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	10/31/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record reviews and interviews during an abbreviated survey (NY00333515, NY00331035, NY00327139, NY00321114) the facility did not ensure the resident representative was immediately informed of a significant change in the resident's physical status or a need to alter treatment significantly. This was evident for 3 out of 4 residents (Residents #17, #19, #20) reviewed for notification of changes. Specifically, (1) Resident #17 had an electrocardiogram on 12/22/2023 in the facility which revealed a low heart rate, and their anti-hypertension medication was discontinued, Resident #17's guardian was not informed. (2) Resident #19 on 10/05/2023 was discontinued from the tracheostomy collar oxygenation and was placed on a ventilator, Resident 19's daughter was not notified. (3) Resident #20 had an episode of respiratory distress with decreased oxygen saturation on 07/29/2023, and on 07/30/2023 they vomited x 1 and had decreased oxygen saturations and was placed on a ventilator. There was no documented evidence of Resident #20's family being informed of the resident's change in status/condition. Findings include: The facility Notifications policy dated 04/2019 documented except in a medical emergency, the facility must consult with the resident immediately if the resident is competent and notify the resident's physician and designated representative when there is: (1) a significant improvement or decline in the resident's physical, mental, or psychological status or a need to alter treatment significantly; (2) when there is a significant alteration in treatment a nurse will promptly notify the resident and/or their representative of any changes in the residents care and treatment initiated by nursing measure or a physicians order. Examples of alteration in treatment are change in medication, treatment, and equipment. Notification of a change is documented in the nurse's progress notes and reflects the name of the person notified and the change in condition and/or treatment. 1) Resident #17 and had diagnoses including but not limited to Vascular Dementia, Atherosclerotic Heart Disease and Bradycardia. A Comprehensive Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 07/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). (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: 335046	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electrocardiogram results dated 12/22/2023 documented sinus bradycardia, first degree atrioventricular block, right bundle branch block. If clinically warranted 24-hour [NAME] monitor could be obtained for further evaluation. Review of a nursing progress note dated 12/23/2023 documented Metoprolol discontinued due to bradycardia, electrocardiogram done, pending results. Review of Nurse Practitioner #2's progress note dated 12/25/2023 documented Resident #17 was seen and examined for follow up electrocardiogram done, results stable. Metoprolol discontinued due to bradycardia and staff to monitor blood pressure. There was no documented evidence of Resident #17's representative being notified of their new diagnosis of bradycardia and the changes made to their medication regimen. During a telephone interview on 09/13/2024 at 12:17 PM, Resident #17's representative stated in December of 2023, Resident #17 was found to have a significant low heart rate and they were never notified of this. Resident #17's representative stated they found out about the diagnosis reading the paperwork they were provided to take with them to a doctor's appointment scheduled for the resident. Resident #17's representative stated communication was nonexistent in the facility. They asked the facility in January 2024 if the follow up dental, cardiology and neurology appointments had been scheduled. They were informed it had not been done and Resident #17's guardian stated they scheduled an appointment in February 2024 for the follow up with cardiology, and they brought the resident to the appointment. During the appointment, the cardiologist stated the residents heart rate was very low at 30 and the resident needed to be admitted for further review. The resident was brought to the hospital by the representative and was admitted and a pacemaker was placed to regulate the heart rate. 2) Resident #19 was admitted and had diagnoses including but not limited to Acute and Chronic Respiratory Failure, Dependence on Respirator and Dementia. Review of a Significant Change Minimum Data Set, dated dated dated [DATE] documented the resident is rarely/never understood and was severely cognitively impaired for daily decision making. No behaviors noted. The family was involved in care discussions about resident preferences. The resident was on oxygen and suctioning, tracheostomy care and invasive mechanical ventilation. Review of a progress note dated 10/24/2022 at 8:36AM documented on 10/05/2022 revealed that Resident #19 was placed on a ventilator and the tracheostomy collar was discontinued. Review of a progress note dated 10/19/2022 documented Resident #19 was tolerating ventilator settings, and no acute respiratory distress was noted. Review of a pulmonary consult note dated 10/19/2022 documented Resident #19 was very short of breath a few days ago and was attached to the ventilator on assist/control mode, and now they are comfortable. Review of a Minimum Data Set progress note dated 10/20/2022 at 6:19AM documented the nurse in charge reported that Resident #19 is now on a ventilator. Order for vent 10/19/2022, interdisciplinary team made aware. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that Resident #19's family was made aware of the need to be placed on a ventilator for oxygenation assist/control for respirations. Resident #19's family stated they found the resident on a ventilator and no longer using a tracheostomy collar when they visited the resident. During a telephone interview on 09/17/2024 at 9:34 AM, Resident #19's daughter stated Resident #19 was on a breathing tube to assist them with their breathing and once Resident #19 was changed to 100% ventilator assistance, the facility did not inform them, they came to the facility and found Resident #19 on the ventilator. During an interview on 09/17/2024 at 11:50 AM, the Director of Social Services stated they spoke with the resident's daughter numerous times but it's the physician's or the nurse who should have had informed the family of the change in the resident's condition. 3) Resident #20 had diagnoses but not limited to Contusion and Laceration of Cerebrum, Nontraumatic Intracerebral Hemorrhage and Acute Respiratory Failure with Hypoxia. A 5-day Minimum Data Set, dated dated dated [DATE] documented the resident was rarely/never understood and was severely cognitively impaired with daily decision making. The resident had a feeding tube and was receiving oxygen, suctioning, tracheostomy care and IV medication. Review of an impaired cognition care plan initiated 07/27/2023 documented related to non-traumatic intracerebral hemorrhage disease process Resident #20, would maintain their current function. Interventions listed included ask yes/no questions to determine their needs and communicate with the resident or family representative regarding the residents' capabilities. Review of an alteration in respiratory system care plan initiated 07/27/2023 documented Resident #20 had a tracheostomy and would be free of respiratory distress and receive adequate oxygenation through the review period. Interventions listed included administer nebulizer treatments and medications as per the physician's order and educate on interventions to improve gas exchange. Review of a progress note dated 07/29/2023 documented Resident #20 was having a period of respiratory distress during the shift with fluctuating oxygen saturations. The Nurse Practitioner was informed and ordered labs, antibiotics, and a chest x-ray. Review of a respiratory therapist note dated 07/30/2023 at 7:55AM documented Resident #20 vomited on 7/29/2023 around 8:30 PM and their oxygen saturation level was 75%. The resident was bagged with 100% oxygen. After 10 minutes, Resident #20 was placed back on the tracheostomy collar and oxygen saturation still fluctuated in the 80's. Physician made aware, and physician's assistant ordered to place Resident #20 on the ventilator if the oxygen saturation remains below 90%. Review of Nurse progress note dated 7/30/2023 at 5:44PM documented per physician's order, Resident #20 was transferred to the hospital for further evaluation. There was no documented evidence of Resident #20's family being informed of the resident's change in status/condition with vomiting and decreased oxygen saturation on 7/29/2023. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/17/2024 at 3:10 PM, the Director of Nursing stated family notification should be done right away when there is a change in a resident's status or condition. The Director of Nursing stated the physician should be made aware and a progress note should be written to document the notifications. This incident occurred before their tenure. The Director of Nursing stated now they will also schedule a meeting with the family to discuss the changes in condition in person to address issues in real time. 10 NYCRR 415.3(f)(2)(ii)(b)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record reviews and interviews during an abbreviated survey (NY00339693, NY00341303, NY00343390, NY00333515,) the facility did not ensure resident's right to be free from misappropriation of resident property. This was evident for 3 out of 3 residents (Resident #14, #16, #17) reviewed for personal property. Specifically, Resident #14's advocate stated the resident's glasses went missing during one of their hospitalization s and they have not been returned yet. 2) Resident #16's cell phone was not returned to the family after they expired in the facility on [DATE]. Resident #16's family stated the cell phone was being used by someone in the facility after they expired, and they have since had the service turned off. 3)Resident #17's guardian stated the resident's wallet was missing after their admission to the facility. They discovered a charge from the facility on the debit card shortly after their admission to the facility. There was no documented grievances or investigations, or local enforcement referrals initiated into all concerns regarding residents' properties above. Findings include: The facility Personal Property policy dated ,d+[DATE] and last revised [DATE] documented residents are permitted to retain and use personal possession as space and safety regulations may allow. The facility will inventory the residents' personal possessions upon admission. The facility will keep resident's property securely stored for 30 days while the resident is in the hospital or if they are discharged . If the resident has not returned to the facility after 30 days, the facility will contact the resident's representative to make arrangements for the resident's property to be picked up. If a resident is discharged the facility will securely store their property for 30 days, during which time attempts will be made to contact the resident/representative to arrange for their property to be picked up. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property. 1) Resident #14 was admitted with diagnosis including but not limited to Multiple Sclerosis, Acute Kidney Failure and Acute and Subacute Endocarditis. A Significant Change Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of ,d+[DATE], associated with severe cognition impairment (,d+[DATE] severe impairment, ,d+[DATE] moderate impairment and ,d+[DATE] cognitively intact). No behaviors noted. The resident required a wheelchair for locomotion, supervision for eating and bed mobility and maximal assistance for toileting and transfers. The resident had a foley catheter and was frequently incontinent of bowels. Review of Resident #14's admission progress note dated [DATE] revealed the resident was admitted wearing glasses, there was no documented description of the glasses. Review of inventory binder at the receptionist desk on [DATE], revealed no inventory form for Resident #14. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 2:10 PM, Resident #14's advocate stated during one of the resident's hospitalization s their glasses went missing, and they have not been returned yet. Resident #14's advocate stated when the resident returned from the hospital there were glasses on the windowsill, which did not belong to the resident. The facility gave those glasses to the resident, and they are not sure who those glasses belong to because they do not belong to Resident #14. During an interview on [DATE] at 11:40 AM, the Director of Social Work stated they handle the grievances, and they must be completed within 5 days. The Director of Social Services stated the actions that they take are documented on the grievance forms. and they follow up with the resident and the family regarding the outcomes of the grievances. During a follow up interview on [DATE] at 12:14 PM, the Director of Social Services stated they do not have any investigations on file for Resident #14 regarding their glasses. The Director of Social Services stated the receptionist or the nurse on the unit are responsible for the inventory for the residents' personal belongings and if something was to go missing then social work would be involved and investigate. The Director of Social Work stated the inventory list would either be in the resident's chart or uploaded in the miscellaneous section of point click care. The Director of Social Work stated they do not have any investigations on file for Resident #14 regarding missing glasses. During an interview on [DATE] at 12:05 PM, the Receptionist stated when residents are admitted to the facility, and they have personal belongings they are given a clothing inventory checklist to fill out. The Receptionist stated after the form is completed, they are told to take a picture of the form and a copy of the form goes into the clothing inventory book kept at the front desk and the other copy goes down to the laundry department with the clothing. The form has blank areas to add other items besides clothing, and the forms are all kept at the front desk by the receptionist. The Receptionist stated this is the only place the forms would be located. The Receptionist stated if a resident stated their property was missing the first thing they would do is inform the Director of Housekeeping. 2) Resident #16 was admitted with diagnosis including but not limited to Cirrhosis of Liver, Type 2 Diabetes Mellitus and Fracture of Left Femur. Review of a 5-day Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS score of 15 associated with intact cognition and required supervision for eating and dependent for toileting and transfers. The resident expired in the facility on [DATE]. Review of inventory binder at the receptionist desk on [DATE], revealed no inventory form for Resident #16. During a telephone interview on [DATE] at 12:30 PM, Resident #16's family representative stated after Resident #16 passed someone in the facility was using the residents cell phone. To date, the cell phone is still in use and the facility had not returned it. Resident #16's representative stated they have now had the cell phone service turned off. When the resident passed the phone was being used for a while. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 12:46 PM, Resident #16's daughter stated someone stole the residents cell phone in the facility and they were using it after the resident passed away. Resident #16's daughter stated the only thing of value the resident had was their cell phone and they tried to reach out to the facility about the cell phone and never got a return call. During an interview on [DATE] at 11:20 AM, the Director of Social Services stated they were never informed about Resident #16's cellphone being missing and there was no investigation on file regarding the cell phone. During an interview on [DATE] at 1:45 PM, the Director of Social Services stated they are not sure if Resident #16 had a cellular phone with them in the facility and that the resident was in the facility for a short time. The Director of Social Services stated they would look into it and reach out to Resident #16's family about the cell phone. 3) Resident #17 was admitted with diagnoses including but not limited to Vascular Dementia, Atherosclerotic Heart Disease and Bradycardia. A Comprehensive Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS score of 7 indicating severe cognitive impairment. The resident required supervision for eating and bed mobility and maximum assist for toileting. Resident #17's guardian stated Resident #17's wallet was missing, and they found fraudulent charges on Resident #17's debit card shortly after being admitted in the facility, and that there was a charge from the facility on the debit card after their admission to the facility. Review of the inventory binder at the receptionist desk on [DATE], revealed inventory form for clothing which did not include Resident #17's wallet. During an interview on [DATE] at 11:20 AM, the Director of Social Services stated they were never informed about Resident #17's wallet being missing and there were no grievances or investigations on file regarding the wallet. During an interview on [DATE] at 3:10 PM, the Director of Nursing stated they have developed and will be implementing a new inventory log sheet for the residents' personal possessions and that the form will be completed by the nurse during the resident's admission. The Director of Nursing stated the form will be signed by the resident or family and the nurse will have them filed in the resident's chart once completed. The Director of Nursing stated the new form will itemize all belongings as soon as the resident enters the facility, with a detailed description of the items. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 9:25 AM, the Administrator stated they are involved in all grievances, and they are responsible to sign off on them. The Administrator stated they were never made aware of Resident #17's wallet missing, or any fraudulent charges being made on the resident's debit card from the facility. The Administrator stated they believe a friend got involved with Resident #17 and was requesting reimbursement for somethings at the facility, but it was a fishy case. The Administrator stated they are always cautious when a friend gets involved because they have to look out for the best interest of their residents. The Administrator stated if something like this was brought to their attention, then this would be misappropriation of funds and would be reported and they would have taken it seriously. The Administrator stated if this was something that occurred, they would have remembered, but they do no recall this incident. The Administrator stated they do not recall Resident #16's cell phone being reported missing, and they do not recall speaking with the residents' daughter at any time. 10 NYCRR 415.4(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00341303) the facility did not ensure that services being provided meet professional standards of quality in clinical practice for 1 out of 16 residents (Resident #16) reviewed for medication administration. Specifically, Resident #16 was noted to have an elevated Prothrombin time (which measures the time it takes for liquid portion of blood to clot) and INR (International Normalizing Ratio (a blood test that measures how long it takes the blood to clot) PT/INR of 71XXX,d+[DATE].4(seconds) on [DATE] with a reference range of (PT-9XXX,d+[DATE].7/INR-0XXX, d+[DATE].1) indicating the blood is taking longer than normal to clot. Resident #16 was ordered to receive 10mg Vitamin K (vitamin needed for blood clotting) to be administered intramuscularly by the physician on [DATE] at 4:47PM. The Vitamin K was not readily available in the facility. Staff did not notify the physician that the Vitamin K was not available. Resident #16's Vitamin K was not administered until 12:58 AM on [DATE]. Resident #1 was found unresponsive in their bed and pronounced dead at 6:50AM on [DATE]. Findings include: The facility Anticoagulation therapy policy dated ,d+[DATE] and last revised ,d+[DATE] documented all residents requiring anticoagulation therapy will have labs drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. Clinical staff will monitor Residents as needed for safety of medication therapy. The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications. The physician will help review the progress of individuals who are being anticoagulated, monitor for potential complications and manage related problems. Resident #16 was admitted with diagnoses including but not limited to Cirrhosis of Liver, Type 2 Diabetes Mellitus and Fracture of Left Femur. Review of a 5-day Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of ,d+[DATE], associated with intact cognition. No behaviors noted. Ambulated with a walker previously with lower extremity impairment on one side. The resident required supervision for eating, dependent for toileting and transfers and moderate assistance for bed mobility. Review of a risk for bleeding care plan initiated [DATE] documented Resident #16 is at risk for bleeding secondary to Non Steroidal Anti-Inflamatory Drugss/anticoagulant use/status post Deep Vein Thrombosis. The goal was Resident #16 would be free of signs and symptoms of abnormal bleeding through the review date. Interventions listed included handle the resident gently during activities of daily living care and support the extremities under joints during movement, monitor for abnormal signs of bleeding. Review of a Nurse Practitioner #1's progress note dated [DATE] at 4:25PM documented Resident #16's labs were reviewed, and the Prothrombin Time was 71.6/INR was 7.4. Warfarin discontinued and will give Vitamin K 10 mg IM x 1.Will repeat bloodwork in the morning. Resident #16 is stable no signs of bleeding, will start Eliquis to prevent frequent needlesticks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurse's progress note dated [DATE] at 11:06PM documented PT/INR abnormal and warfarin on hold. Waiting for Vitamin K to be administered, monitored for bleeding. There was no documented evidence of the Physician being made aware of Vitamin K intramuscular injection not being readily on hand. Review of the pharmacy delivery log dated [DATE] revealed the Vitamin K injection (Phytonadione) 10mg/ml was delivered and signed for on [DATE] at 12:38 AM. Review of a nurse's progress note dated [DATE] at 2:55AM documented Vitamin K 10 mg injected subcutaneously one time only for elevated PT/INR, no adverse reaction noted. Review of the Medication Administration record revealed the Vitamin K was administered at 12:58AM on [DATE]. During an interview on [DATE] at 12:04 PM, Nurse Practitioner #1 stated they were on their way out the building when they were informed about Resident #16's lab results. They ordered for Resident #16 to receive Vitamin K intramuscularly now, and the nurse was supposed to give the Vitamin K to the resident stat, but no one called them and told them the facility did not have it available in the automated dispensing machine system. Nurse Practitioner #1 stated they would have ordered an oral dose if they knew the intramuscular dose was not available. Nurse Practitioner #1 stated they do not believe Resident #16 received the dose of Vitamin K in timely. They were informed in the morning that the resident had expired. Nurse Practitioner #1 stated asked the staff if the resident got the Vitamin K and they stated there was none in the automated dispensing machine, and they asked why they were not notified. Nurse Practitioner #1 stated if they have been informed, they would have sent the resident to the hsopital. They have now resolved to send residents to the hospital. Nurse Practitioner #1 stated the evening and the night shifts do not monitor the residents or communicate about them the way they should. During an interview on [DATE] at 4:06 PM, Licensed Practical Nurse #10 stated they have been working in the facility for 1 year and they remember the resident from Unit 2 west the last time they met them. Licensed Practical Nurse #10 stated the order for Vitamin K arrived/was received in the middle of the night between 12AM and 2AM. The medication was administered to Resident #16, and they did not have any signs of bleeding or adverse effects after the administration. During an interview on [DATE] at 3:10 PM the Director of Nursing stated if staff is given an order for a medication and the medication is not on hand, the nurse is expected to check the automated dispensing machine to see if the medication is available and if the medication is not in the automated dispensing machine, then the nurse needs to call the pharmacy for delivery and notify the Physician to see if there is an alternative medication that can be given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 2:52 PM, the Medical Director stated the Vitamin K should have been given when ordered as it is not a routine medication. The Medical Director stated if the resident is not actively bleeding or having any symptoms then an oral dose could be given. The oral dose takes longer to be digested hence the choice to order the medication for intramuscular administration or subcutaneous. The Medical Director stated residents could die with an INR of 3 but that Resident #16 had a history of cirrhosis, and they always had a high INR and no bleeding. The Medical Director stated they do not feel that the delay in treatment caused the resident to expire. The Medical Director stated the INR is usually checked once a week and if the Vitamin K was given right away, and the lab was not drawn within a certain time, there is no way to tell if the medication would have reversed the levels or not. 10 NYCRR 415.11(c)(3)(i)

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 10/31/2024
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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record reviews and interviews during an abbreviated survey (NY00343390, NY00339693, NY00345193, NY00341303, NY00331035, NY00325315) the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 6 out of 7 residents (Residents #1, #14, #15, #16, #19, #21) reviewed for quality of care. Specifically, (1) Resident #1's certified nurse assistant accountability documentation revealed that in a 2-month period, there were no signatures for bladder/incontinence care being provided on 9 occasions; (2) On 090/06/2024 Resident #14 was observed lying in bed with a catheter draining leg bag in place Review of Resident #15's certified nurse assistant accountability record revealed that in a 3-month period there were no signatures for bladder/bowel incontinence care being provided on 25 occasions; (4) Resident #16's certified nurse assistant accountability report for April 2024 revealed on 5 occasions there was no signature indicating bladder/bowel incontinence care was rendered. (5) Review of Resident #19's certified nurse assistant accountability report for October 2022 revealed no signatures, indicating task completed for the application of heel booties on 3 occasions and turning and positioning on 2 occasions. Review of Resident #19's certified nurse assistant accountability report revealed in a 2-month period there were no signatures for the application of heel booties on 7 occasions and turning and positioning on 6 occasions (6) Resident #21's certified nurse accountability report revealed that in a 2-month period the following tasks were not signed off as completed: bowel/bladder continence, toileting, and skin observation on 7 occasions. Findings include: The facility Activities of Daily Living Care and Support policy dated 08/2016 and last revised 03/13/2024 documented the facility shall provide residents with Activities of Daily Living care and support in accordance with current standards of practice, State and Federal regulations and are based on the resident's assessed needs, personal preference, and goals. Activities of Daily Living care and support will be provided for residents who are unable to carry out Activities of Daily Living independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, that includes but is not limited to supervision and assistance with hygiene and elimination. Nail care should be provided as needed for the resident and may require a licensed nurse to perform if certain medical conditions are present. Toileting/Perineal care/Incontinence care will be provided with care and as needed. 1) Resident #1 was admitted with diagnoses including but not limited to Sickle Cell Disease with Crisis, Chronic Obstructive Pulmonary Disease and Chronic Pain Syndrome. An Admission Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS used to determine attention, orientation, and ability to recall information) score of 15/15, associated with intact cognition). The resident required supervision for eating, dependent for toileting, bed mobility and transfers. Review of a bladder incontinence care plan dated 05/21/2024 documented interventions listed as apply incontinence devices as identified as appropriate for resident, monitor for signs and symptoms of urinary tract infection, bladder/bowel incontinence. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a bowel incontinence care plan dated 06/04/2024 documented the resident had bowel incontinence. The goal was the resident would not have any skin breakdown due to incontinence. Interventions listed included check and provided incontinence care every 2-4 hours as tolerated and toilet every 2-4 hours as tolerated during waking hours and assist with toileting as needed. Review of a grievance form dated 06/12/2024 documented Resident #1 was interviewed by Registered Nurse Manager #1 and complained that Certified Nurse Assistant #1 was not providing them with activities of daily living care in a timely manner. Certified Nurse Assistant #1 was in-serviced on customer service and activities of daily living time. Review of Resident #1's certified nurse assistant accountability record for May of 2024 revealed there was no documented evidence of Resident #1 receiving bladder/bowel incontinence care on 3 occasions . Review of the certified nurse aide accountability record for June of 2024 revealed there was no documented evidence of Resident #1 receiving bladder/bowel incontinence care on 9 occasions. During an interview on 09/06/2024 at 4:00 PM, Certified Nurse Assistant #2 stated they were the only certified nurse assistant on Resident #1's unit the night of 06/09/2024, so it was a little harder to get the residents cares done. Certified Nurse Assistant #2 stated when there is one certified nurse assistant it is rough with 36 residents. Certified Nurse Assistant #2 stated they tried their best to do what they could that night, because it is hard to take care of 36 people , and they got to the resident when they could. During an interview on 9/13/2024 at 11:33 AM, Registered Nurse Unit Manager #1 stated they did an in-service with Certified Nurse Assistant #2 because Resident #1 complained that they were not changing them timely. Registered Nurse Unit Manager #1 stated the issue was regarding customer service, and that Resident #1 had complained, and the social worker had written a grievance, because Certified Nurse Assistant #2 was not changing their adult diaper or their sheets on time. 2) Resident #14 was admitted with diagnosis including but not limited to Multiple Sclerosis, Acute Kidney Failure and Acute and Subacute Endocarditis. A Significant Change Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 6/15 associated with severe cognitive impairment. The resident required maximal assistance for toileting and transfers. The resident had a foley catheter and was frequently incontinent of bowels. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 9/15 associated with moderate cognitive impairment. The resident required moderate assistance for toileting and bed mobility and maximal assistance for transfers. The resident had a foley catheter and was frequently incontinent of bowel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Indwelling Foley Catheter for obstructive uropathy care plan initiated 03/11/2024 and last revised 07/30/2024 documented the resident will show no signs and symptoms of urinary tract infection and will remain free from catheter related trauma through the review date. Interventions listed included catheter/perineal care, change catheter as ordered, ensure catheter tubing is anchored to prevent pulling, maintain privacy bag, maintain urine collection bag below the level of the bladder, monitor and document output as per facility policy, monitor/document for pain/discomfort due to catheter, monitor/record/report to physician any signs and symptoms of urinary tract infection, Urology consult as ordered and voiding trail as ordered. During an interview on 09/06/2024 at 10:44 AM, Licensed Practical Nurse #1 stated Resident #14 has a leg bag in place. Licensed Practical Nurse #1 stated Resident #14 is going to be taken out of bed for therapy that is why they have a leg bag on in bed. Resident #14 was observed lying in bed with the leg bag in place in bed in their gown on 09/06/2024 at 10:40AM. During an interview on 09/09/2024 at 1:25 PM, Nurse Practitioner #1 stated as soon as they try to take Resident #14's urinary catheter out, the resident cannot urinate. Nurse Practitioner #1 stated Resident #14 is not mentally able to state they cannot urinate and when they are assessed they are found with a distended abdomen. Nurse Practitioner #1 stated they had to change the resident's urinary catheter the other day because it was not draining and clogged with sediment. Nurse Practitioner #1 stated they do not normally check the status of the urinary catheter to see if it is draining, but the nurses on the unit had not checked it and Resident #14 had started showing signs of an impending infection. Nurse Practitioner #1 stated Resident #14 is followed by Urology and that the resident will drink fluids if they are provided to them. During an interview on 09/09/2024 at 1:30 PM, the Registered Nurse Unit Manager #1 stated the certified nurse assistants empty the Foley catheters and change the bag from a drainage bag to a leg bag when the resident is out of bed. Registered Nurse Unit Manager #1 stated when a resident is going to or coming from therapy, they are always supposed to have a leg bag in place and that the staff are good with changing the bag. 3) Resident #15 was admitted with diagnoses including but not limited to Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease with Acute Exacerbation and Anxiety Disorder. A Comprehensive Minimum Data Set date 05/28/2024 documented the resident had a Brief Interview for Mental Status score of 15/15, associated with intact cognition. The resident required moderate assistance for toileting and bed mobility and dependent for transfers. A Significant Change Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 14/15, associated with intact cognition. The resident required moderate assistance with toileting, bed mobility and transfers. Review of a bladder incontinence care plan dated 05/23/2024 documented Resident #15 would remain free from skin breakdown related to incontinence and brief use. Interventions listed included apply incontinence devices as identified appropriate for the resident, monitor for signs and symptoms of urinary tract infection and monitor/document/report to physician as needed any changes in incontinence. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an impaired gastrointestinal function care plan initiated 6/4/2024 documented related to constipation Resident #15 will have regular bowel movements throughout the review date. Interventions listed included administer medications as ordered by the physician, evaluate bowel status with any change in behavior or mental status. During an interview on 9/10/2024 at 4:30 PM, Resident #15 stated they ring their call bell and no one comes in, the staff ignore the call bell and are not attentive to the residents, taking their time to change them. Resident #15 stated they are made to sit in their wet/soiled diaper until the staff are ready to put them back to bed. Resident #15 stated they are afraid to have a bowel movement, because when they ring the call bell no one comes, and they do not want to sit in feces all night. Resident #15 stated it is so bad that they have to get enemas from holding their stool for so long and that they got a urinary tract infection from sitting in their dirty diaper. Resident #15 stated the staff change their diaper for the last time at 6 PM and then they do not get changed again until 5 AM. Review of Resident #15's certified nurse assistant accountability record revealed bladder/bowel incontinence was not signed as being completed as follows: June 2024- 8 occasions, July 24- 7 occasions and in August 24-7 occasions. During an interview on 9/16/2024 at 12:04 PM, Nurse Practitioner #1 stated Resident #15 is monitored well during the day shift, but they may have an issue with having their diaper changed during the evening and night shifts. 4) Resident #16 was admitted with diagnoses including but not limited to Cirrhosis of Liver, Type 2 Diabetes Mellitus and Fracture of Left Femur. Review of a 5-day Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15 associated with intact cognition. No behaviors noted. The resident required supervision for eating and was dependent for toileting and transfers and moderate assistance for bed mobility. Review of a self-care and mobility care plan initiated 4/18/2024 documented the goal was Resident #16's status will improve through the review date. Interventions listed included encourage to participate to the fullest extent possible with each interaction, monitor for changes in status and notify interdisciplinary team as needed, lying to sitting on side of bed dependent with 2 or more staff assistance, toilet transfer with 2 person assist and mechanical lift and bed mobility with substantial assist of 2 staff. During a telephone interview on 9/12/2024 at 12:30 PM Resident #16's family representative stated Resident #16 would lay for hours ringing their call bell, to be changed and no one would come and help them. Resident #16's family representative stated Resident #16 was a clean person and they kept themselves clean and at the facility they just put diapers on the resident and leave them. Resident #16's family representative stated Resident #16 did not like the feeling of being wet and they had wounds that were painful from sitting in wetness. During a telephone interview on 9/12/2024 at 12:46 PM, the Resident #16's daughter stated Resident #16 was unable to get out of bed and sat in soiled diaper for 3 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's certified nurse assistant accountability report for April 2024 revealed on 5 occasions there was no signature indicating that bladder/bowel incontinence care was rendered. 5) Resident #19 was admitted with diagnoses including but not limited to Acute and Chronic Respiratory Failure, Dependence on Respirator and Dementia. Review of Resident #19's certified nurse assistant accountability report for November 2022 revealed no signatures, indicating task completed for the application of heel booties on 4 occasions and turning and positioning on 4 occasions. Review of an alteration in skin integrity care plan initiated 1/9/2023 documented an actual pressure ulcer to the posterior head. The goal was Resident #19's wound would show improvement appropriately through the review period. Interventions listed included assess wound weekly and document measurements and appearance, monitor dressing daily to ensure clean, dry and intact, monitor wound daily for signs and symptoms of infection and wound care consult as needed. Review of an alteration in skin integrity care plan initiated 1/10/2023 documented an actual pressure ulcer to the left elbow stage 4. The goal was Resident #19's wound would show improvement appropriately through the review period. Interventions listed included assess wound weekly and document measurements and appearance, monitor dressing daily to ensure clean, dry and intact, monitor wound daily for signs and symptoms of infection and wound care consult as needed. Review of an alteration in skin integrity care plan initiated 1/26/2023 documented an actual pressure ulcer right heel blister 2x2.5 cm. The goal was Resident #19's wound would show improvement appropriately through the review period. Interventions listed included monitor dressing daily to ensure clean, dry and intact, and monitor wound daily for signs and symptoms of infection. Review of an alteration in skin integrity care plan initiated 1/26/2023 documented an actual pressure ulcer to the left lateral foot 4x2.5 cm. The goal was Resident #19's wound would show improvement appropriately through the review period. Interventions listed included monitor dressing daily to ensure clean, dry and intact, and monitor wound daily for signs and symptoms of infection. Review of an alteration in skin integrity care plan initiated 1/26/2023 documented an actual pressure ulcer to the left inner heel 2.5x 3 cm. The goal was Resident #19's wound would show improvement appropriately through the review period. Interventions listed included monitor dressing daily to ensure clean, dry and intact, and monitor wound daily for signs and symptoms of infection. Review of Resident #19's's certified nurse accountability report for January 2023 revealed no signature for heel booties, pillows for positioning and turning and positioning on 4 occasions and was not consisitently signed offf. During a telephone interview on 9/17/2024 at 9:34 AM Resident #19's daughter stated Resident #19 was not being turned and positioned while in the facility and had large wounds because of this. Resident #19's daughter stated Resident #19's equipment such as the feeding tube and the tracheostomy were dirty, as well as the heel booties, which were not placed properly. 6) Resident #21 was admitted with diagnoses including but not limited to Unspecified Cord Compression, Peripheral Vascular Disease and Muscle Weakness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a BIMS score of 9 with no behaviors noted. The resident required extensive assistance with bed mobility and toileting by 2 people, totally dependent for transfers and supervision for eating. Review of a bladder incontinence care plan initiated 8/23/2023 documented related to Type 2 Diabetes Mellitus the goal was Resident #21 would maintain incontinence through the waking hours through the review date. Interventions listed included apply incontinence devices as identified as appropriate for resident, monitor for signs and symptoms of urinary tract infection, monitor/document/report as need to physician any changes in incontinence. Review of a bowel incontinence care plan initiated 8/26/2023 related to medication side effects documented Resident #21's incontinence would be managed in a timely manner through the review period. Interventions listed included bowel retraining program, check resident every 2 hours and assist with toileting as needed, provide peri-care after each incontinence episode. Review of an activities of daily living care plan initiated 8/26/2023 documented the goal was Resident #21's activities of daily living status would improve, and they would maintain the current status through review date. Interventions listed included encourage to participate to the fullest extent possible with each interaction, encourage to use call bell for assistance. Review of Resident #21's certified nurse accountability report for September 2023 revealed tasks were not signed as completed for the following activities: bowel/bladder continence, toileting, and skin observation on 6 occasions. Review of Resident #21's certified nurse accountability report for October 2023 revealed tasks were not signed as completed for the following activities: bowel/bladder continence, toileting, and skin observation on 1 occasion. During an interview on 9/6/2024 at 11:00 AM, Registered Nurse Unit Manager #1 stated on the certified nurse assistant accountability sheet reflects each task a resident is to be provided and that states if a task is scheduled for every shift, then each box should have a signature in the box. Registered Nurse Unit Manager #1 stated if there is no signature in a box, then it means the task was not done. During an interview on 9/16/2024 at 1:12 PM Licensed Practical Nurse Unit Manager #1 stated in the certified nurse assistant accountability record if a task is scheduled for every shift, then there should be a entry at least one time per shift that the task was completed. Licensed Practical Nurse Unit Manager #1 stated this documentation is monitored via the dashboard, and if everything is completed then it will appear green. During an interview on 9/17/2024 at 3:10 PM the Director of Nursing stated the call bell response is an issue, staff were not responding in a timely manner. The Director of Nursing stated they are addressing leadership styles and ensuring hand off is effective and incorporating teamwork. The Director of Nursing stated the residents were complaining of not being changed in a timely manner and their call bell response has not been in a timely manner. The Director of Nursing stated the staff have been in serviced on incontinence care and call bell response. Stated they have checked all the call bells to ensure they are working appropriately. The Director of Nursing stated they are also making off hour rounds to ensure the residents are cared for properly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.12

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 49372 Based on record review and interviews during an abbreviated survey (NY00343390, NY00345193, NY00341303, NY00339693, NY00333515, NY00331035, NY00327139, NY00321114, NY00325315), the facility did not ensure residents were free from significant medication errors. This was evident for 13 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13) out of 19 residents reviewed for medication administration. Specifically, the Residents on the Center 2 Unit did not receive their scheduled medications on 06/09/2024 during the 7:30 AM to 3:30 PM shift. There was no evidence in the Medication Administration record that the scheduled physician prescribed medications were administered to the residents and no notification to the physician the medications were missed or not administered. Findings include: The Facility Medication Administration policy dated 09/2015 and last revised 08/2019 documented Licensed Nurses must ensure that prior to the end of their shift all medications administered/refused/held etc., are properly documented on the Medication Administration Record. Failure to do so is considered an omission in the medical record. When the medication pass is complete, the nurse is to recheck the Medication Administration records to make sure all medications have been administered and documented appropriately. The Nurse will follow up and document appropriately on medications that were administered but not documented. The facility will utilize the Clinical Dashboard electronic medication administration record completion report during daily clinical meeting for review of potential omissions of documentation. Nursing Management will follow up with the nurse within 24 hours to correct documentation if applicable. 1) Resident #1 had diagnoses including but not limited to Sickle Cell Disease with Crisis, Chronic Obstructive Pulmonary Disease and Chronic Pain Syndrome. The Physician's order dated 6/4/2024 documented Hydrocodone-Acetaminophen 5-325 milligram tablet give 1 tablet by mouth every 6 hours for pain. Review of Resident #1's medication administration record for June 2024 revealed no documented evidence of the pain medication being administered on 06/09/2024 or signed out as administered on the narcotic log sheet for Resident #1's scheduled 12:00 PM dose. 2) Resident #2 had diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Major Depressive Disorder and Anxiety Disorder. The Physician's order dated 4/21/2024 documented Buspirone HCL 5 mg- 1 tablet by mouth 3 times daily for anxiety. Review of Resident #2's medication administration record for June 2024 revealed the 9 AM and 1 PM doses were not signed as administered on 06/09/2024. 3) Resident #3 had diagnoses including but not limited to Type 2 Diabetes Mellitus, Embolism and Thrombosis of Arteries of the Lower Extremities and Cerebral Infarction. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician's order dated 6/5/2024 documented Ceftriaxone 2 gm intravenously daily for 26 days for infection. Review of Resident #3's medication administration record for June 2024 revealed dose omissions on 06/09/2024. The Physician's order dated 6/5/2024 documented Gabapentin 100 mg capsule give 1 capsule by mouth 3 times daily for pain. Review of Resident #3's medication administration record for June 2024 revealed the medication was not signed out as administered 9 AM or 12 PM on 6/9/2024. The Physician's order dated 6/5/2024 documented Levetiracetam 500 mg 1 tablet by mouth 2 times daily for seizures. Review of Resident #3's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. The Physician's order dated 6/7/2024 documented Lovenox injection solution 120mg/0.8 ml inject 0.8 ml subcutaneously daily for cerebral vascular accident and atrial fibrillation. Review of Resident #3's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. The Physician's order dated 6/5/2024 documented Humalog Kwikpen subcutaneous solution 100U/ml inject as per sliding scale. Review of Resident #3's medication administration record for June 2024 revealed no documented evidence of the resident's blood sugar being logged or insulin signed out as being administered at 8 AM and 12 PM on 6/9/2024. 4) Resident #4 had diagnoses including but not limited to Dementia, Schizophrenia and Anxiety disorder. The Physician's order dated 5/2/2024 documented Lamotrigine 200 mg 1 tab let by mouth 2 times a day for seizures. Review of Resident #4's medication administration record for June 2024 revealed the medication was not signed out as administered on 6/9/2024 at 9 AM. The Physician's order dated 6/5/2024 documented Tramadol 100 mg 1 tab let by mouth every 12 hours for pain. Review of Resident #4's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024 or signed out as administered on the narcotic log sheet for Resident #4's scheduled 12:00 PM dose. The Physician's order dated 5/2/2024 documented Enoxaparin Sodium 40mg/0.4 ml inject 40 mg subcutaneously every 12 hours to prevent blood clots. Review of Resident #4's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. 5) Resident #5 had diagnoses including but not limited to Metabolic Encephalopathy, Type 2 Diabetes Mellitus and Parkinson's disease. The Physician's order dated 6/4/2024 documented Humalog injection solution 100U/ml inject as per sliding scale. Review of Resident #5's medication administration record for June 2024 revealed no documented evidence of the resident's blood sugar being logged or insulin signed out as being administered at 8 AM and 12 PM on 6/9/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician's order dated 6/4/2024 documented Carbidopa-Levodopa 25-100 tablet 1 via gastrostomy tube 4 times daily for Parkinson's. Review of Resident #5's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM and 1 PM on 6/9/2024. 6) Resident #6 had diagnoses including but not limited to Myasthenia Gravis, Secondary Parkinsonism and Spinal Stenosis. The Physician's order dated 4/17/2024 documented Carbidopa-Levodopa 25-100 tablet 1 tablet by mouth 3 times daily for Parkinson's Disease. Review of Resident #6's medication administration record for June 2024 revealed the medication was not signed out as administered at 10 AM and 2 PM on 6/9/2024. The Physician's order dated 4/17/2024 documented Gabapentin 600 mg 1 tablet by mouth every 8 hours for back pain. Review of Resident #6's medication administration record for June 2024 revealed the medication was not signed out as administered at 2 PM on 6/9/2024. 7) Resident #7 had diagnoses including but not limited to Fracture of Right Femur, Pain in Leg and Low Back Pain. The Physician's order dated 6/6/2024 documented Oxycodone-Acetaminophen 5-325 mg 1 tablet by mouth every 12 hours for pain. Review of Resident #7's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024 or signed out as administered on the narcotic log sheet for Resident #7's scheduled 9 AM dose. 8) Resident #8 had diagnoses including but not limited to Displaced Subtrochanteric Fracture of Left Femur, Type 2 Diabetes Mellitus and Venous Insufficiency. The Physician's order dated 2/23/2024 documented Eliquis 5 mg 1 tablet 2 times daily for deep vein thrombosis. Review of Resident #8's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. 9) Resident #9 had diagnoses including but not limited to Fracture of Unspecified Part of Neck of Left Femur, Primary Hypertension and Schizophrenia. The Physician's order dated 5/20/2024 documented Eliquis 5 mg 1 tablet 2 times daily for deep vein thrombosis. Review of Resident #9's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. 10)Resident #10 had diagnoses including but not limited to Convulsions, Fracture of Unspecified Part of Neck of Left Femur and Severe Intellectual Disabilities. The Physician's order dated 4/11/2024 documented Carbamazepine ER 12 Hour 400 mg 1 tablet by mouth 2 times daily for Seizures. Review of Resident #10's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. (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 10/31/2024

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician's order dated 4/11/2024 documented Gabapentin 300 mg 1 capsule by mouth 2 times a day for pain. Review of Resident #10's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024. The Physician's order dated 4/11/2024 documented Methocarbamol 750 mg 1 tablet by mouth 3 times a day for pain. Review of Resident #10's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM or 1 PM on 6/9/2024. 11)Resident #11 had diagnoses including but not limited to Muscle Weakness, Other Cervical Disc Degeneration and Opioid Abuse. The Physician's order dated 3/6/2024 documented Gabapentin 300 mg 1 capsule by mouth every 8 hours for neuropathy. Review of Resident #11's medication administration record for June 2024 revealed the medication was not signed out as administered at 2 PM on 6/9/2024. 12)Resident #12 had diagnoses including but not limited to Unspecified Intellectual Disabilities, Hydrocephalus and Anxiety Disorder. The Physician's order dated 5/8/2024 documented Clonazepam 0.5 mg 1 tablet by mouth every morning and at bedtime for anxiety. Review of Resident #12's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM on 6/9/2024 or signed out as administered on the narcotic log sheet for Resident #12's scheduled 9 AM dose. 13) Resident #13 had diagnoses including but not limited to Intervertebral Disc Disorders with Radiculopathy, Low Back Pain and Spinal Stenosis. The Physician's order dated 9/17/2022 documented Gabapentin 300 mg 2 capsules by mouth 3 times a day for pain. Review of Resident #13's medication administration record for June 2024 revealed the medication was not signed out as administered at 9 AM or 1 PM on 6/9/2024. Review of the daily staffing sheet for 6/9/2024 revealed Licensed Practical Nurse #1 was a no show for the 7 AM- 3 PM shift and was scheduled to work on the Center 2 unit. Licensed Practical Nurse #1 was noted on the staffing schedule as working the 3PM-11PM shift on 6/9/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/6/2024 at 12:00 PM the Nurse Practitioner stated they were never called and informed that Resident #1 never received any of their daytime medication, including their narcotic on 6/9/2024. The Nurse Practitioner stated that the nurses in the facility have been better with informing them about refused or missed medications in general, but they were not informed about the missed doses on 6/9/2024. During an interview on 9/5/2024 at 12:32 PM Licensed Practical Nurse #1 stated they do not recall Resident #1 or working with the resident on 6/9/2024. Licensed Practical Nurse #1 stated that a blank spot on the medication administration record would indicate that the medication was not given. If a narcotic is not administered, they would have to let the physician and the supervisor know. Licensed Practical Nurse #1 stated they would also document that the medication was not given in the medication administration record and in a progress note. During an interview on 9/9/2024 at 1:30 PM the Registered Nurse Unit Manager #1 stated they do not remember an alert that 19 residents on their unit, Center 2, did not get their medications on 6/9/2024.The Registered Nurse Unit Manager #1 Stated when they came in on Monday, 6/10/2024, they were not going to sign for any missed medication, but they did not alert the administration either. During a telephone interview on 9/20/2024 at 2:52 PM the Medical Director stated they were not informed on 6/9/2024 that 19 residents did not receive their medications. The Medical Director Stated they are in the facility on the weekends, and they know that the facility is short staffed. The Medical Director Stated they the nurses will let them know if they are not able to give all medications. The Medical Director stated some medications being missed is not a big deal and no harm is done. It is not best practice, but there is no harm. The Medical Director stated if any medications are missed and they are informed, they will tell the nurse to ensure the residents receives all medications they need. The Medical Director stated they are aware of residents missing some medications at times or delay in administration but best practice is to make sure all residents get their medications timely. The medical director stated there are times when they have been informed that the facility did not have a nurse to administer medications as scheduled, and when a nurse arrives the residents would receive their medications. They were not aware of missed medications for 19 residents on 6/9/2024. During a telephone interview on 9/24/2024 at 12:41 PM the Registered Nurse Supervisor stated they do not recall there being no nurse working on Center 2 unit on 6/9/2024. The Registered Nurse supervisor stated if a nurse did not show up, They would call other staff until they find someone to work. The Registered Nurse Supervisor stated they would also pull another nurse, from another unit to cover the floor that had missing staff. The Registered Nurse supervisor stated they have access to the dashboard which shows if residents did not receive their medications and if the dashboard showed residents had not received their medications, then they would talk to the nurse that was on duty to see why they did not document giving the medication. Registered Nurse supervisor stated they do not recall any of the residents on Center 2 unit missing their medications on 6/9/2024 and if there was no nurse for the unit, then they would give the medications to the resident themself. 10 NYCRR 415.12(m)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on observations and interviews during an abbreviated survey (NY00343390, NY00339693), the facility did not ensure the environment was functional, sanitary, and comfortable for residents, staff, and the public. Specifically, the kitchen floor by the washing machine had about 2 inches of water pooled, and staff were actively working in the area, multiple areas of the building had chipped paint, scratched paint, scuff marks, visible dirt and stains on the walls and floors, peeling wallpaper and foul odors. Finding include: During an observation in the kitchen on 9/6/2024 at 10:20AM, surveyor observed a pool of water about 2inches on the floor by the wash machine. During an interview on 090/06/2024 at 10:20 AM, the Dietary Aide stated an outside vendor was called to repair the leak from the wash machine which had been leaking for a week. The vendor came in on 9/4/2024 with their supervisor and the repairs was not completed. There was still water on the floor after they left. During a walk through on the units on 09/12/2024 from 10:00 AM until 11:39 AM, the following was observed: -In room [ROOM NUMBER]W, there were scratches along the molding around the walls and holes along with scratched -paint underneath the paper towel dispenser. -In room [ROOM NUMBER]W, there was a black smudge with missing paint on the wall next to the resident's bed. -In room [ROOM NUMBER]W, the molding was off the wall around the entire perimeter of the room behind the resident's beds. -At the Center 2 hallway, the lower portion of the wall and the rubber baseboards had visible dirt, scuff marks and stains. - At the dining room, the walls were dirty with some chipped paint on the walls and around the windows. -Along the corridor of Center 2, observed chipped paint on the walls. -At the Center 1 hallways, the walls had visible debris, dirt, and scuff marks. - At the Center 1, the floor by the elevator was visibly dirty and had chipped paint on the walls as well as dirty baseboards -In room [ROOM NUMBER], the wallpaper was peeling, and paint chipped at room entry (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a walk through on the 3rd floor unit on 09/13/2024 from 11:53 AM until 11:56 AM the following was observed: - At the 3rd floor unit, there was an odor of urine and multiple visible stains on the floor. - At the 3rd floor unit, walls of the corridor were visibly soiled and had chipped plaster and paint. - At the 3rd floor unit, below the handrail down the entire hallway the paint was scratched off. - At the 3rd floor unit, the radiator in the hallway had paint scrapped off and a piece of duct tape was in place holding the panel in place -Outside of room [ROOM NUMBER], there was bubbled up wallpaper with a brown stain going down the wall - At the 3rd floor unit, emergency exit door had chipped paint around the window and was visibly dirty with stains - At the 3rd floor unit, the base board of unit manager's office door had visible dirt and stains - At the 3rd floor unit, there was a brown stain on the wall near the treatment cart. - At the 3rd floor unit, the paint was scrapped off sections of the handrail. - At the 3rd floor unit, there was a large area of paint peeled off the wall by the radiator, and the wall behind the radiator was visibly dirty on the 3rd floor unit During a walk-through on the unit 2 North [NAME] on 9/16/2024 at 1:35 PM the floor was noted to be sticky, and the hall smelled of feces and urine. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/10/2024 at 10:14 AM, the Director of Maintenance stated each unit and the kitchen have a book for work order requests. The Director of Maintenance stated their staff check the book daily and sign off the sign in sheet. The Director of Maintenance stated throughout the day the facility staff will call them to inform them of any environmental issues in the facility and they or their staff will respond. The Director of Maintenance stated they follow up with repairs within the next day or if it is something that can be handled immediately, then they will address it right away. The Director of Maintenance stated if a room needed to be painted then they let the nurse manager know and request the resident be moved out the room, for the room to be painted. The Director of Maintenance stated they make environmental rounds with the staff and the Administrator weekly to see if the rooms need to be repainted or refreshed. The Director of Maintenance stated they know some of the rooms need touch up paint jobs, but the residents are in the rooms and that they are working on it right now, but it is a work in progress and that they work on about 2 rooms per week. The Director of Maintenance stated the last time they did any work in the kitchen was last week, the sink was dripping, and they had to change the entire unit. The Director of Maintenance stated they were unaware of the pool of water on the floor in the kitchen by the dishwashing area. After walkthrough with surveyor through the kitchen, the Director of Maintenance stated they never received a work order request for that and that they would call the vendor and have someone come out right away to repair. During an interview on 9/17/2024 at 3:10 PM, the Director of Nursing stated they are part of the environmental rounds. The Director of Nursing stated they go around and check the rooms to ensure the resident is safe, that there are no smells and if any safety issues are observed, they are addressed by the department it belongs to. The Director of Nursing stated they will follow up before the end of the day to ensure they are in compliance. The Director of Nursing stated if it is something out of their control then they bring it to the administrator. The Director of Nursing stated they text the department head immediately if they see something. During a telephone interview on 10/31/2024 at 9:25 AM, the Administrator stated environmental rounds are done in the facility daily for the past year and a half and that they take the facility very seriously. The Administrator stated they have been working on keeping the facility up and making it aesthetically appeasing. The Administrator stated the Director of Nursing, Director of Housekeeping and the Maintenance Director make the environmental rounds with them. The Administrator stated that they pick certain units weekly with maintenance and housekeeping and they make thorough rounds on the units and with that schedule, the entire building should be covered at least once a month. The Administrator stated when a repair is needed sometimes it takes a day or 2 for the work to get completed. The Administrator stated a reasonable time for repairs to be done is within 24 hours and that sometimes residents need to be moved from rooms for repairs to be made. The Administrator stated sometimes a repair may require more time, for example if a wall needs to be plastered. The maintenance department would have to allow time for the plaster to dry before they could re-paint. The Administrator stated identified concern areas were probably in the process of being repaired and that they would go and inspect the areas, but a lot have been addressed. The Administrator stated they were informed of the water on the floor in the kitchen, and they went down and saw it, and the vendor came and fixed it. 10 NYCRR 415.29