

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 05/21/2024
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48849</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00312813), the facility did not ensure grievances were resolved in a timely manner. This was evident for 1 of 3 resident (Resident # 3) reviewed for grievances/complaints. Specifically, there was no documented evidence that a thorough investigation was completed after Resident #1 and family representative reported missing clothing's.</p> <p>The findings are:</p> <p>The facility Policy and Procedure titled Investigation of Grievance/concerns dated 3/2016, reviewed on 1/18/2023 documented that the facility residents and representatives may submit a grievance orally, in writing and anonymously. The Director of Social Work is the facility's Grievance Officer and is responsible for facilitating the complaint/grievance process, and the corresponding department will investigate the allegation(s) and submit a written report of such findings within 7 business days.</p> <p>Resident # 3 was admitted with diagnoses including but not limited to Urinary tract infection, benign neoplasm of the meninges (brain), and seizures.</p> <p>The Admission Minimum Data Set (MDS, an assessment tool) dated 1/30/2023 documented the resident was cognitively intact and able to make self-understood and understands others.</p> <p>Review of the Social Services Progress Note from 02/01/2023 to 03/31/2023 revealed no documented evidence pertaining to Resident #3 grievance and missing property complaint.</p> <p>During a record review of the clothing inventory log for Resident #3, the property inventory log form dated 2/2/2023 revealed a documentation the residents clothing not logged.</p> <p>During an interview on 4/26/2024 at 2:33 pm, Staff # 1 (certified nurse assistant) stated that resident clothing need to be labeled, goes to the receptionist then it goes to housekeeping.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/30/2024 at 11:04 am, Social Worker # 2 stated they were not aware of missing property, and if a resident or family member is complaining about missing property, they ask them if they want to file a grievance. The family member was in contact with the administrator, and the administrator never told them to complete a grievance form. Social worker #2 stated they are the grievance officer, and any grievance form is returned to them to contact the family with the results within 7 days. All grievances are kept in one binder in the director of social services office; if the form was not initiated, filed or in the binder, no grievance was filed.</p> <p>During an interview on 4/30/2024 at 3:10 pm, the Front Desk Receptionist stated they have been working at the facility for 6 months and when someone brings items in, they give them a form to complete, the yellow copy goes in a bag and kept behind the desk for housekeeping and the white copy is placed in a binder at the front desk. They stated there is a form for Resident # 3 dated 2/2/2023 but clothing not logged was written in marker that is not timed or indicate the person who wrote the information.</p> <p>During an interview on 05/9/2024 at 10:46 am, the Administrator stated the social worker completes a missing property form and missing items are investigated when residents have missing property issues. If they are aware of the missing property themselves then they would ask the social worker to write up a grievance. If a grievance was not documented, then they are not sure why.</p> <p>During an interview on 5/9/2024 at 11:04 am, the Director of Housekeeping and Laundry stated that clothing is logged in on a (triplicate) form at the front desk by the family member and the front desk staff. One copy is placed in the clothing bag; the second copy is given to the family; and the third is placed in a binder at the front desk. There must have been a complaint by Resident # 1 or the family of missing property because the process is that when there is a complaint, they check the laundry and the clothing inventory log form in the binder at the front desk. If there is no form, they write on a new clothing inventory log form clothing not logged. At that point, the social worker would be told by them; however, they do not recall the incident.</p> <p>10 NYCRR 483.10(j)(2)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews during an abbreviated survey (NY0333863), the facility did not ensure that an alleged violation involving abuse was reported to the New York State Department of Health. In addition, the results of all investigation were not reported within 5 working days of the incident with corrective action taken to the New York State Department of Health in accordance with State law. This was evident for 1 (Resident# 1) out of 3 residents reviewed for abuse. Specifically, Resident #1 alleged they reported that they were sexually assaulted 3 times by facility staff on 12/2/23 and 12/3/23, there was no documented evidence that the allegation was reported to the New York State Department of Health.</p> <p>Findings include:</p> <p>Resident#1 had diagnoses that included dependence on respirator [ventilator] status, neuromuscular dysfunction of the bladder and legal blindness.</p> <p>The Discharge Minimum Data Set (MDS, an assessment tool) dated 12/7/23 documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 13/15, associated with intact cognition (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact), had unclear speech but is usually understood and understands with severely impaired vision. The resident had impairment to both upper and lower extremities and was dependent for toileting, personal hygiene, dressing, bed mobility and transfers. The resident had a gastrostomy tube for feedings, an indwelling catheter and was frequently incontinent of bowels. Section E documented no psychosis or behavioral symptoms exhibited.</p> <p>During an interview on 3/19/24 at 11:10 AM, the Director of Nursing stated the Administrator said that they reported the allegation. The Director of Nursing stated they left a voicemail on the hotline, and the allegation was investigated. The Director of Nursing stated the police report may not be on file, but they had a badge number in their statements.</p> <p>During a follow up interview on 3/19/24 at 4:10 PM, the Director of Nursing stated the facility process is that any allegation of abuse is reported to the administration. The allegation will be investigated. Staff may need to be suspended depending on the findings. The allegation is then called in and reported to the New York State Department of Health, then a facility Accident/Incident report is completed. A determination is then made as to whether it rises to a reportable incident. The Director of Nursing stated if the allegation is reported through the New York State website, there is a printout of the confirmation receipt. If the report is completed through the hotline, the State will call back to confirm that the call was received.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/24 at 4:48 PM, the Administrator stated they called the allegation into the State on a Sunday. The Administrator stated they called it into the hotline and left a voicemail, then followed up with a call to the Metropolitan Area Regional Office ([NAME]) office a few days later. The Administrator stated they did not recall the name of the person they spoke with, but inquired about the reporting and was instructed to call the number again. The Administrator stated when they and their assistant administrator heard about the allegation, and they called it in right away. The Administrator stated they have the investigation conclusion which states when they called in the report on a word document.</p> <p>On 3/20/24 at 10:15 AM, the Director of Nursing showed the Administrators phone call log, which revealed the call to the New York State hotline. The call log revealed a 3-minute call to a [PHONE NUMBER] number (which is not a New York State Department of Health phone number) at 3:11 PM. There was no documentation of confirmation that information was received, and no documentation of 5-day investigative result report submitted available for review.</p> <p>The facility did not provide documentation that the alleged incident that was reported to New York State Department of Health.</p> <p>10 NYRCC 415.4(b)(1)(i)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews during the an abbreviated survey (NY03333863) , the facility did not ensure that an alleged violation involving abuse was reported to the New York State Department of Health. In addition, the results of all investigation were reported within 5 working days of the incident with corrective action taken to the New York State Department of Health in accordance with State law. This was evident for 1 (Resident# 1) out of 3 residents reviewed for abuse. Specifically, Resident #1 alleged they were sexually assaulted 3 times by facility staff on 12/2/23 and 12/3/23, there was no documented confirmation or receipt of reporting of the allegation or the results of the allegation to the New York State Department of Health.</p> <p>Findings include:</p> <p>Resident#1 was admitted to the facility on [DATE] with diagnoses that included dependence on respirator [ventilator] status, neuromuscular dysfunction of the bladder and legal blindness.</p> <p>The Discharge Minimum Data Set (MDS, an assessment tool) dated 12/7/23, documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 13/15, associated with intact cognition (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact), had unclear speech, but is usually understood and understands with severely impaired vision. The resident had impairment to both upper and lower extremities and was dependent for toileting, personal hygiene, dressing, bed mobility and transfers. The resident had a gastrostomy tube for feedings, a indwelling catheter and was frequently incontinent of bowels. Section E documented no psychosis or behavioral symptoms exhibited.</p> <p>During an interview on 3/19/24 at 11:10 AM the Director of Nursing stated the Administrator said that they reported the allegation to the New York State Department of Health. Stated they left a voicemail on the hotline, and the allegation was investigated. Stated the police report may not be on file, but they had a badge number in their statements.</p> <p>During a follow up interview on 3/19/24 at 4:10 PM the Director of Nursing stated from their expectation is that any allegation of abuse would be reported to administration, then the allegation will be investigated. Staff may need to be suspended depending on the situation. The allegation is then called in and reported to the New York State Department of Health, then a facility Accident/Incident report is completed. A determination is then made to see if the criterion for abuse is met for reportable incidents. If the allegation is reported through the New York State website, there is a printout of the confirmation of receipt. If the report is completed through the hotline, the State will call back to confirm the call was received and follow up.</p> <p>During an interview on 3/19 at 4:48PM the Administrator stated they called the allegation into the State on a Sunday. The Administrator stated they called it into the hotline and left a voicemail, then followed up with a call to the Metropolitan Area Regional Office ((NAME)) office a few days later. Stated they did not recall the name of the person they spoke with, but inquired about the reporting and was instructed to call the number again. Stated when they and their assistant administrator heard about the allegation, and they called it in right away. Stated they have the investigation conclusion which states when they called in the report on a word document.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/20/24 at 10:15 AM the Director of Nursing delivered the Administrators phone call log, stating it reveals the call to the New York State hotline, The call log revealed a 3-minute call to [PHONE NUMBER] at 3:11 PM. There was no documentation of confirmation that information was received, and no documentation of 5-day investigative result report submitted available for review.</p> <p>Additional Medical records requested from the hospital was not received.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48849</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00312813), the facility did not ensure that a resident was given the opportunity to participate in their care plan meeting. This was evident for 1 out of 3 residents (Resident #3) reviewed for care plans. Specifically, there was no documented evidence that the resident and resident representative/family was invited and/or attended a care plan meeting during their stay in the facility.</p> <p>The findings are:</p> <p>Resident # 3 was admitted with a diagnosis including but not limited to Urinary tract infection, benign neoplasm of the meninges (brain), and seizures.</p> <p>The admission Minimum Data Set (MDS, an assessment tool) dated 1/30/2023 documented the resident was cognitively intact and was able to make self-understood and understands others.</p> <p>Record review of the Social Services Progress Notes revealed no documented evidence that Resident #3 participated in any interdisciplinary care plan meeting during their stay in the facility from 01/30/2023 to 03/16/2023.</p> <p>During an interview on 4/30/24 at 11:04 am, Social Worker # 2 stated there are documented notes that a care plan meeting was scheduled for 2/28/2023 for Resident #3 but the meeting never happened, and they are not sure why. Social Worker # 2 stated that Social Worker #1 usually does the invitation to the Care Plan meeting which normally consist of the social worker, the resident, the resident's representative/family, nursing, the dietician, the physical therapist. There was no documentation on why the care plan meeting did not take place or any rescheduling done.</p> <p>10 NYCRR 483.21(b)(2)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record reviews and interviews conducted during an abbreviated survey (NY0333863), the facility did not ensure a resident that had an indwelling catheter received appropriate treatment and services as evidenced for 1 (Resident #1) out of 3 residents reviewed for indwelling catheter care. Specifically, Resident #1 who had a history neuromuscular dysfunction of the bladder had no documented evidence of receiving indwelling catheter care every day and every shift as ordered on 7 occasions in December 2023 and subsequently was diagnosed with a urinary tract infection.</p> <p>Findings include:</p> <p>Review of the catheter care policy dated 7/2016 and last revised 5/2019 documented that the purpose of the procedure is to prevent catheter-associated urinary tract infections and provide required care of resident's who have an indwelling catheter.</p> <p>Resident#1 was admitted to the facility on [DATE] with diagnoses that included dependence on respirator [ventilator] status, neuromuscular dysfunction of the bladder and legal blindness.</p> <p>The Discharge Minimum Data Set (MDS), an assessment tool) dated 12/7/2023, documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 13/15, associated with intact cognition (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact), had unclear speech, but is usually understood and understands with severely impaired vision. The resident had impairment to both upper and lower extremities and was dependent for toileting, personal hygiene, dressing, bed mobility and transfers. The resident had a gastrostomy tube for feedings, an indwelling catheter and was frequently incontinent of bowels</p> <p>A physician's order dated 12/1/2023 documented catheter care every day every shift.</p> <p>A physician's order dated 12/1/2023 documented catheter- urinary, change urinary collection bag if soiled, broken, leaking or with a catheter change.</p> <p>Review of the Certified Nurse Aide Accountability documentation for December 2023 revealed no documented evidence of the resident was receiving catheter care on the following dates: 12/2/2023 11:30 PM - 7:30 AM shift; 12/3/2023 3:30 PM-11:30 PM and 11:30 PM-7:30 AM shift; 12/4/2023 7:30 AM - 3:30 PM; 12/5/2023 7:30 AM - 3:30 PM shift and 11:30 PM -7:30 AM shift and 12/6/2023 11:30 PM-7:30 AM shift.</p> <p>Review of Nurse Practitioner #2's progress note dated 12/5/2023 documented the resident was seen and examined today after they spiked a low-grade temperature of 99 and will obtain a urinalysis and culture and give Tylenol. Ordered for labs to be repeated in the morning.</p> <p>Review of the resident's lab results of a blood sample collected on 12/6/2023 and reported on 12/7/2023 documented a white blood cell count 15.30 (elevated-indicating infection).</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Nurse Practitioner #2's progress note dated 12/7/2023 documented the resident continued to spike a low-grade temperature of 99 today and their white blood cell count increased to 15. Documented will start the resident on Levaquin antibiotic for presumed urinary tract infection.</p> <p>Review of the resident's urinalysis results collected 12/7/2023 documented the following: urine cloudy, large amount of leukocyte esterase (normal negative; detects a substance that suggests there are white blood cells in the urine), urine white blood cells 11-20 (high- normal range 0-5), urine red blood cell 6-10 (normal 0-2), urine bacteria many (normal-none seen), hyaline casts 3-5 (normal 0-20). Urine culture result identified the microorganism as enterococcus and yeast and antibiotic susceptibilities listed.</p> <p>During an interview on 3/19/2024 at 11:10 AM, the Director of Nursing stated the Resident #1 was being monitored, due to spiking fevers, and elevated white blood cells (WBC), and they did test positive for a urinary tract infection, which may have caused them some confusion.</p> <p>During an interview on 3/20/2024 at 10:34 AM, the Attending Physician stated they were made aware of a change in Resident #1's condition. The Attending Physician stated the resident was spiking low-grade temperatures and had a catheter related infection, there was no indication of anything relating to limitation of cares provided. The Attending Physician stated they were going to treat the resident for the urinary tract infection, but the resident went to the hospital.</p> <p>During a telephone interview on 3/20/2024 at 11:12 AM, Nurse Practitioner #2 stated that Resident #1 was spiking a fever and they wanted to start an antibiotic to treat them. The resident's spouse wanted them transferred out. Nurse Practitioner #2 stated the resident was lethargic, according to their spouse, but that was their usual state as viewed by staff. Nurse Practitioner #2 stated could not recall any other specifics, would need to review the chart.</p> <p>During a telephone interview on 3/20/24 at 1:02 PM, Staff #7 (Certified Nurse Assistant) stated nothing happened with Resident #1 on the night shift. Staff #7 stated they always worked with another staff when providing cares on the vent unit. Staff #7 stated they worked on the unit the night in question and did not know anything about the allegation made by Resident #1. Staff #7 stated there are no male certified nurse aides working on their unit. Staff #7 stated they always work on the unit with Staff #8 (certified nurse aide). Staff #7 stated the resident's spouse always complained about the evening shift not the night shift. Staff #7 stated the husband always complained and calls the police. Staff #7 stated if the catheter bag is full, they will empty it and if it leaks on the floor, they will report it to the nurse. The nurse would change the bag and the catheter if needed. Staff #7 stated would then have the housekeeper clean the spill in the morning. Staff #7 stated that if there is no signature in the box, then the assignment was not done.</p> <p>Attempts to reach Staff #8 by phone on 3/20/24, 4/19/24, was unsuccessful.</p> <p>10 NYRCC 415.12(d)(2)</p>		