

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/01/2024
NAME OF PROVIDER OR SUPPLIER  Northern Manor Geriatric Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  199 N Middletown Road Nanuet, NY 10954	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49372</p> <p>Based on observation, interview and record review conducted during the abbreviated survey (NY00334847), the facility did not ensure sufficient nursing staff to provide nursing care to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for 7 of 7 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7). Specifically, on 3/3/2024 during the 11:30 PM to 7:30 AM shift the residents who resided on the third-floor dementia unit did not receive their scheduled medications due to inadequate staffing. The scheduled licensed practical nurse for the unit did not arrive for their shift and the night nursing supervisor was not able to administer the resident's medications, due to being called to other units.</p> <p>The findings include:</p> <p>Review of the facility Policy and procedure titled, Staffing Hours revised on 04/2019 documented 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services.</p> <p>Review of Facility assessment dated [DATE] staffing plan documented Center 3 was a Dementia unit with bed count of 37. Day shift indicated zero Registered Nursing (RN) Staff, one (1) Licensed Practical Nurse (LPN) for day, evening, and night shift and three (3) Certified Nursing Aides (CNA) for days and evenings, Two (2) CNA for nights.</p> <p>Review of the Staffing Sign-In Sheet dated 03/02/2024 revealed there was no Licensed Practical Nurse and four (4) certified nurse aide staff scheduled on the 3:30 PM to 11:30 PM shift, for the Center 3 unit.</p> <p>Review of the Staffing Sign-In Sheet dated 03/02/2024 revealed there was no Licensed Practical Nurse and two (2) certified nurse aide staff scheduled on the 11:30 PM to 7:30 AM shift, for the Center 3 unit.</p> <p>Review of the Staffing Sign-In Sheet dated 03/03/2024 revealed there was one (1) Licensed Practical Nurse and four (4) certified nurse aide staff scheduled on the 3:30 PM to 11:30 PM shift, for the Center 3 unit.</p> <p>(continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Staffing Sign-In Sheet dated 03/03/2024 revealed there was no Licensed Practical Nurse and two (2) CNA staff scheduled on the 11:30 PM to 7:30 AM shift, for the Center 3 unit.</p> <p>Resident #1 admitted to the facility with diagnosis including schizoaffective disorder, post-traumatic stress disorder and seizures.</p> <p>Review of the Medication Administration Record (MAR) dated March 2024, for Resident #1, revealed there was no documented evidence that medications were signed out as being administered as follows: 4 medications on 3/2/24, 6 medications on 3/3/24, 3 medications on 3/4/24 and 1 medication on 3/7/24.</p> <p>Resident #2 admitted to the facility with diagnosis and conditions of but not limited to dementia, anxiety and insomnia.</p> <p>Review of the Medication Administration Record (MAR) dated March 2024, for Resident #2, revealed there was no documented evidence that medications were signed out as being administered as follows: 4 medications on 3/2/24 and 4 medications on 3/3/24.</p> <p>Resident #3 admitted to the facility with diagnosis and conditions of but not limited to dementia, hypertension, and anxiety.</p> <p>Review of the Medication Administration Record (MAR) dated March 2024, for Resident #3, revealed there was no documented evidence that medications were signed out as being administered as follows: 6 medications on 3/2/24, 7 medications on 3/3/24, 1 medication on 3/4/24 and 1 medication on 3/7/24.</p> <p>Resident #4 admitted to the facility with diagnosis and conditions of but not limited to dementia, glaucoma, and hypertension.</p> <p>Review of the Medication Administration Record (MAR) dated March 2024, for Resident #4, revealed there was no documented evidence that medications were signed out as being administered as follows: 4 medications on 3/2/24 and 3 medications on 3/3/24.</p> <p>Resident #5 admitted to the facility with diagnosis and conditions of but not limited to dementia, hypertension, and glaucoma.</p> <p>Review of the Medication Administration Record (MAR) dated March 2024, for Resident #5, revealed there was no documented evidence that medications were signed out as being administered as follows: 7 medications on 3/2/24 and 7 medications on 3/3/24.</p> <p>Resident #6 admitted to the facility with diagnosis and conditions of but not limited to dementia, schizophrenia, and insomnia.</p> <p>Review of the Medication Administration Record (MAR) dated March 2024, for Resident #6, revealed there was no documented evidence that medications were signed out as being administered as follows: 3 medications on 3/2/24, and 3 medications on 3/3/24.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #7 admitted to the facility with diagnosis and conditions of but not limited to Alzheimer's, diabetes mellitus and hypertension. Review of the Medication Administration Record (MAR) dated March 2024, for Resident #7, revealed there was no documented evidence that medications were signed out as being administered as follows: 8 medications on 3/2/24 and 8 medications on 3/3/24.</p> <p>During an interview on 03/07/2024 at 11:47 AM with Registered Nurse Supervisor #1, they stated the staffing coordinator was currently on vacation and they were covering the position. Registered Nurse #1 stated last week the staffing coordinator printed out the schedules and instructed them to fill in any openings on the schedule, they were to try to find staff to fill in. Registered Nurse #1 stated they notified the Director of Nursing on 03/01/2024 that they were unable to fill the openings on the schedule for 3/3/2024. Registered Nurse #1 stated the Director of Nursing told them they would work on filling the openings. Registered Nurse #1 confirmed that if the schedule had a blank space on it, that indicated there was no staff for that shift. They stated that all nurses can pass medications if needed during the day, but they did not have the staff at night to assist when needed.</p> <p>During an interview on 03/07/2024 at 4:30 PM with Staff #2 (certified nurse aide) stated they worked on Center 3 on 03/03/2023, from 3:30 PM to 7:30 AM. Staff #2 stated there was no nurse on 03/03/2024 and no one administered the residents' medications that day from 3:30 PM to 7:30 AM. Staff #2 stated the nursing supervisor for the 3:30 PM to 11:30 PM shift, was Registered Nurse Supervisor #3 and the nursing supervisor for the 11:30 PM to 7:30 AM shift was Registered Nurse Supervisor #2.</p> <p>During an interview on 03/08/2024 at 09:58 AM the Registered Nurse Supervisor #2, stated they were the nursing supervisor on 3/3/2024, on the 11:30 PM to 7:30 AM shift. Registered Nurse Supervisor #2 stated there was no nurse for units South 1, South 3 and Center 3. They stated they called the nurses that were on the schedule to work that day, but no one answered. Registered Nurse Supervisor #2 stated they then did their rounds and observed no nurses present on units South 1, South 3 and Center 3. Registered Nurse Supervisor #2 then stated they administered medications on the units South 1 and South 2 and instructed the staff on the units to notify them if anything was needed. Registered Nurse Supervisor #2 stated some residents on Center 3 received their medications, but some did not due to them being called away for supervisory duties and staff on other units needing assistance. Registered Nurse Supervisor #2 stated they have been the night shift nursing supervisor for a year now and sometimes they are responsible for other units as well as being the supervisor. Registered Nurse Supervisor #2 could not state how many nights they were without nursing staff on different units in the facility. Registered Nurse Supervisor #2 stated they were unable to complete their supervisory duties as well as cover scheduled duties for multiple units as well.</p> <p>During an interview on 03/08/2024 at 12:00 PM the Nurse Practitioner stated a lot of times medications are not given due to staffing issues. The Nurse Practitioner stated they had been having issues with medications not being administered for about 3 to 6 months now. The Nurse Practitioner stated they did not expect staff to notify them every time a medication was not administered because they would be called quite frequently.</p> <p>During an interview on 03/08/2024 at 1:49 PM the Attending Physician stated they are at the facility every Sunday and Registered Nurse Supervisor #3 was there. They stated the weekends are tough and the facility had been short staffed since the COVID-19 pandemic.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/13/2024 at 12:37 PM with Registered Nurse Supervisor #3, stated they work per diem at the facility and had worked the 3:30 PM to 11:30 PM shift on 3/3/2024. Registered Nurse Supervisor #3 stated they could not really recall what happened that day, but stated they always get report from the previous shift and then they check the staffing schedule for the units. They stated the staffing on the weekends at the facility has been a problem for about a year and that is why they started working per diem status. They stated often the schedule is left blank for nursing staff on the weekends and it is the expectation that the Registered Nurse supervisor will get the shifts filled. They stated normally they can talk nursing staff into doing double shifts or calling in other staff members to fill the openings. Registered Nurse supervisor#3 stated they had no issue with the certified nurse aide staffing on the weekends. They stated if there were medications not administered on 3/3/2024 it was more than likely due to their being no nurse for that unit. Stated they are expected to let the Director of Nursing or Administrator know if they are unable to fill missing openings on the schedule and that they are aware of the issue because they leave the schedule on Friday for the weekends. Registered Nurse supervisor #3 stated on Sunday's there are normally 2 to 3 units that do not have a nurse and it is difficult to complete supervisory duties as well as the nursing unit duties at the same time.</p> <p>10NYCRR 415.13 (A)(1)(i-iii)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>49372</p> <p>Based on record review and interview conducted during an abbreviated survey (NY00334847), the facility did not ensure that residents were free of significant medication errors. This was evident for 7 of 7 Residents (#1, #2, #3, #4, #5, #6 and #7) reviewed for medication administration. Specifically, a registered Nurse did not follow physician orders to administer scheduled medications during the 11:30pm to 7am shift on 2/2/2024, 2/3/2024, 2/4/2024, 2/5/2024, 2/8/2024, 3/2/2024, 3/3/2024, 3/4/2024, and 3/7/2024. There was no evidence in the Medication Administration record that the scheduled physician prescribed medications were administered to the residents.</p> <p>The findings are:</p> <p>The facility Policy titles Medication Errors dated 10/2015 and revised 8/2019 stated the staff and practitioner shall try to prevent medication errors and adverse medication consequences and shall strive to identify and manage them appropriately when they occur. The Director of Nursing should investigate the error. Counsel staff members as needed. Educate staff members on how to avoid making similar errors in the future. File the report according to state and federal regulations. Share the report with the Quality Assurance department, Administrator, Medical Director, and Safety Committee for facility statistics and a Plan of Correction on improving facility practices. Maintain the report on file in the Director of Nursing's office according to state and federal regulations.</p> <p>Resident #1 was admitted to the facility with diagnosis and conditions including schizoaffective disorder, post-traumatic stress disorder and seizures.</p> <p>Review of the February 2024 Medication Administration record for Resident #1 revealed the following medications were not signed out as being administered: Levoxyl 125 mcg tablet on 2/3/2024, 2/4/2024, 2/5/2024 and 2/8/2024 at 5 AM; Valproic acid 250 mg/5 ml solution on 2/2/2024 at 10 PM and on 2/3/2024, 2/4/2024, 2/5/2024 and 2/8/2024 at 6 AM; Keppra 500 mg tablet on 2/2/2024 at 9 PM; Nitrofurantoin Macrocrystal capsule 100 mg on 2/8/2024 at 12 AM and 6 AM.</p> <p>Review of the March 2024 Medication Administration record for Resident #1 revealed the following medications were not signed as being administered: Levoxyl 125 mcg tablet on 3/3/2024, 3/4/2024 and 3/7/2024 at 5 AM; Onfi 10 mg tablet on 3/2/2024 and 3/3/24 at 5 PM; Valproic acid 250 mg/5 ml solution on 3/2/24 at 10 PM, on 3/3/2024 at 6AM and 10 PM and on 3/4/2024 at 6 AM; Ezetimibe 10 mg tab on 3/3/2024 and 3/4/2024 between 7PM-10PM; Keppra 500 mg tablet on 3/2/24 and 3/3/2024 at 9 PM; Midodrine HCL 5 mg tablet on 3/2/2024 and 3/3/2024 at 5 PM.</p> <p>Resident #2 was admitted to the facility with diagnosis and conditions including dementia, anxiety, and insomnia.</p> <p>Review of the February 2024 Medication Administration record for Resident #2 revealed the following medications were not signed out as being administered: Melatonin 10 mg tablet on 2/2/24 at 9 PM; Mirtazapine 15 mg tablet on 2/2/24 at 10 PM; Mirtazapine 7.5 mg on 2/2/24 at 10 PM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the March 2024 Medication Administration record for Resident #2 revealed the following medications were not signed as being administered: Melatonin 10 mg tablet on 3/2/24 and 3/3/24 between 7 PM-10 PM; Alprazolam 0.25 mg tablet on 3/2/24 and 3/3/24 at 5 PM; Mirtazapine 15 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM-10 PM; Mirtazapine 7.5 mg on 3/2/2024 and 3/3/2024 between 7 PM-10PM (dose is given combined for a total dose of 22.5 mg).</p> <p>Resident #3 was admitted to the facility with diagnosis including dementia, hypertension and anxiety.</p> <p>Review of the February 2024 Medication Administration record for Resident #3 revealed the following medications were not signed out as being administered: Levothyroxine sodium 200 mcg tablet on 2/3/24, 2/4/24, 2/5/24 and 2/8/24 at 5 AM.</p> <p>Review of the March 2024 Medication Administration record for Resident #3 revealed the following medications were not signed as being administered: Ativan 0.5 mg tablet on 3/2/2024 and 3/3/2024 at 5 PM; Lipitor 40 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM-10 PM; Melatonin 3 mg tablet(2 tablets) on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM; Levothyroxine sodium 200 mcg tablet on 3/3/2024, 3/4/2024 and 3/7/2024 at 5 AM; Metoprolol Tartrate 12.5 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM; Mirtazapine 15 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM-10 PM.</p> <p>Resident #4 was admitted to the facility with diagnosis and conditions including dementia, glaucoma and hypertension.</p> <p>Review of the March 2024 Medication Administration record for Resident #4 revealed the following medications were not signed out as being administered: Latanoprost solution 0.005% on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM; Valsartan 40 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM.</p> <p>Resident #5 was admitted to the facility with diagnosis including but not limited to dementia, hypertension and glaucoma.</p> <p>Review of the March 2024 Medication Administration record for Resident #5 revealed the following medications were not signed out as being administered: Seroquel 25 mg tablet on 3/2/2024 and 3/3/2024 at 9 PM; Dorzolamide HCL- Timolol Mal Ophthalmic solution 22.3-6.8 mg/ml on 3/2/2024 and 3/3/2024 between 7 PM- 9 PM; Clonidine HCL 0.1 mg tablet on 3/2/2024 and 3/3/2024 at 9 PM; Labetalol HCL 100 mg tablet on 3/2/2024 and 3/3/2024 at 9 PM; Latanoprost solution 0.005% on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM; Melatonin 3 mg on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM.</p> <p>Resident #6 was admitted to the facility with diagnosis including but not limited to dementia, schizophrenia, and insomnia.</p> <p>Review of the March 2024 Medication Administration record for Resident #6 revealed the following medications were not signed out as being administered: Seroquel 75 mg tablet on 3/2/2024 and 3/3/2024 at 9 PM; Clonazepam 0.5 mg on 3/2/2024 and 3/3/2024 at 5 PM; Trazodone HCL 150 mg on 3/2/2024 and 3/3/2024 between 7 PM and 10 PM.</p> <p>Resident #7 was admitted to the facility with diagnosis including but not limited to Alzheimer's, diabetes mellitus and hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the February 2024 Medication Administration record for Resident #7 revealed the following medications were not signed out as being administered: Novolog (Insulin aspart) per sliding scale on 2/3/2024, 2/4/2024, 2/5/2024 and 2/8/2024 at 6 AM.</p> <p>Review of the March 2024 Medication Administration record for Resident #7 revealed the following medications were not signed as being administered: Lantus insulin 6 units on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM; Eliquis 2.5 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM and 9 PM; Atorvastatin calcium 40 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM- 10 PM; Carvedilol 6.25 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM- 9 PM; Clonazepam 0.5 mg tablet on 3/2/2024 and 3/3/2024 at 9 PM; Clonidine HCL 0.1 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM- 9 PM; Quetiapine fumarate 25 mg tablet on 3/2/2024 and 3/3/2024 between 7 PM - 10 PM; Sevelamer carbonate 800 mg tablet on 3/2/2024 and 3/3/2024 at 5 PM.</p> <p>During an interview on 03/08/2024 at 9:58 AM, the Registered Nurse supervisor-night shift stated they did not have a nurse on 3 units, South 1, South 2 and Center 3, on Sunday 3/3/2024. The Registered Nurse supervisor-night shift stated they texted the Director of Nursing to inform them they needed help with staff in the building. The Registered Nurse supervisor-night shift stated they texted them back, but they do not remember what they said as they continued to work. The Registered Nurse supervisor-night shift stated they administered the medications on South 1 and South 2 but were only able to administer some resident's medication on Center 3, due to being called to different units. The Registered Nurse supervisor-night shift stated occasionally they are without a nurse on the floors at night. The Registered Nurse supervisor-night shift stated when there are no nurses, not all residents are going to receive their medications. One person cannot administer medications on all units alone.</p> <p>During an interview on 3/8/2024 at 12:00 PM, the Nurse Practitioner stated they were not notified that no medications were administered on Sunday evening or night shift. The Nurse Practitioner stated a lot of times medications are not given because of staffing issues. The Nurse Practitioner stated if a psychiatric medication was not administered by the floor nurse, the nursing supervisor should be informed. The Nurse Practitioner Stated that the staffing issue and medication not being administered has been ongoing for about 3 to 6 months now.</p> <p>During an interview on 3/8/2024 at 12:34 PM, the Director of Nursing stated the nursing supervisor will assist to make sure medications are administered. Director of Nursing Stated they expect that if a medication is not administered then the staff would contact the physician for an appropriate intervention. The Director of Nursing stated they did not run a medication administration report for this weekend but would expect to be contacted if there was an issue. The Director of Nursing stated they did receive a text from the nursing supervisor but did not get it until early the next morning. The Director of Nursing stated ideally, the supervisor is to try to call in the staff who are not in the building to see if they can come and cover. Supervisors are expected to try and fill the spot if there is a call out. The supervisor in the building will assist to make sure the medications are given and complete their supervisory activities. The Director of Nursing stated if they are made aware of a situation of a call out, they would also assist in trying to reach out to staff, as they have a roster for all staff with their contact numbers at home. The Director of Nursing stated unfortunately, on this day, they were asleep when they were texted. They stated that they were not aware that medications were not administered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/8/2024 at 1:49 PM, the Attending physician stated that weekend staffing is tough, and the facility is usually short staffed. This has been going on since COVID. The Attending Physician Stated generally staff is expected to call them when a medication is not administered. Generally, if a medically necessary medication for seizures, blood pressure or oral diabetic medication is not administered, the staff is expected to inform the physician. If it is a medication that is not medically necessary, then they will okay the delay until the medication can be given.</p> <p>During an follow up interview with the Director of Nursing on 4/1/24 at 9:30 AM, they stated they looked at the medication administration report from the weekend of the incident and saw there were medications that were not administered. The Director of Nursing stated that the medical team was made aware of the missed medications and the residents were assessed, but their vital signs and overall clinical presentation were not found with any gross variances from their baselines. The Director of Nursing stated the medication administration report is routinely run to identify missed medications. If it is determined that medications are missed, the medical team is made aware and the medical team decide what the next steps should be. The Director of Nursing stated education is provided to the staff to ensure they are aware of what to do to prevent reoccurrence but they were not sure if there is a facility policy regarding missed medications. The Director of Nursing stated some of the reasons for a medication not been administered could be lack of staffing. The facility is doing its best to to mitigate the staffing issues, they are trying to fill positions and staff each unit and shift adequately.</p> <p>10NYCRR 415.12(m)(2)</p>		