanical lift when they heard Registered Nurse #8 call for help. Certified Nursing Assistant #10 stated that when they responded to the room, Resident #90 was standing in front of Resident #184's room, and Resident #184 was sitting in their wheelchair inside their room. Certified Nursing Assistant #10 stated Resident #184's forehead was red and the resident (continued on next page)

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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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was communicating through non-verbal gesture, indicating Resident #90 had hit them (Resident #184) with a television remote control. During an interview on 09/29/2025 at 01:18 PM, Licensed Practical Nurse # 3 stated that they were called earlier in the day to assist in translating for the residents after the altercation had occurred on 08/03/2025, as both residents' primary language was not English. Licensed Practical Nurse #3 stated that Resident #184 reported that Resident #90 had been arguing with them (Resident #184) over money and calling them a thief, and Resident #184 was very upset. Licensed Practical Nurse # 3 stated Resident #90 accused Resident #184 of keeping their (Resident #90) money that they (Resident #90) gave to Resident #184 for safekeeping before going into the shower. Licensed Practical Nurse # 3 stated that they were again called to translate at approximately 08:45 PM on the same day (08/03/2025) when the second incident occurred, and Resident #184 told them (Licensed Practical Nurse # 3) that Resident #90 had hit them in the face with a television remote control. During an interview on 09/30/2025 at 09:15 AM, Certified Nursing Assistant #13 stated they were sitting at the nursing station when they heard noises at approximately 1:25 PM. Certified Nursing Assistant #13 stated they saw Resident #90 and Resident #184 in front of Resident #184's room, exchanging words in a language they did not understand. Resident #90 was tapping Resident #184's shoulders. Resident #184 was sitting in their wheelchair, trying to avoid Resident #90. Certified Nursing Assistant #13 stated they immediately separated the residents, and both residents were placed on half half-hour visual round. During an interview on 09/29/2025 at 03:58 PM, Registered Nurse #10, the evening shift (3:00 PM to 11:00 PM) Nursing Supervisor on 08/03/2025, stated that they were on the unit and responded to Registered Nurse #8's call for help. Upon entering Resident #184's room, Registered Nurse # 10 observed Resident #184 on the floor. The resident was bleeding from a laceration to the left side of the nose. Registered Nurse # 10 stated that Resident #184 was alert and responsive and reported that Resident #90 hit them in the face. Registered Nurse #10 stated Resident #90 was not roommates with Resident #184. There was a clear indication that Resident #90 was again trying to seek out Resident #184 to complete the unfinished argument they both had during the previous shift. Registered Nurse #8 was unavailable for an interview despite multiple attempts. During an interview on 09/30/2025 at 10:23 AM, the Risk Manager stated they concluded that abuse had occurred through review of resident and staff interviews and statements. The Risk Manager stated there was evidence to indicate that Resident #90 acted out against Resident #184 with reason and intent, although the reason was unfounded, as Resident #90 did not have any money on their person. During an interview on 09/30/2025 at 11:01 AM, the Administrator stated there was evidence that abuse had occurred when an altercation between Resident #90 and Resident #184 took place. Resident #90 hit Resident #184 as they (Resident #90) were upset that Resident #184 had refused to return their money. During an interview on 08/30/2025 at 11:31 AM, the Director of Nursing Services stated that there was evidence to indicate abuse had taken place as Resident #90 had intent and targeted Resident #184 twice on the same day for the same reason, even though the reason was unrealistic. The Director of Nursing Services stated Resident #184 sustained a minor injury requiring a transfer to the hospital for evaluation after the second incident, when Resident #90 hit Resident #184 in the face (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a television remote control. 10 NYCRR 415.4(b)(1)(i)

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not coordinate and refer all Level II residents and all residents with newly evident or possible mental disorder, intellectual disability, or a related condition for Level II resident review upon a significant change in status assessment. This was identified for one (1) (Resident #5) of 37 residents reviewed for Pre-admission Screening and Resident Review (PASARR). Specifically, there was no documented evidence that the facility referred Resident #5 for Level II resident review when the resident was newly diagnosed with Schizoaffective Disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder) during the course of their stay in the facility.The finding is:The facility's policy titled Pre-admission Screening and Resident Review, last revised June 2023, documented that in the event a resident is admitted with a level I screen, and further exploration reveals information indicating that there is a serious mental illness, a referral shall be made to the appropriate Pre-admission Screening and Resident Review agency immediately. In the event that a resident is determined prior to admission to require a Level II screen, that resident shall not be admitted without authorization from the appropriate Pre-admission Screening and Resident Review agency. Resident #5 was originally admitted to the facility prior to 2009 with diagnoses including Dementia (a group of conditions characterized by the impairment of at least two brain functions, such as memory and judgment), and Oral Thrush. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of six (6), which indicated the resident had severely impaired cognition. The Minimum Data Set indicated the resident had diagnoses of Depression and Schizophrenia. The Physician admission History and Physical assessment dated [DATE] documented that Resident #5 had periods of confusion. Resident #5 was prescribed medications, including but not limited to Risperdal (an antipsychotic medication) 0.5 milligrams at bedtime. The Assessment did not document that Resident #5 had a diagnosis of schizoaffective disorder. There was no documented evidence of the resident's diagnosis of schizoaffective disorder prior to 06/29/2018. A review of the Psychiatric evaluation dated 06/29/2018 documented that Resident #5 was seen for follow-up. The assessment indicated the resident has a history of schizoaffective disorder and Unspecified Dementia. The evaluation documented a recommendation to continue Cymbalta (a medication to treat depression and anxiety) 30 milligrams at bedtime and Depakote (a medication to treat seizures and bipolar disorder) 25 milligrams at bedtime. A review of the hospital Discharge summary dated [DATE] documented that the resident was sent from the nursing facility with a complaint of Shortness of breath. The history of present illness documented past diagnoses, including but not limited to schizoaffective disorder. The summary documented that the resident was successfully treated for hospital-acquired Pneumonia and Acute Chronic Congestive Heart Failure and was discharged back to the nursing facility in stable condition. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The assessment documented Resident #5 had an active diagnosis of Schizophrenia (schizoaffective and schizophreniform disorders) and did not exhibit any behaviors. The assessment's Pre-admission Screening and Resident Review (PASARR) section documented that Resident #5 was not currently considered by the State level II Pre-admission Screening and Resident Review (PASARR) process to have serious mental illness, intellectual disability, or other related conditions. The Level II screen condition section was not completed. The Significant Change Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated Resident #5 had severely impaired cognition and had an active diagnosis of Schizophrenia (schizoaffective and schizophreniform disorders) and Depression. The resident did not exhibit any behaviors. The Pre-admission Screening and Resident Review (PASARR) section documented that (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 was currently considered by the State level II Pre-admission Screening and Resident Review (PASARR) process to have serious mental illness, intellectual disability, or other related conditions. The Level II screen condition section was completed and indicated the resident has a condition of serious mental illness. The medical record lacked documented evidence that a Level 1 or Level II Pre-admission Screening and Resident Review (PASARR) was completed for the resident. During an interview on 09/25/2025 at 01:54 PM, the Director of admission stated that Resident #5 did not have a completed Level 1 or Level II Pre-admission Screening and Resident Review on file during the entire course of their stay. The Director of admission stated that when Resident #5 was discharged and returned to the facility in October 2023, the facility did not require the resident to have a Level 1 Pre-admission Screening and Resident Review because the resident's discharge was anticipated, and the resident returned to the facility within 30 days. During an interview on 09/26/2025 at 01:53 PM, the Minimum Data Set Assessor stated that Resident #5 had a significant change in condition due to weight loss, activities of daily living function, and presence of a new venous ulcer. The Minimum Data Set Assessor stated that there was no significant change noted in mood or psychiatric behavior in the assessment. During an interview on 09/26/2025 at 02:32 PM, the Social Work Supervisor stated that they were responsible for completing the Minimum Data Set assessment's Pre-admission Screening and Resident Review (PASARR) section dated 10/26/2023. The Social Work Supervisor stated that they were aware of Resident #5's schizoaffective disorder diagnosis, which existed prior to their employment in 2022. The Social Work Supervisor stated that a Level II Pre-admission Screening and Resident Review referral should be done at the time when the resident had a change in psychiatric condition or had a new psychiatric diagnosis. The Social Work Supervisor stated that there was no documented evidence to indicate that a Level 1 or Level II Pre-admission Screening and Resident Review referral was completed for Resident #5 since their admission to the facility. During an interview on 09/29/2025 at 03:05 PM, the Director of Nursing Services stated that Resident #5 did not have any psychiatric diagnosis except Dementia when they were first admitted to the facility in 2002. The Director of Nursing Services stated they were unable to establish the onset date of Resident #5's Schizoaffective Disorder diagnosis due to the resident's long history of stay in the facility, and the resident's medical records were maintained primarily on paper only. During an interview on 09/30/2025 at 02:24 PM, the Administrator stated that residents who received a new diagnosis of a serious mental illness after admission to the facility should be screened to see if they require additional mental health services. The Administrator stated that the Social Worker can refer to an outside agency or utilize an in-house qualified screener to determine if the resident requires a Level II Pre-admission Screening and Resident Review (PASARR) further services. 10 NYCRR 415.11(e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during the Recertification Survey initiated on 09/23/2025 and completed on 09/30/2025, the facility did not ensure that a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical and nursing needs that are identified in the comprehensive assessment was implemented for each resident. This was identified for one (1) (Resident #6) of three (3) residents reviewed for Position/Mobility and for one (1) (Resident #70) of three (3) residents reviewed for Position and Mobility Specifically, 1) Resident #6 was observed on three separate occasions without a right-hand splint as ordered by a Physician. 2) Resident #70 had a physician's orders to apply a gauze roll to the right anterior (in the front) elbow. Resident #70 was observed on multiple occasions without the gauze roll in place as ordered. The findings are: 1) The facility's undated policy titled Splinting/Bracing/Orthotic Devices documented splints/braces/orthotics are types of orthotic devices that support or correct musculoskeletal deformities or abnormalities. The device is applied by nursing staff if the resident requires assistance or applied by the resident when the resident is independent in donning/doffing (putting on/taking off) the device. Resident #6 has diagnoses including Hypertension (high blood pressure) and Diabetes Mellitus. The significant change Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident had moderately impaired cognitive skills for daily decision making. The Minimum Data Set (MDS) also documented Resident #6 required substantial/maximal assistance for upper body dressing and was dependent on staff for lower body dressing. The Physician's Order dated 03/17/2025, last renewed 08/27/2025, documented: Right hand splint, apply in the morning and remove at the hour of sleep for the right-sided Hemiparesis (muscle weakness) due to Cerebral Vascular Accident. The Certified Nursing Assistant Assignment/Accountability Record dated September 2025 documented a right-hand splint under Devices. The Comprehensive Care Plan did not include the use of the right-hand splint. On 09/23/2025 at 11:55 AM, the resident was observed sitting upright in their bed, not wearing their right-hand splint. On 09/24/2025 at 10:40 AM, the resident was observed sitting upright in their bed, not wearing their right-hand splint. On 09/24/2025 at 2:50 PM, the resident was observed seated in their wheelchair, not wearing their right-hand splint. During an interview on 09/25/2025 at 10:35 AM, Certified Nursing Assistant #1, who cared for the resident on 09/24/2025 during the 7:00 AM-3:00 PM shift, stated they did not put on the resident's splint yesterday because they did not know where the splint was, and they had notified Registered (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 that the splint was missing. Certified Nursing Assistant #1 stated they did not remember when they made Registered Nurse #1 aware that the resident's splint was missing. During an interview on 09/25/2025 at 10:55, Registered Nurse #1 stated, sometime after 3:00 PM, they went to look for the resident's splint and found the splint in the top drawer of their dresser. Registered Nurse #1 stated they did not know why Certified Nursing Assistant #1 was not able to find it. Registered Nurse #1 stated the resident's splint should have been applied by Certified Nursing Assistant #1. During an interview on 09/25/2025 at 1:40 PM, Certified Nursing Assistant #2, who cared for the resident on 09/23/2025 during the 7:00 AM-3:00 PM shift, stated they should have applied the splint after they provided morning care to the resident. During an interview on 09/26/2025 at 11:05 AM, the Director of Nursing Services stated the resident's splint should have been applied according to the Physician's Order. The Director of Nursing Services stated the splint should have been applied as soon as the Certified Nursing Assistant was finished providing morning (AM) care to the resident. The Director of Nursing Services also stated if Certified Nursing Assistant #1 could not find the resident's splint, they should have reported that to the Nurse as soon as possible and should have also looked in the resident's drawers themselves. 10 NYCRR 415.11(c)(1) 2) The facility policy titled Care Planning, dated 10/2023, documented that it is the responsibility of the discipline that triggers the Care Area Assessment (CAA) to initiate and update the plan of care. It is the responsibility of the Registered Nurse supervisor/Nurse manager to be familiar with each resident and review the care plan for accuracy, and to reflect the current condition. Resident #70 was admitted with diagnoses of Diffuse Traumatic Brain Injury (damage to the brain from a sudden, external force, like a bump, blow, or jolt to the head), functional Quadriplegia (unable to move their arms and legs), and Dysphagia (difficulty swallowing). An Annual Comprehensive Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0, indicating severe cognitive impairment. Resident #70 was dependent on caregivers for dressing, bathing, toileting, eating, and all personal care. The Occupational Therapy screen dated 06/19/2025 documented that Resident #70 had impairments on both sides of the upper extremities. The Occupational Therapy screen documented the use of a gauze roll on the right anterior elbow. A physician's order dated 08/11/2025 documented a gauze roll to the right anterior elbow for skin care. The Comprehensive Care Plan did not document the use of a rolled gauze to the right anterior elbow as an intervention. The September 2025 Certified Nursing Assignment Accountability Record documented assistive devices: a gauze roll to the right anterior elbow. The Certified Nursing Assistants documented that the gauze roll was applied to the resident's elbow daily, on all shifts. During an observation on 09/23/2025 at 12:54 PM, Resident #70 was in bed without the gauze roll (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applied to their right anterior elbow. During an observation on 09/24/2025 at 10:06 AM, Resident #70 was in bed without the gauze roll applied to their right anterior elbow. During an observation on 09/25/2025 at 9:44 AM, Resident #70 was in bed without the gauze roll applied to their right anterior elbow. During an interview on 09/25/2025 at 9:51 AM, Certified Nursing Assistant #5 stated they did not know that the gauze roll was supposed to be applied to the resident's elbow. They would usually put the gauze roll in the resident's hand, never in the elbow. Certified Nursing Assistant #5 stated they did not realize the accountability record instructions included placing the gauze roll in the resident's right elbow. They had mistakenly signed that they applied the gauze roll for Resident #70. During an interview on 09/25/2025 at 10:47 AM, Registered Nurse #2 stated Resident #70 had a physician's order for a gauze roll to be applied to the right elbow. The Certified Nursing Assistants were responsible for reviewing the accountability record and following the instructions, and the nurses on the unit were responsible for ensuring the Certified Nursing Assistnats were following the physician's orders. Resident #70 should have had a gauze roll placed in the right elbow to prevent skin breakdown. During an interview on 09/25/2025 at 11:40 AM, the Director of Occupational Therapy stated they completed the annual Occupational Therapy evaluation of the resident on 06/19/2025, and recommended a gauze roll be applied to the right elbow for skin integrity. The Director of Occupational Therapy stated that nursing staff should apply the gauze roll to prevent skin from rubbing together and reduce moisture buildup. The Director of Occupational Therapy stated that after they complete their recommendations, the Doctor will sign off, and they will notify the unit nurse. The Director of Occupational Therapy stated that they are responsible for initiating the care plan, and the intervention should have been documented in the Skin Integrity care plan. The Comprehensive Care Plan titled 'Skin Problems' dated 07/15/2025 was revised on 09/26/2025 to include the use of a gauze roll on the right anterior elbow as an intervention. During an interview on 09/26/2025 at 8:23 AM, the Director of Nursing Services stated the Certified Nursing Assistant would be responsible for applying the gauze roll as ordered and then signing the Certified Nursing Assistant accountability that it was completed. The Director of Nursing Services stated the Nurse should also check to ensure the task was completed. 10 NYCRR 415.11(c)(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** Based on observations, record review, and interviews during a Recertification survey initiated on [DATE] and completed on [DATE], the facility did not ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team. This was identified for one (1) (Resident #70) of one (1) resident reviewed for Advanced Directives. Specifically, Resident #70 had a physician's order for Medical Orders for Life Sustaining Treatment (MOLST), which included a Do Not Resuscitate (DNR) order; however, the resident's advance directives care plan documented to provide cardiopulmonary resuscitation (CPR). The finding is: The facility policy titled ?Advance Directives: Ascertaining existence of' last revised 05/2021 documents, Advance Directives are expressions of the patient's wishes as to how future care should be delivered or declined, including decisions that must be made when the patient is not capable of expressing those wishes. When the resident is transferred into the facility, Social Work reviews with the resident/family the Advance Directives. Policies and procedures address the use of such directives in the care of the resident: the face sheet of the comprehensive care plan indicates the advance directives. The facility policy titled ?Care Planning' dated 10/2023 documents, the care plan will be reviewed and revised to reflect the resident's current condition per policy and regulations. It is the responsibility of the discipline that triggers the Care Area Assessment (CAA) and to initiate and update the plan of care. It is the responsibility of the Registered Nurse supervisor/nurse manager to be familiar with each resident and review the care plan for accuracy, and to reflect the current condition. Resident #70 was admitted with diagnoses of Diffuse Traumatic Brain Injury (damage to the brain from a sudden, external force, like a bump, blow, or jolt to the head), functional Quadriplegia (unable to move their arms and legs), and Dysphagia (difficulty swallowing). An Annual Comprehensive Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0, indicating severe cognitive impairment. Resident #70 was dependent on caregivers for dressing, bathing, toileting, eating, and all personal care. Minimum Data Set documented the resident's advance directive in section S to be Do Not Resuscitate. A Comprehensive Care Plan titled Advance Directives dated [DATE] documented Medical Order For Life Sustaining Treatment (MOLST) and Full Cardiopulmonary Resuscitation (CPR) to be performed. A Medical Order for Life Sustaining Treatment (MOLST) dated [DATE] documented a Do Not Resuscitate (DNR) order (allow natural death). A physician's order dated [DATE] documented Do Not Resuscitate (DNR).During an interview on [DATE] at 1:14 PM, Registered Nurse #5 stated that Resident #70's physician order and Medical Order for Life Sustaining Treatment (MOLST) indicated Do Not Resuscitate. Registered Nurse #5 stated that the nurses can identify the residents who are a Do Not Resuscitate based on a color-coded system on the chart and wrist band. Registered Nurse #5 stated the care plan and the physician's order should match. During an interview on [DATE] at 12:11 PM, Social Worker Supervisor #1 stated they were responsible for the Advance Directive care plans. Social Worker Supervisor #1 stated that Resident #70's care plan documented the resident was a full code (requiring cardiopulmonary resuscitation); however, the Medical Order for Life Sustaining Treatment (MOLST) dated [DATE] indicated Do Not Resuscitate. Social Worker Supervisor #1 stated the care plan should have been revised on [DATE] to accurately identify the resident's advance directive wishes. During an interview on [DATE] at 8:23 AM, the Director of Nursing Services stated that the resident's care plan should reflect the current advance directive orders. They stated the Social Worker is responsible for completing that section of the care plan, and it should have been revised to reflect the current Do Not Resuscitate (DNR) status. 10NYCRR 415.11(c)(2)(i-iii)

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	335023	A. Building B. Wing	09/30/2025

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification survey initiated on 09/23/2025 and completed on 09/30/2025, the facility did not ensure all drugs and biologicals were stored in a locked compartment and accurately labeled. This was identified for one (Unit 22 medication cart) of seven (7) medication carts, one (Unit 22 medication room) of six (6) medication rooms reviewed for the Medication Storage and Labeling task, and one (1) (Resident #94) of eleven residents reviewed for Accidents. Specifically, 1) the Unit 22 medication cart was noted to be unlocked in the hallway without any staff members present, 2) the Unit 22 medication room refrigerator contained an injectable medication (Ozempic-medication for Diabetes Mellitus) that was opened and was not dated. 3) Resident #94 was observed with an unlabeled Spiriva Handihaler (a medication used for relaxing and opening the airway) on their nightstand and an unlabeled Advair (medication to treat Asthma) inhaler on the bed. There was no nursing staff in the vicinity of Resident #94's room. 4) Resident #1 was observed with a physician-ordered pain patch in their room. The resident did not have a physician's order to self-administer their medication. The findings are: The facility's policy titled 'Medication administration' dated 03/2024 documents that, during the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. The expiration on the medication label must be checked prior to administering. When opening a multi-dose container, the date shall be recorded on the container. 1) During an observation on 09/25/2025 at 9:30 AM, a medication cart was unlocked without a staff member present at the end of the hallway on Unit 22. At 9:32 AM, Registered Nurse #3 exited a resident's room two doors down from the cart and approached the medication cart. During an interview on 09/25/2025 at 9:37 AM, Registered Nurse #3 acknowledged that the medication cart was unlocked and stated they were administering medications to a resident inside a room nearby. Registered Nurse #3 stated they forgot to lock the medication cart before leaving the cart in the hallway. Registered Nurse #3 stated the medication cart should be locked when unattended, as other residents can get into the cart and take a medication from the cart. 2) Resident #399 has diagnoses that include Diabetes Mellitus Type 2 (a chronic condition that affects how the body uses sugar), Hypertension (high blood pressure), and Chronic Ischemic Heart Disease (a condition that restricts blood and oxygen to the heart). The Annual Minimum Data Set, dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident had intact cognition. The physician's order dated 07/15/2025 documented Ozempic 0.25 milligrams per 0.5 milligrams, inject 0.5 milligrams subcutaneously (under the skin) weekly, every Wednesday at 10 AM. A record review of the Medication Administration Record from July 2025 to September 2025 documented that Ozempic was administered to Resident #399 weekly, as ordered. During an observation of the medication room in Unit 22 on 09/25/2025 at 12:21 PM, the medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refrigerator was opened by Registered Nurse #4. An opened Ozempic pen was stored inside the medication refrigerator with no open date. The medication label indicated the Ozempic pen was for Resident #399. The pharmacy label on the box of the medication indicated that the prescription was fulfilled on 06/11/2025. Registered Nurse #4 stated all injectable medications should be dated when opened, and Ozempic should be discarded 28 days after opening. The medication instructions for Ozempic, dated 09/2023 documented the Ozempic pen should be disposed (thrown away) after 56 days, even if it still has Ozempic left in it. Write the disposal date on your calendar. During an interview on 09/26/2025 at 8:23 AM, the Director of Nursing Services stated the medication cart should never be left unlocked without a nurse present. The Director of Nursing Services stated that someone can potentially take and ingest a medication from the cart if the medication cart is left unlocked. The Director of Nursing Services stated that all insulin and insulin pens should be dated when opened and discarded after twenty-eight (28) days. The Director of Nursing Services stated nurses should date all injectable medications when opened to ensure medications are never administered after the discard date. 3) Resident #94 was admitted to the facility with Diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Bronchitis (inflammation of the bronchial tubes, the airways that carry air to and from the lungs), and Colon Cancer. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #94's Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #94 had intact cognition. Resident #94 did not receive any respiratory treatments. A Comprehensive Care Plan dated 05/31/2025 titled, Respiratory Distress related to Chronic Obstructive Pulmonary Disorder documented interventions including administering treatments and medications as ordered by the Physician, monitoring for effectiveness, observing adverse drug reactions, and notifying the Physician of any abnormal findings. A Physician's Order dated 11/15/2024 documented Advair HFA eight (8) grams 230 per 21 inhaler, two (2) puffs per inhalation by mouth twice a day. A Physician's Order dated 09/15/2025 documented Spiriva 18 micrograms Handihaler two (2) puffs per inhalation per one capsule by mouth once a day. A review of Resident #94's electronic medical record revealed that Resident #94 did not have a Physician's order to self-administer their own medications. During an observation on 09/23/2025 at 11:00 AM, Resident #94 was sitting in their wheelchair in their room. An unlabeled box of Spiriva Handihaler was on the nightstand, and an unlabeled Advair inhaler was on Resident #94's bed. During an interview on 09/23/2025 at 11:02 AM, Resident #94 stated that they administer their own inhalers. Resident #94 stated they know their medications and are aware of when to take them. Resident #94 stated that the Nursing staff were aware that they (Resident #94) had the inhalers in their room. Resident #94 stated that the Nurses administer all their medications except for the inhalers. During an interview on 09/23/2025 at 11:15 AM, Licensed Practical Nurse #2, Medication Nurse, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that Resident #94 was alert and oriented and was capable of self-medicating their inhalers. Licensed Practical Nurse #2 stated they did not know the inhalers were not stored in a locked cabinet in the resident's room. During an interview on 09/24/2025 at 12:20 PM, the Registered Nurse #6, Charge Nurse, stated that they were not aware that Resident #94 kept the inhalers unlocked in their room. During an interview on 09/26/2025 at 8:23 AM, the Director of Nursing Services stated that Resident #94 should have a locked drawer to keep their medications. The Director of Nursing Services stated that Resident #94 should have been assessed by the Physician and Nursing staff for self-administration of medication. 10NYCRR 415.18(e)(1-4)

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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. Based on observation, record review, and staff interviews during the Recertification Survey initiated on 09/23/2025 and completed on 09/30/2025, the facility did not ensure it established and maintained an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections for one (1) (Resident #314) of four (4) residents reviewed for Pressure Ulcers. Specifically, during the wound care observation of Resident #314's left heel pressure ulcer, Licensed Practical Nurse #4 allowed the cleansed heel wound to come in contact and rest on a dirty surface.The finding is:The facility's policy titled Wound Dressing, dated 12/2023, documented the nurse to bring a Certified Nursing Assistant for assistance; remove the old dressing, observe the area; wash hands, put on new gloves, and cleanse the wound as ordered, with circular motion, inside to outside.Resident #314 was admitted with diagnoses including Muscle Weakness, Lack of Coordination, and Osteoarthritis (a common joint disease that causes pain, stiffness, and loss of mobility). The 06/30/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of nine (9), indicating the resident had moderate cognitive impairment. The resident had one unstageable (covered by dead tissue or scab and unable to determine true depth) pressure ulcer.A Comprehensive Care Plan, effective 04/07/2025 and last updated 09/29/2025, titled Potential for Further Pressure Injuries, Related to Actual Pressure Ulcer, Unstageable to Left Heel, Fragile Skin, Incontinence, Impaired Mobility. The interventions included administering supplements, treatments, and medications as per the physician's order and monitoring effectiveness. An update on 09/29/2025 documented a new treatment order for the left heel pressure.A physician's order dated 09/29/2025 documented Carrasyn Wound Gel, apply to the left heel two times a day after cleansing with normal saline and cover with a dry protective dressing.During an observation and interview on 09/30/2025 at 8:40 AM, Resident #314's left heel wound care was performed by Licensed Practical Nurse #4. Licensed Practical Nurse #4 stated the wound care order was changed yesterday (09/29/2025) because the dry scab came off the wound, and now the wound was open. Licensed Practical Nurse #4 stated they did not need assistance during wound care and would work alone. Licensed Practical Nurse #4 then instructed the resident to lift their leg and to keep the leg elevated so the wound to the heel could be attended to. Licensed Practical Nurse #4 placed a clean field under the heel. The wound was approximately 1.5 centimeters in width x 1.5 centimeters in length and about 0.1 centimeters in depth. The wound appeared to have mostly granulation tissue (healing tissue) with a small amount of slough (dead tissue). There was serosanguinous (blood-tinged) drainage on the old dressing that the nurse removed. The nurse left the old dressing on the clean field rather than discarding it. After the nurse cleansed the wound with normal saline, the resident appeared to have a grimacing look on their face and brought their leg down to a resting position on the bed. The already cleansed heel wound came in contact and rested on the old dressing, which was folded in half. The nurse was ready to apply the treatment wound gel to the wound bed when the surveyor pointed out that the cleansed wound was now resting on the old dressing. The nurse stated they would have to re-cleanse the wound because it was contaminated by the dirty dressing.During an interview on 09/30/2025 at 12:05 PM, Registered Nurse Educator #1 stated that the nurse should have asked for help from another nurse or the Certified Nursing Assistant to assist them during wound care. If, after the wound was cleansed and came in contact with a dirty surface, the wound would have to be re-cleaned.During an interview on 09/30/2025 at 12:15 PM, Registered Nurse Wound Care #1 stated that it could be painful and uncomfortable for a resident to hold their leg up by themselves for an extended time while wound care is being done. The nurse should have asked the resident if they were comfortable and should have asked for assistance from another staff member to hold the resident's leg to provide treatment to the resident's heel wound. Registered Nurse Wound Care #1 stated that once the heel wound came back in contact with a dirty surface, the nurse would have to re-cleanse the wound.During an interview on 09/30/2025 at 12:22 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, Registered Nurse Infection Preventionist #1 stated that once the wound comes in contact with the dirty surface, it has to be re-cleansed; there is no point in putting the wound medication on the wound because the wound is still dirty.During an interview on 09/30/2025 at 12:45 PM, the Director of Nursing Services stated the nurse should have asked for assistance from another staff member when performing the heel wound care. Once the wound came in contact with the dirty surface, the nurse should have re-cleansed the wound.10 NYCRR 415.19(a)(1-3)