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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335046	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Manor Geriatric Center Inc	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)
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. 43478 Based on record review, and interviews conducted during an abbreviated survey (NY00339051), the facility did not ensure residents right to be free from abuse for 2 of 4 residents reviewed for abuse. Specifically, on 4/12/2024, Resident #3 was transferred to a different unit due to verbal aggression with their roommate. The receiving unit was not notified of the incident of verbal aggression with their roommate which prompted the transfer. Resident #3 punched Resident #4 in the face and was transferred to the hospital and was admitted for psychosis. Findings include: The facility policy, 'Abuse' revised 12/2022 documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Resident #3 had diagnoses including but not limited to schizophrenia, hypertension, and hyperlipidemia. The Quarterly Minimum Data Set (resident assessment tool) dated 2/8/2024 documented that the resident had intact cognition. The assessment documented Resident #3 required supervision with eating, transfers, ambulation in room and corridor. The Behavior Symptoms care plan dated 2/8/2024 documented behavior symptoms such as restlessness, paranoia, delusions, noncompliance with their medication regimen. Interventions included to administer psychoactive medications as ordered, determine cause of the behavior, and maintain resident's safety. The Psychoactive Medications related to Schizophrenia care plan dated 12/12/2023 documented interventions which included to administer medications as ordered by physician, monitor/record/report refusal to eat and behavior symptoms not usual to the person, monitor/record occurrence of target behavior symptoms and document per facility protocol. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Psychiatry Consult dated 1/11/2024 documented recommendation given Resident #3 history of schizophrenia per chart review and Resident #3s' report of previous psychotic symptoms keep medications as prescribed, no gradual dose reduction indicated at this time. The Psychiatry Consult dated 1/18/2024 documented gradual dose reduction not indicated at this time. The Physician's orders included Haldol 2 mg, 1 tab twice a day for schizophrenia, and Invega Sustenna Intramuscular 156 mg every 30 days for schizophrenia, The April 2024 Medication Administration Record was blank on 4/11/2024 for all prescribed medications on the day shift, and no reason was documented. There was no nurse's note on 4/11/2024 documenting Resident #3 refusals to take any medications on the day shift, or that the medical provider was notified. The April 2024 Medication Administration Record documented on 4/11/2024 at 5 PM, under comment that Resident #3 refused Haldol and all other medications on the evening shift and there was no nurse's note documenting that the provider was notified of Resident #s's refusal or his behavioral symptoms. There was no Physician's Note in Resident #3's medical record related to Resident #3's behavioral symptoms on 4/11/2024 and 4/12/2024, or Resident #3's refusal of medication on 4/11/2024. The Nurse's Note dated 4/11/2024 at 11:43PM written by Licensed Practical Nurse (Staff #20), documented Resident #3 was alert with confusion, refused all medications this evening and his meal and claimed that staff are trying to poison him. Resident #3 put their snack in the garbage. Resident #3 continues to refuse care despite encouragement. The Nurse's Note dated 4/12/2024 at 10:32 AM written by Registered Nurse Unit Manager (Staff #10), documented that at 7:45 am staff overheard Resident #3 and roommate in a verbal altercation in their room and Resident #3 stating, F you I will kill you. On assessment Resident #3 stated I was talking to myself because they are trying to give me poison, I curse them. Resident #3 was provided emotional support and transferred to another unit. The Nurse's Note dated 4/12/2024 at 11:57 AM written by Registered Nurse Unit Manager (Staff #10), documented Resident #3 displayed verbal outbursts, refusal of care, hallucinations / delusions, refused food and medications, resident stated they are trying to poison me. Resident #3 was able to be redirected with some effect and received food and medications. Haldol 2 mg was last administered 4/12/2024 at 9:23 AM. Non-Pharmacological Interventions: Resident was redirected to less stimulating environment. Result of intervention: better. The Nurse's Note dated 4/12/2024 at 9:49 PM written by Licensed Practical Nurse (Staff #9), documented Resident #3 was observed verbally and physically abusive to roommate. Non-Pharmacological Interventions- verbal redirection. Result of intervention: unchanged. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note 4/12/2024 at 11:11 PM written by Registered Nurse Supervisor (Staff #22) documented Resident #3 physically assaulted new roommate. Incident was witnessed by Licensed Practical Nurse, who intervened and removed the roommate from the room. Resident #3 was highly agitated, cursing at unit nurse and nurse supervisor. Resident #4 had diagnoses including but not limited to hemiplegia & hemiparesis affecting left side, aphasia, severe depression with psychotic features, dementia with behavioral disturbance, psychosis. Resident #4 Quarterly Minimum Data Set (resident assessment tool) dated 1/22/2024 documented moderately impaired cognition. The resident had delusions, no verbal or physical behavioral symptoms, and wandering behavior 1-3 days. The resident had impairments to upper & lower extremities on one side. The assessment documented the resident required supervision with eating & bed mobility, moderate assistance with bathing & dressing & hygiene & transfers. The 'At risk for Potential Abuse' care plan initiated 05/05/2016 included interventions to provide support and ensure the resident is free from abuse. The 'Impaired Cognitive Function' care plan dated 1/22/2024 documented long term memory loss. Interventions included administer medications as ordered, ask yes/no questions to determine needs, encourage simple activities, consistent routine, monitor/document/report any changes in cognitive function. The 'Self-Care and Mobility' care plan dated 1/10/2024 documented limited mobility, limited range of motion, stroke. Interventions included to encourage resident to participate to the fullest extent possible The Accident &Incident report for Resident #4 dated 4/12/2024 at 9:20 PM documented a Resident-to-Resident Altercation with roommate. The nurse witnessed Resident #3 punching Resident #4 in the mouth, immediately intervened and pulled Resident #4 out of the room. Prior to the incident, they had observed Resident #4 sitting in the hallway. Resident #4 was observed with bruise to right mouth and small internal gum laceration from contact with teeth s/p hit from roommate. Resident immediately separated from his assailant and safety ensured with change in room and assessment. First aid was provided. Resident without any further injuries. Resident assessed by Social Services 4/15/24 with no evidence of anguish 2/2 incident. New York State Department of Health notified of incident due to resident-to-resident status. On 5/21/2024 at 4:21 PM during an interview, Licensed Practical Nurse (Staff #20), stated they worked the evening shift on 4/11/2024. Staff #20 stated they did not notify the medical provider that Resident #3 refused all medications and refused their meal and claimed that staff were trying to poison them, and put their snack in the garbage, and refused care despite encouragement. Staff #20 stated that when they came to work on 4/11/2024, they were informed by the day nurse that Resident #3 refused their medications on the day shift. Resident #3 continued to refuse medications throughout the evening shift. Staff #20 stated that when a resident refuses medication and has unusual behaviors, they are to call the medical provider and make the supervisor aware. Staff #20 stated they did not do so. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/2024 at 4:43 PM during an interview, the Director of Nursing stated that when a resident refuses medication, the nurse should document the refusal in the Medication Administration Record, notify the medical provider, and write a note. On 5/21/2024 at 5:10 PM during an interview, Registered Nurse Supervisor (Staff #23) who worked on 4/11/2024 on the evening shift stated the unit nurse did not report any concerns with Resident #3 regarding medication refusals or behavioral symptoms. Staff #23 stated they would have notified the medical provider if any concerns had been reported. During an interview on 5/21/2024 at 6:35 PM, the primary physician stated they were not made aware of Resident #3 behavioral symptoms and medication refusals on 4/11/2024. The physician stated they should have had been notified. During an interview on 5/21/2024 at 6:54 PM and at 7:04 PM, the Nurse Practitioner stated they were not made aware of Resident #3 medication refusals and behaviors on 4/11/2024 or on 4/12/2024. The Nurse Practitioner stated they were in the building all day on 4/11/2024 and 4/12/2024 and they would have assessed Resident #3 and documented the assessment if they had been made aware. During an interview on 5/22/2024 at 8:42 AM, Registered Nurse Unit Manager (Staff #10), stated they worked on 4/12/2024 on the Center 2 unit on the day shift. Staff #10 stated they were not made aware that Resident #3 had refused medications on 4/11/2024 or that Resident #3 had stated to the nurse that they thought they are being poisoned, and therefore they did not notify the Nurse Practitioner on duty. During an interview on 5/22/2024 at 8:36 AM, Licensed Practical Nurse (Staff #9) stated they worked on 4/12/2024 on the unit on the evening shift and witnessed the altercation between Resident #3 and their previous roommate. Staff #9 stated they were not given report as to the reason why Resident #3 was transferred to the new unit, they were not made aware of the verbal altercation between Resident #3 and their previous roommate, and they were not made aware that Resident #3 had refused medications the day before and had told staff they thought they were being poisoned. During an interview on 5/24/2024 at 2:44 PM, Licensed Practical Nurse (Staff #24), they stated they worked on the evening shift on 4/12/202024, on the unit Resident #3 was transferred to. They stated they do not remember receiving report as to why Resident #3 was transferred to that unit. During an interview on 5/24/2024 at 2:56 PM with certified nurse aide (Staff #16), they stated they were assigned to Resident #3 on the day and evening shifts on 4/12/2024 on the new unit. They stated they did not receive report as to the reason why Resident #3 was transferred to the unit. They stated they were not informed that Resident #3 had a verbal altercation with their previous roommate or that Resident #3 thought the food was poisoned. During a follow-up interview On 5/29/2024 at 10:59 AM, Registered Nurse Unit Manager (Staff #10) stated they gave a verbal report to the receiving unit nurse when Resident #3 was transferred. Staff #10 stated that the nurse who was responsible for medicating Resident #3 should have brought Resident #3 medications to the receiving unit and give report. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2024 at 1:18 PM, Registered Nurse (Staff #21) stated they worked on the receiving unit on 4/12/2024 on the day shift, but Staff #25 (Licensed Practical Nurse) did not bring Resident #3 medications to the receiving unit. Staff #21 also stated they did not get report as to the reason that Resident #3 was transferred to receiving unit. 10NYRCC 415.4(b)(1)(i)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on record review, and interviews conducted during the abbreviated surveys (NY00339051), the facility did not ensure that appropriate behavioral care was provided to address the problem of refusals and delusions for 1 of 4 residents (Resident #3) reviewed for the use of psychoactive medications. Specifically, Resident #3 refused their antipsychotic medication Haldol as ordered by the medical provider at 9 AM and 5 PM on 4/11/24, refused to eat, and stated they thought they were being poisoned, and the medical provider was not notified. The following day, Resident #3 punched their roommate in the face, Resident #3 was transferred to the hospital, and was admitted for psychosis. Findings include: The Facility Policy titled Psychotropic Medication revised 7/2019 documented that the facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions as well as psychopharmacological medications can be utilized to meet needs of the individual resident. The Policy and Procedure Medication Administration revised 12/2019 documented, medications must be administered in accordance with the orders, including any required timeframe. Resident #3 had diagnoses including but not limited to schizophrenia, hypertension, and hyperlipidemia. The Quarterly Minimum Data Set (resident assessment tool) dated 2/8/2024 documented intact cognition. The assessment documented the resident required supervision with eating, transfers, ambulation in room and corridor. The Behavior Symptoms care plan dated 2/8/2024 documented behavior symptoms such as restlessness, paranoia, delusions, noncompliance with his medication regimen. Interventions included to administer psychoactive medications as ordered, determine cause of the behavior, and maintain resident's safety. The Psychoactive Medications related to Schizophrenia care plan dated 12/12/2023 documented interventions which included to administer medications as ordered by physician, monitor/record/report refusal to eat and behavior symptoms not usual to the person, monitor/record occurrence of target behavior symptoms and document per facility protocol. The Psychiatry Consult dated 1/11/2024 documented recommendation given Resident #3 history of schizophrenia per chart review and Resident#3 report of previous psychotic symptoms keep medications as prescribed, no gradual dose reduction indicated at this time. The Psychiatry Consult dated 1/18/2024 documented recommendation gradual dose reduction not indicated at this time. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's orders included Haldol 2 mg, 1 tab twice a day for schizophrenia and Invega Sustenna Intramuscular 156 mg every 30 days for schizophrenia. The April 2024 Medication Administration Record was blank on 4/11/2024 for all prescribed medications on the day shift, and no reason was documented. There was no consistent documented evidence regarding Resident #3 refusals to take any medications on 4/11/2024 or that the medical provider was notified. The April 2024 Medication Administration Record documented on 4/11/2024 at 5 PM, comment 2, Resident #3 refused Haldol. The Medication Administration Record documented on 4/11/2024 documented Resident #3 refused all other medications on the evening shift. The Nurse's Note written by Licensed Practical nurse(Staff #20) dated 4/11/2024 at 11:43PM did not include documentation that the medical provider was made aware of Resident #3's medication refusals or of the Resident's behavioral symptoms. The Nurse's Note documented that the Resident is alert with confusion, refused all medications and their meal this evening and claimed that staff are trying to poison them. They put their snack in the garbage and continues to refuse care despite encouragement. Resident #3 medical record did not document Physician's Notes related to Resident #3 behavioral symptoms on 4/11/2024 and 4/12/2024, or Resident #3 medication refusals on 4/11/2024. The Resident's medical record did not document Physician's notes related to the Resident's behavioral symptoms on 4/11/2024 and 4/12/2024, or the Resident's medication refusals on 4/11/2024. The Nurse's Note dated 4/12/2024 at 10:32 AM documented by Staff #10, (Registered Nurse Unit Manager), documented at 7:45 am staff overheard Resident #3 and roommate on Center 2 unit in room [ROOM NUMBER] in a verbal altercation stating, F you I will kill you. On assessment Resident #3 stated I was talking to myself because they are trying to give me poison, I curse them. Resident was provided emotional support and transferred to a different unit (room [ROOM NUMBER]). The Nurse's Note dated 4/12/2024 at 11:57 AM documented by Staff #10 (Registered Nurse Unit Manager), documented Resident #3 displayed verbal outbursts, refusal of care, hallucinations / delusions. Pharmacological interventions: Haldol 2 mg last administered 4/12/2024 at 9:23 AM. Non-Pharmacological Interventions: Resident was redirected to less stimulating environment. Result of intervention: better. Notification Physician. Resident had a verbal altercation with roommate, transferred to another unit. The Nurse's Note dated 4/12/2024 at 9:49 PM documented by Staff #9 (Licensed Practical Nurse), documented Resident #3 was observed verbally and physically abusive to roommate. Non-Pharmacological Interventions: verbal redirection. Result of intervention: unchanged. The Nurse's Note 4/12/2024 at 11:11 PM documented by Staff #22 (Registered Nurse Supervisor), documented Resident #3 physically assaulted roommate, witnessed by Licensed Practical Nurse, who intervened and removed roommate from the room. Resident #3 was highly agitated, cursing at unit nurse and nurse supervisor. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2024 at 4:21 PM, Staff #20 (Licensed Practical Nurse), stated they worked on the Center 2 unit on 4/11/2024 on the evening shift. Staff #20 stated they did not notify the medical provider that Resident #3 refused all medications and refused their meal and claimed that staff were trying to poison them and put their snack in the garbage and refused care despite encouragement. Staff #20 stated that when they came to work on 4/11/2024, they were made aware by the day nurse that Resident #3 refused their medications on the day shift. Staff #20 stated it was unusual for Resident #3 to refuse medications from them and they thought Resident #3 would take their medications but stated Resident #3 continued to refuse throughout the evening shift. Staff #20 stated that when a resident refuses medication and has unusual behaviors, they should call the medical provider and make the supervisor aware. Staff #20 stated they did not do so. During an interview on 5/21/2024 at 4:43 PM, the Director of Nursing stated that when a resident refuses medication, the nurse should document the refusal in the Medication Administration Record, notify the medical provider, and write a note. During an interview on 5/21/2024 at 5:10 PM, Staff #23 (Registered Nurse Supervisor) who worked on 4/11/2024 on the evening shift stated the unit nurse did not report any concerns with Resident #3 regarding medication refusals or behavioral symptoms. Staff #23 stated they would have notified the medical provider if any concerns had been reported. During an interview on 5/21/2024 at 6:35 PM, the primary physician stated they were not aware of Resident #3 behavioral symptoms and medication refusals on 4/11/2024. The physician stated if they should have had been notified. During an interview on 5/21/2024 at 6:54 PM and at 7:04 PM, the Nurse Practitioner stated they were not made aware of Resident #3 medication refusals and behaviors on 4/11/2024 or on 4/12/2024. The Nurse Practitioner stated they were in the building all day on 4/11/2024 and 4/12/2024 and they would have assessed Resident #3 and documented the assessment if they had been made aware. During an interview on 5/22/2024 at 8:42 AM, Staff #10 (Registered Nurse Unit Manager), stated they worked on 4/12/2024 on the Center 2 unit on the day shift. Staff #10 stated they were not made aware that Resident #3 had refused medications on 4/11/2024 or that Resident #3 had stated to the nurse that they thought they are being poisoned, and therefore they did not notify the Nurse Practitioner on duty. During an interview on 5/22/2024 at 9:53 AM, Staff #21 (Registered Nurse) stated they worked 4/11/2024 on the Center 2 unit on the day shift. Staff #21 stated that Resident #3 refused their medications on the day shift. Staff #21 stated they forgot to sign the Medication Administration Record to document the refusals, and they did not notify the physician or the nurse supervisor. Staff #21 stated they should have notified the physician and the supervisor of the refusals. Staff #21 stated they gave verbal report to the evening nurse about the medication refusals. 10 NYCRR 415.12

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 43478 Based on record review and interviews during the abbreviated survey (NY00339051), the facility did not ensure that a resident was free of significant medication errors for 1 of 4 residents (Resident #3) reviewed. Specifically, on 4/11/2024 Resident #3 refused their significant medications that included antipsychotic medication, anticoagulant, cardiovascular, and steroid/bronchodilator. There was no consistent documentation on the Medication Administration Record of the refusal and that the medical provider was notified of the missed medications. Consequently, on 4/12/2024, Resident #3 punched their roommate in the face and was transferred and admitted to the hospital with admitting diagnosis of psychosis. The findings are: The facility policy, 'Medication Administration' revised 12/2019 documented medications must be administered in accordance with the orders, including any required timeframe. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document as such in designated format (hard copy or electronic) space provided for that drug and dose. Resident #3 had diagnoses including but not limited to schizophrenia, hypertension, and hyperlipidemia. The Quarterly Minimum Data Set (resident assessment tool) dated 2/8/2024 documented that Resident # 3 had intact cognition. The assessment documented the resident required supervision with eating, transfers, and ambulation in room and corridor. Resident #3's active Physician's Orders included Haldol 2 mg (antipsychotic medication), 1 tab twice a day for schizophrenia; Invega Sustenna Intramuscular 156 mg every 30 days for schizophrenia; Eliquis 5 mg, 1 tab twice a day for Deep Vein Thrombosis prophylaxis; Sodium Chloride Tab 1 gm, 1 tab twice daily for hyponatremia; Advair Discus 250-50 mcg, 1 inhalation every 12 hours for Chronic Obstructive Pulmonary Disorder and Metoprolol Tartrate 25 mg, 1 tab twice a day for Hypertension. The Physician's note dated 4/7/2024 documented a review of medications and to continue Metoprolol for hypertension, Advair for Chronic Obstructive Pulmonary Disorder, Eliquis for Deep Vein Thrombosis prophylaxis, and Haldol and Invega for schizophrenia. The April 2024 Medication Administration Record on 4/11/2024 on the day shift did not document evidence that any medications were administered, and no reason was documented Registered Nurse (Staff #21) was assigned to administer medications to Resident #3 on 4/11/2024 on the day shift. There was no documented evidence during the day shift on 4/11/2024 pertaining to Resident #3' refusal of their medications and/or that the medical provider was notified. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The April 2024 Medication Administration Record on 4/11/2024 at 5 PM documented under comment that Resident #3 refused all medications which included Haldol 2 mg for schizophrenia, Eliquis 5 mg for Deep Vein Thrombosis prophylaxis, Sodium Chloride Tab 1 gm for hyponatremia, Advair Discus for Chronic Obstructive Pulmonary Disorder, Metoprolol Tartrate 25 mg for Hypertension. The Nurse's Note dated 4/11/2024 at 11:43PM written by Staff #20 (Licensed Practical Nurse) documented that Resident #3 was alert with confusion, refused all medications this evening and their meal and claimed that staff are trying to poison them. Resident #3 put their snack in the garbage. Resident #3 continues to refuse care despite encouragement. The Nurse's Note dated 4/11/2024 at 11:43PM did not document evidence that the medical provider was made aware of Resident #3 medication refusals and behavioral symptoms. Review of Resident #3 medical record did not reveal evidence of Physician's Notes related to Resident #3's medication refusals/behaviors on 4/11/2024. During an interview on 5/21/2024 at 4:21 PM, Staff #20 (Licensed Practical Nurse), stated they worked on the Center 2 unit on 4/11/2024 on the evening shift. Staff #20 stated they did not notify the medical provider that Resident #3 refused all medications and refused their meal and claimed that staff were trying to poison them, that Resident #3 put their snack in the garbage and refused care despite encouragement. Staff #20 stated that when they came to work on 4/11/2024, they were made aware by the day nurse that Resident #3 refused their medications on the day shift. Staff #20 stated it was unusual for Resident #3 to refuse medications from them and they thought Resident #3 would take their medications but Resident #3 continued to refuse their medications throughout the evening shift. Staff #20 stated that when a resident refuses medication and has unusual behaviors, they are expected to call the medical provider and make the supervisor aware. Staff #20 stated they did not do that. During an interview on 5/21/2024 at 4:43 PM, the Director of Nursing stated that when a resident refuses medication, the nurse should document the refusal in the Medication Administration Record, notify the medical provider, and write a note. During an interview on 5/21/2024 at 5:10 PM, Staff #23 (Registered Nurse Supervisor) who worked on 4/11/2024 on the evening shift stated the Center 2-unit nurse did not report any concerns with Resident #3 regarding medication refusals or behavioral symptoms. Staff #23 stated they would have notified the medical provider if any concerns had been reported. During an interview on 5/21/2024 at 6:35 PM, the primary physician stated they were not aware of Resident #3 behavioral symptoms and medication refusals on 4/11/24. The physician stated if they should have had been notified. During an interview on 5/21/2024 at 6:54 PM and at 7:04 PM, the Nurse Practitioner stated they were not made aware of Resident #3's medication refusals and behaviors on 4/11/2024 or on 4/12/24. The Nurse Practitioner stated they were in the building all day on 4/11/2024 and 4/12/2024 and they would have assessed Resident #3 and documented the assessment if they had been made aware. (continued on next page)

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 05/29/2024
NAME OF PROVIDER OR SUPPLIER Northern Manor Geriatric Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 199 N Middletown Road Nanuet, NY 10954	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 8:42 AM, Staff #10 (Registered Nurse Unit Manager), stated they worked on 4/12/2024 on the Center 2 unit on the day shift. Staff #10 stated they were not made aware that Resident #3 had refused medications on 4/11/2024 or that Resident #3 had stated to the nurse that they thought they are being poisoned, and therefore they did not notify the Nurse Practitioner on duty. During an interview on 5/22/2024 at 9:53 AM, Staff #21 (Registered Nurse) stated they worked 4/11/2024 on the Center 2 unit. Staff #21 stated that Resident #3 refused their medications on 4/11/2024 on the day shift. Staff #21 stated they forgot to sign the Medication Administration Record to document the refusals, and they did not notify the physician or the nurse supervisor. Staff #21 stated they should have notified the physician and the supervisor of the refusals. Staff #21 stated they gave verbal report to the evening nurse on 4/11/2024 about the medication refusals. 10NYRCC 415.12(m)(2)