STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335100	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isabella Geriatric Center Inc	515 Audubon Avenue New York, NY 10040

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on observation, interview, and record review conducted during the Recertification survey from 3/26/2024 to 4/2/2024, the facility did not ensure that notice of the availability of the survey results was posted in prominent areas accessible to the public. This was evident for 10 (Resident #s 60, 410, 571, 74, 113, 611, 287, 371, 470, and 250) of 10 resident attendees during Resident Council Meeting. Specifically, notification of survey result availability was not posted in prominent areas of the facility accessible to the public. The findings are: The facility policy titled Resident Rights and Responsibilities dated 7/2022 documented residents and their representatives are informed of their rights. During observation of the facility on 3/26/2024 at 9:00 AM and 3/29/2024 at 11:00 AM, notification of survey result availability was posted in the lobby entrance of the main building. There were no observations of the notification posted on the 18 residential units or 1st floor frequented by residents, staff, and visitors. On 03/27/2024 at 11:12 AM, Resident Council Meeting was held with Resident #s 60, 410, 571, 74, 113, 611, 287, 371, 470, and 250. All attendees stated and agreed they did not know where the survey results were posted in the facility and have not seen a notification regarding location of posted survey results. On 03/29/2024 at 11:52 AM, the Administrator was interviewed and stated the state survey results were in a [NAME] located in the lobby by the entrance to the facility. The signs posting notification regarding location of the survey results were posted throughout the facility in prominent locations. The Administrator stated they were not aware the residential units did not have signs posting information regarding the location of the facility's survey results. 10NYCRR 415.3(d)(1)(v)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49081 Based on record review and interview conducted during the Recertification survey from 3/26/2024 to 4/02/2024, the facility did not ensure that appropriate notices were provided to Medicare beneficiaries when they were discharged from skilled services. This was evident for 2 (Residents #311 and #554) of 3 residents reviewed for Beneficiary Notification out of 39 total sampled residents. Specifically, a copy of the Notice of Medicare Non-Coverage was not mailed to the resident's representative on the same date that the telephone notification was made. The findings are: The facility policy titled Notice of Medicare Non-Coverage (NOMNC) dated 11/2023 documented that the MDS Coordinator/Designee will issue the NOMNC to the patient and/or responsible party. A copy of the signed NOMNC will be given to the patient and a copy will be kept in the clinical compliance office. The MDS Coordinator must ensure that the beneficiary or responsible party signs and dates the NOMNC to demonstrates that the beneficiary or representative received notice and understands that the termination decision can be disputed. If the Designated Representative is unable to be reached via phone a proof of mail delivery must be secured in the patient's medical record. The Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 documented the requirement that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. The instructions also documented that if the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. 1. The Notice of Medicare Non-Coverage form dated 1/8/2024 issued for Resident #311 documented that the last covered day for Medicare Part A service was 1/10/24. The Notice of Medicare Non-Coverage form also documented that the significant other was provided telephone notification from the staff designee on 01/8/2024 at 11:33 AM. There was no documented evidence that a Notice of Medicare Non-Coverage form had been mailed out on the same date that notification was made. 2. The Notice of Medicare Non-Coverage form issue for Resident #554 dated 11/27/2023 documented that the last covered day for Medicare Part A service was 12/1/23. The Notice of Non-Coverage form also documented that the family member was provided telephone notification from the staff designee on 11/27/2023 at 2:40 PM. There was no documented evidence that a Notice of Medicare Non-Coverage form had been mailed out on the same date that notification was made. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/24 at 4:06 PM, the Minimum Data Set Coordinator stated that once a date of discharge is determined, they contact the resident or their representative and explain the Notice of Medicare Non-Coverage and provide LIVANTA's contact information that they can call to appeal the discharge. The Minimum Data Set Coordinator also stated that if they provided telephone communication, they fill out the telephone notification area on the form with the time, date and sign it. If the resident or resident representative understand all the information, we mail the notification. The Minimum Data Set Coordinator further stated that they send notices by certified mail notification to the resident's representative if they were not able to reach them by phone. The Minimum Data Set Coordinator stated that they do not mail or email notices when telephone notification is made so was not able to provide any evidence that this was done. 10 NYCRR 415.3(g)(2)(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observation, interviews, and record review conducted during the Recertification and Complaint (NY00315735 & NY00330475) Survey from 3/26/2024 to 4/2/2024, the facility did not ensure residents unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene. This was evident for 2 (Resident #175 and Resident #210) of 9 residents reviewed for Activities of Daily Living out of 38 total sampled residents. Specifically, 1) Resident #175 did not receive staff assistance and was unable to shower in 12/2023 and 1/2024, and 2) Resident #210 was not provided with physical assistance necessary to transfer out of bed. The findings are: 1) Resident # 175 had diagnoses of anemia and heart failure. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #175 was cognitively intact and required the physical assistance of two people for bathing. On 03/27/2024 at 10:06 AM, Resident #175 was interviewed and stated staff did not provide them with the necessary assistance to shower in 12/2023 and 1/2024 due to staffing shortages. Resident #175 stated they did not receive the twice weekly scheduled showers until 2/2024. The Certified Nursing Assistant Accountability Record for 12/2023 and 1/2024 documented Resident #175 was provided with assistance for bathing. The record did not document a shower schedule for Resident #175 or that Resident #175 received showers. There was no documented evidence Resident #175 was provided with assistance to have showers in 12/2023 and 1/2024. On 04/01/2024 at 12:00 PM, Certified Nursing Assistant #13 was interviewed and stated there were only 3 staff on the unit to provide assistance to residents to perform activities of daily living. The staff did their best to address each resident's needs and ensure that residents were showered according to their shower schedule. On 04/01/2024 at 04:07 PM, Registered Nurse #4 was interviewed and stated Resident #175 was scheduled for showers twice weekly. It was difficult to residents who required total assistance with scheduled showers when the unit was short of staff. There were residents who were not showered on their scheduled shower days. 2) Resident #210 had diagnoses of heart failure and hyperlipidemia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #210 was severely cognitively impaired and required maximal staff assistance to transfer out of bed. On 03/26/24 at 10:34 AM, on 03/27/24 10:25 AM , on 03/28/24 10:36 AM, on 03/29/24 10:57 AM, on 04/01/24 12:27 PM and on 04/01/24 04:25 PM, resident #210 was observed in bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nursing Assistant Accountability Record for 5/2023 did not document that Resident #210 was transferred out of bed. There was no documented evidence staff provided Resident #210 with the assistance necessary to be transferred out of bed. On 03/29/24 at 10:59 AM, Certified Nursing Assistant #18 was interviewed and stated most residents on the unit require 2 staff to transfer them out of bed and there were only 3 staff members working on the unit. Resident #210 did not refuse to come out of bed but usually remained in the bed because it was difficult for staff to address all the needs of the residents on the unit. On 04/01/24 04:27 PM, Certified Nursing Assistant # 19 was interviewed and stated Resident #210 was supposed to come out of bed during the day but most of the staff assigned to the unit were not regularly assigned to the unit and did not transfer resident #210 out of bed. On 04/02/24 at 01:07 PM, the Director of Nursing was interviewed and stated the Registered Nurses were responsible for ensuring unit staff addressed resident needs and they made rounds twice daily to observe resident care. Residents were supposed to be provided with the assistance to shower according to their schedule and be transferred out of bed daily. 10 NYCRR 415.12(a)(3)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observation, record review, and interviews conducted during the Recertification Survey from 3/26/2024 to 4/2/2024, the facility did not ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. This was evident for 1 (Resident #210) of 3 residents reviewed for limited range of motion out of 38 total sampled residents. Specifically, Resident #210 had a right-hand contracture and was observed without a carrot splint per Physician Order. The findings are: Resident #210 had diagnoses of dementia and cerebral vascular accident with right hemiplegia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #210 was severely cognitively impaired and had functional limitation in range of motion on 1 side of their upper extremities. Between 03/26/2024 at 10:34 AM and 4/1/2024 at 4:25 PM, there were multiple observations of Resident #210 with a right-hand contracture and without a carrot splint in their right hand. The Physician Order initiated 3/10/2023 and last renewed 2/29/2024 documented Resident #210 was ordered to always wear a carrot splint in their right hand and to remove the carrot splint during range of motion, hygiene care, and skin checks. The Comprehensive Care Plan related to contractures initiated 4/5/2023 and last reviewed 3/28/2024 documented a Resident #210 always wore a carrot splint in their right hand to prevent new contractures. On 03/29/2024 at 10:59 AM, Certified Nursing Assistant #18 was interviewed and stated they usually applied Resident #210's carrot splint to their right hand after providing the resident with care. Certified Nursing Assistant #18 stated they did not know the reason Resident #210 did not have their carrot splint in place. The carrot splint should have been applied to Resident #210. On 03/29/2024 at 11:15 AM, Registered Nurse #11 was interviewed and stated they conducted rounds every 30 minutes to ensure residents were receiving proper care. Resident #210 was ordered to always wear a carrot splint in their right hand. On 04/02/2024 at 01:07 PM, the Director of Nursing was interviewed and stated the Registered Nurses were responsible for conducting rounds on the resident units twice per shift to ensure care was provided by the Certified Nursing Assistants. All splints should be applied per Physician Order. 10 NYCRR 415.12(e)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48711 Based on observation, interview, and record review conducted during the Recertification and Complaint (NY00327086) Survey from 3/26/2024 to 4/2/2024, the facility did not ensure a resident remained free of accident hazards. This was evident for Resident #494 reviewed for accidents out of 38 total sampled residents. Specifically, The findings are: The facility policy titled Microwave - Reheating of Food Items dated 11/2023 documented Nursing and Nutrition staff were responsible for microwaving food and testing the internal temperature until it reaches 165 degrees Fahrenheit. Resident #494 had diagnoses of diabetes mellitus and anemia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #494 had mild cognitive impairment and required 1 person to assist with activities of daily living. The Comprehensive Care Plan related to impaired skin integrity initiated 5/10/2023 documented to assess Resident #494's skin every shift and assess risk factors on an ongoing basis. activity report last reviewed on 11/16/2023 documented Resident # 494 will be injury free. The Comprehensive Care Plan related to fall risk initiated 5/10/2023 documented to provide a safe environment and encourage Resident #494 to ask for assistance. The Comprehensive Care Plan related to activities of daily living and self-care deficit initiated 5/11/2023 documented to anticipate Resident #494's needs. The care plan did not specify activities of daily living, or the level of assistance Resident #494 needed. The Comprehensive Care Plan related to vision, and sensory perception alteration initiated 5/18/2023 documented nursing was responsible for assisting with and supervising Resident #494's activities of daily living to ensure the resident remained injury free. The Comprehensive Care Plan related to dementia initiated 7/6/2023 documented Resident #494 had cognitive loss and their needs should be anticipated. The Nursing Situation Background Assessment and Recommendation Form dated 10/28/2023 documented Resident #494 sustained right and left upper thigh burns on 10/25/2023 and did not report the burns to staff. Resident #494 was not in pain. The Nursing Note dated 10/28/2023 documented Resident #494 reported they warmed their water in the microwave located in the unit dining room and spilled the water on their lap while self-propelling back to their room resulting in bilateral upper thigh burns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medical Doctor Note dated 10/28/2024 documented Resident #494 was evaluated for a burn on their left thigh from spilling tea on themselves a few days ago. Resident #494 had some discomfort but declined hospital transfer. The left thigh wound appeared as a large medical eschar with surrounding redness and cellulitis. Silvadene and Keflex antibiotic were ordered for Resident #494. The Wound Care Doctor Note dated 10/31/2023 documented Resident #494 was evaluated for a right upper thigh burn measuring 2.5 centimeters by 1.8 centimeters and left upper thigh burn measuring 5.5 centimeters by 7.8 centimeters. Both burns were draining serous fluid, presented with tunneling, had unstable surrounding skin, and had suboptimal potential to heal. MediHoney Gel treatment was ordered. The facility Incident Investigation initiated 10/28/2023 and completed 11/2/2023 documented Resident #494 was alert and oriented, was able to independently perform their activities of daily living, tended to refuse skin checks, and did not report burning their bilateral upper thighs with a hot liquid after using the microwave. There was no documented evidence Resident #494 was provided with the necessary supervision when using the dining room microwave resulting in the resident sustaining bilateral upper thigh burns on 10/25/2023. On 04/01/2024 at 11:50 AM, Certified Nursing Assistant #20 was interviewed and stated, prior to Resident #494's burn incident, unit staff informed facility Administration the microwave in the dining room needed to be removed because it was easily accessible to all residents on the unit. On 04/01/2024 at 11:11 AM, Registered Nurse #14 was interviewed and stated the Certified Nursing Assistant assigned to Resident #494 on 10/28/2023 reported the resident had burn marks on their bilateral upper thighs. Resident #494 reported they burned themselves on 10/25/2023 with hot water they warmed in the dining room microwave. Resident #494 did not report the burns to staff and none of the unit staff were aware Resident #494 used the microwave and sustained burns. On 04/01/2024 at 12:41 PM, the Director of Nursing was interviewed and stated unit staff were not aware Resident #494 used the dining room microwave without assistance and sustained burns. Residents were no supposed to use microwaves without staff assistance. 10 NYCRR 415.12(h)(1-2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observations, record review, and interviews conducted during the Recertification and Complaint (NY00315735 & NY00330475) survey from 03/26/24 to 04/02/24, the facility did not ensure there was sufficient numbers of nursing assistants available to provide nursing care to all residents in accordance with the resident's plan of care. This was evident during review of the Sufficient and Competent Nurse Staffing task. Specifically, 1) Review of facility par level revealed short staffing on 9 of 9 weekends reviewed, 2) Resident #175 did not receive scheduled showers during the Months of December 2023 and January 2024 due to shortage of staff, 3) Resident #210 required two persons assistance for Activities of Daily Living to get out of bed and was not consistently taken out of bed due to short staffing, 4) During Resident Council meeting 10 of 10 residents in attendance reported the facility is consistently short staff and they had to wait between 20 minutes and 4 hours before the staff responded to the call device, and 5) Multiple staff complained of short staffing which affected their ability to provide care according to the resident's plan of care. The findings include but are not limited to: 1. The Facility Assessment revised June 2023 documented a census of 611. The Staffing Plan included in the Facility Assessment documented an average of 328 nurses aides and 116 nurses were needed to provide direct care. The Facility Assessment did not document the specific staffing needs per resident unit or per shift. The undated document with heading Par provided by the Staffing Coordinator documented the total Certified Nursing Assistants needed daily as follows: Day=68 Evening=66 Night=44 Review of weekend staffing from 2/3/24 to 3/30/24 documented less than the par level of Certified Nursing Assistants on the following dates: 2/3/24 Day shift minus 11, Evening minus 11.5, Night minus 7 2/4/24 Day shift minus 14, Evening minus 19, Night minus 9 2/10/24 Day shift-minus 12, Evening minus 8.5, Night minus 5 2/11/24 Day shift minus 13, Evening minus 9.5 2/17/24 Day shift minus 12, Evening minus 11.5, Night minus 15 2/18/24 Day shift minus 13, Evening minus 11.5, Night minus 7 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/24/24 Day shift minus 14 2/25/24 Day shift minus 27, Night minus 7 3/2/24 Day shift minus 20.5, Evening minus 10.5, Night minus 10 3/9/24 Day shift minus 16, Evening minus 13 3/10/24 Day shift minus 24, Evening minus 16, Night minus 10 3/16/24 Day shift minus 18, Evening minus 5, Night minus 4 3/17/24 Day shift minus 19.5, Evening minus 17.5, Night minus 9.5 3/23/24 Day shift minus 10, Evening minus 13.5 3/24/24 Day shift minus 19, Evening minus 12 3/30/24 Day shift minus 6 Evening minus 12.5 2. Resident #175 diagnoses included Cancer, Heart failure, and Non-Alzheimer's Dementia. The Admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented that Resident #175 was cognitively intact, and required the physical assistance of two staff for bathing and toileting. During an interview on 03/27/24 at 10:06 AM, Resident #175 stated that they did not receive any showers in December 2023 and January 2024 due to shortage of staff. During an interview on 03/27/24 at 10:12 AM, the complainant (NY00330475) stated that in December 2023 and January 2024 the staff were not assisting Resident #175 with showers due to shortage of staff. Resident #175 is supposed to be showered twice a week and did not start receiving showers until February 2024. The Certified Nursing Assistant Accountability Records dated December 2023 and January 2024 contained no documented evidence that Resident #175 received showers. On 04/01/24 at 12:00 PM, Certified Nursing Assistant #13 stated that the assignment for Certified Nursing Assistants varies and there are times when there are only 3 of 4 Certified Nursing Assistants on the floor. When there are only 3 Certified Nursing Assistants, each Certified Nursing Assistant will have 15 or more residents on their assignment and we try our best. The Certified Nursing Assistants work together to get the work done. We ensure that residents who are scheduled to be showered for the day receive their showers as scheduled. Certified Nursing Assistant #14 also stated that there are times it is impossible to take a lunch break. If we have to give showers on a day we are short, we may have to change the resident's shower days and we let the residents know first. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/24 at 04:07 PM, Registered Nurse #4 stated Resident #175 is alert and oriented and is scheduled to receive showers twice a week. When we are short of staff, the resident may have to wait to get assistance. Registered Nurse #4 also stated that they do not always have 4 Certified Nursing Assistants on the unit, and when there are only 3 Certified Nursing Assistants it is very difficult to ensure all residents scheduled for showers are able to be showered. Registered Nurse #4 further stated that there are over 20 residents on the unit who require total care, so it is really hard for them. 20 out of 45 residents need assistance with feeding. Registered Nurse #4 also stated that residents are scheduled for showers twice a week and the staff try their best to ensure all residents receive showers on their scheduled days. Registered Nurse #4 stated that they do have floaters on the unit sometimes, and it is possible that not all residents have received showers on their scheduled shower days. On 04/02/24 at 10:03 AM, Registered Nurse #13 stated that they supervise six units. Residents are supposed to be showered twice a week. We do check with the nurses to ensure all residents scheduled to be showered are showered on scheduled days. Registered Nurse #13 also stated that they try to offer the showers on a later day if, for some reason, the showers cannot be provided. We do rounds twice per shift and check on all of the residents. We check on all units and we ensure all residents are receiving care. 3. Resident # 210 diagnoses include Heart Failure, Cerebrovascular Accident, and Dementia. The Annual Minimum Data Set 3.0 assessment dated [DATE] documented Resident #210's cognitively was severely cognitively impaired and required maximal assistance for eating, toileting, upper and lower body dressing. The Minimum Data Set 3.0 assessment also documented that Resident #210 had impairment on one side of the upper extremities, both sides of the lower extremities, and used a walker for ambulation. The complaint intake summary (NY00315735) dated 05/01/23 documented that the complainant stated that they asked staff to change Resident #210 and they were told there was not enough staff and they would have to wait till the next shift. The complainant also stated that Resident #210 was left in bed all day since they did not have the staff to get them up. On 03/26/24 at 10:34 AM, 03/27/24 at 10:25 AM, 03/28/24 at 10:36 AM, 03/29/24 at 10:57 AM, 04/01/24 at 12:27 PM and 04/01/24 at 04:25 PM, Resident #210 was observed in bed. On 03/29/24 at 10:59 AM, Certified Nursing Assistant #18 stated that there are only 3 of 4 Certified Nursing Assistants on the unit today, and they had 15 residents on their assignment today. Certified Nursing Assistant #18 also stated that most of the resident need assistance of two staff for activities of daily living care. Certified Nursing Assistant #18 further stated that it is hard to get everyone out of bed when they are short staffed because most of the residents need assistance of two staff persons for transfers. Certified Nursing Assistant #18 further stated that Resident #18 is usually in bed and does not refuse care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/24 at 04:27 PM, Certified Nursing Assistant #19 stated that Resident #210 requires total care, is supposed to be taken out of bed during the day, and does not refuse to come out of bed. If the regular Certified Nursing Assistants are not on the unit, the aides available do not take the residents out of bed. Certified Nursing Assistant #19 also stated that most of the staff on the day shift are floaters. Certified Nursing Assistant #19 further stated that when there are 3 Certified Nursing Assistants instead of 4 Certified Nursing Assistants on the unit they have to take care of 15 residents and it is hard. Certified Nursing Assistant #19 stated that they are not able to take their break when they are assigned 15 residents. On 03/29/24 at 11:15 AM, Registered Nurse #11 stated that they usually have 3 Certified Nursing Assistants on the unit and it is supposed to be 4 Certified Nursing Assistants. Registered Nurse #11 also stated that if there are a lot of call outs they work short. On 04/01/24 at 04:33 PM, Registered Nurse #12 stated Resident #210 needs to be out of bed after they are assisted with care and does not refuse care. On the evening shift, there are usually 3 Certified Nursing Assistants on the unit for 45 residents. We have residents with dementia and residents who needs extensive assist to total dependence. The residents on the unit need to be always supervised. Registered Nurse #12 also stated that they are the only nurse on the floor and it is very hard to pass medications to 45 residents. Registered Nurse #12 further stated that when there are only 3 Certified Nursing Assistants on the unit instead of 4, they have to respond to every call for assistance while passing medications. There are times, the 3 Certified Nursing Assistants are in the rooms assisting residents. Registered Nurse #12 stated that they are unable to take their lunch break on most days. 44843 4. The Resident Council minutes dated 12/19/23 documented nursing staff was discussed, and more nursing staff were needed. The Resident Council Meeting Minutes dated 2/16/24 documented the response time of call device was slow, and the residents must wait for assistance until their assigned Certified Nursing Assistant comes back from break. The Resident Council Meeting Minutes dated 3/19/23 documented call bell response was still a concern, and the residents were not able to tell who their assigned Certified Nursing Assistant or nurse was. On 03/27/24 at 11:12 AM, during the Resident Council Meeting, 10 out of 10 residents in attendance stated that staffing was an issue at the facility, and staff took too long to respond to call bells. The residents stated that they sometimes had to wait up to four hours for someone to respond to the call bells or they have to wait for the next shift to have somebody answer the call bell. Resident # 470 stated the lunch tray stayed in their room until 4 PM and they had to take it out themselves sometimes. Resident #113, Resident 287, Resident 371, and Resident 571 stated there was only 1 Certified Nursing Assistant for day shift on Sunday sometimes. They did not get assistance they needed for the day or had to wait a long time before getting any assistance. 41709 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 04/02/24 at 12:09 PM, an interview was conducted with Licensed Practical Nurse #5 who stated that the staffing is very bad. They are responsible for administering medications and treatments, and must help the Certified Nursing assistant at the same time because of short staff. Licensed Practical Nurse #5 stated they leave at 7 pm at nights to ensure all the medications or treatments are given to the residents. If there are only 3 Certified Nursing Assistant on the unit, with no extra staff for the resident on 1:1 monitoring, they must help the Certified Nursing Assistants with feeding the residents as there are a lot of residents who need assistance with feeding on the 9th floor. There was a meeting with management and a meeting with the union, but there has been no change in the staffing. Licensed Practical Nurse #5 also stated there were only 2 Certified Nursing Assistants on the unit yesterday unit to provide morning care with a resident who was on 1:1 monitoring. An aide come in at 10 :00 am to do the 1:1 monitoring. Licensed Practical Nurse #5 further stated Sunday night into Monday morning there was one Certified Nursing Assistant on the floor to start the shift and the staff assigned to the resident on 1:1 monitoring arrived at 1:00 am. On Monday morning most of the residents were wet, because the one Certified Nursing Assistant was not able to change all the residents. Licensed Practical Nurse #5 stated on the floor today there was 1 regular staff and 3 agency staff. On 04/02/24 at 10:30 AM, an interview was conducted with Certified Nursing Assistant #8 who stated they are short of staff sometimes during the week but the weekends are the worst. There used to be 3 aides on the unit, but now there is a resident on 1:1 monitoring and they have not been given additional staff, so only two Certified Nursing Assistants are on the floor to give care. Certified Nursing Assistant #8 also stated they do not take a break until they finish their shift, because the residents will not get care, and they feel rushed, hurried, and are constantly going to get everything done. Certified Nursing Assistant #8 further stated that staff has gotten worst, staff just do their best, but it is an impossible task. During an interview on 04/02/24 at 10:23 AM, Certified Nursing Assistant #9 stated that they work on the morning and evening shift and every weekend and came in to help out this weekend because the staffing was not good. The evening shift had two Certified Nursing Assistant and one person for 1:1 supervision on the unit which had 45 residents. Certified Nursing Assistant #9 stated they feel rushed to do everything because of the short staff, and do not get to take breaks so eats after they finish work as they are about to go home. On 04/02/24 at 10:14 AM, an interview was completed with Certified Nursing Assistant #10 who stated the staffing is terrible, with one weekend good and the other weekend not good. When working we prioritize the quadriplegics and the tube feeders to ensure they get care first. Certified Nursing Assistant #10 also stated that every other weekend and they are still on the unit at this time to help colleagues and they stayed to help give showers to the residents before leaving. Certified Nursing Assistant #10 further stated they worked overnight with two Certified Nursing Assistant and there was a resident on 1: 1 monitoring on the unit. On 03/26/24 at 11:57 AM, an interview was completed with Certified Nursing Assistant #4 who stated the staffing is very bad and was cut from 3 to 4 staff down to 2 aides only. When there are only 2 Certified Nursing Assistants it is hard to give showers and answer call bells. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/24 at 12:05 PM, the Staffing Coordinator stated that document titled Par is the guide the Staffing Coordinators use to determine staff needed for each unit and was provided to them by Nursing Administration. When there are residents who require 1:1 monitoring, additional staff is given to cover the one to one. The challenge here is the call outs which happen every day, on every shift. Staff say they are ill and can't make it in today. Weekends are also a challenge to get staff, they call out or do not show up to work. Staffing Coordinators also work on weekends and stay until 10pm on evenings to make sure there are staff to cover. We use our regular staff and will reach out to staff to come into their shift earlier. The Staffing Coordinator also stated that one weekend does have less staff than the other, but we have to give notice when we need to change the weekend schedule to even it out. We also have a few people out on medical leave on every shift. The Staffing Coordinator further stated that we try to meet the Par level for each unit and the Par level has been the same for the past year. The Staffing Coordinator stated that they do have a referral process and offer sign on bonuses to attract new employees. The Staffing Coordinator also stated that staff are required to take their breaks. On 04/02/24 at 01:07 PM, the Director of Nursing was interviewed and stated we started a Certified Nursing Assistant school so they can recruit more Certified Nursing Assistants. We hired two new recruiters to assist us with recruiting nursing staff and nurse managers. We have incentives such as sign on bonuses, referral bonuses. The Director of Nursing also stated we have thirteen agencies assisting us to obtain staff at all levels, and we contact the agencies if they have a lot of call outs. We do call regular staff to see if they can work extra hours. The Director of Nursing further stated that all of the department heads are constantly meeting to ensure that we have adequate staffing. We do discuss keeping the census at the same level. We are looking closely at prospective residents to determine the level of staff needed to take care of them. During an interview on 04/02/24 at 02:34 PM, the Administrator stated we have been consistent with the census, and the census is going to stay the same. We are trying to increase staffing to ensure we have adequate staff to meet the needs of the residents. The staffing issues goes up and down. We are working with at least ten agencies and we hired two new recruiters to help us with recruiting staff. Sometimes when the staff call out, it set us back. The Administrator also stated that we started a Certified Nursing Assistant school and are on our seventh class. We are trying to hold class every six weeks and are working on getting another educator to be able to teach two classes at the same time. We also provide financial incentives to all new staff and we have referral programs. Some of the agency's staff are joining us as well. The Administrator further stated that their staffing coordinators work seven days a week to obtain staff when needed. We do want to increase staffing and we are constantly recruiting and actively working on improving staffing. 415.13(a)(1)(i-iii)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observation, record review, and staff interviews conducted during the Recertification survey from 03/26/2024 to 04/2/2024, the facility did not ensure psychotropic drugs were not given to residents unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. This was evident for 2 (Resident #190 and #141) of 5 residents reviewed for Unnecessary Medications out of 38 total sampled residents. Specifically, 1) Resident #190 was prescribed Risperdal without documented evidence of behavior or staff attempts to use nonpharmacological interventions, and 2) there was no documented evidence Resident #141 displayed behavior, nonpharmacological interventions were used, or a medical assessments was done prior to placing Resident #141 on psychotropic medication. The findings are: The facility policy titled Psychotropic Medications dated 05/2023 documented psychotropic medications require proper indications for use, alternatives when appropriate, appropriate dosage and duration of use, and effective monitoring for effectiveness and side effects. Prior prescribing psychotropic medication, staff must consider and use appropriate nonpharmacological interventions. The Medical Doctor must assess the resident with new or worsening behavioral symptoms for underlying medical causes. 1) Resident #190 was admitted with diagnoses which included Alzheimer's disease, Dementia, Depression, and insomnia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #190 had severely impaired cognition and did not display behaviors. The Patient Review Instrument assessment dated [DATE] documented Resident #190 was diagnosed with dementia. There was no documented evidence Resident #190 had a severe mental illness or received psychotropic medication prior to their admission to the facility. The Psychiatry note dated 12/6/2023 documented Resident #190 did not have behavioral disturbances, was not agitated, and denied visual hallucinations. The Psychiatry note dated 01/19/2024 documented Resident #190 had dementia with severe psychotic disturbance, was verbally disruptive, and was paranoid and delusional. The Psychiatrist recommended ordering Resident #190 Risperdal 0.25 milligrams for psychosis due to visual hallucinations and delusions. The Physician Order dated 01/25/2024 documented an order for Resident #190 to receive Risperdal 0.5 milligrams daily at bedtime due to unspecified psychosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence from 11/1/2023 to 1/19/2024 that Resident #190 displayed behaviors, delusions, or hallucinations. There was no documented evidence of nonpharmacological interventions were attempted or assessment for underlying medical causes was done prior to ordering Risperdal for Resident #190. On 04/01/2024 at 03:53 PM, Certified Nursing Assistant #17 was interviewed and stated Resident #190 did not display inappropriate behavior. On 04/01/2024 at 04:07 PM, Registered Nurse #4 was interviewed and stated that Resident #190 had some episodes of anxiety and crying in the evenings related to their desire to be discharged to their home in the community. Resident #190 was not aggressive and was ordered Risperdal to address their crying and screaming. During an interview on 04/02/2024 at 10:03 AM, Registered Nurse #13 stated nursing staff were responsible for documenting a resident's behavior in daily behavior progress notes. Nonpharmacological interventions should be attempted to address a resident's behavior prior to placing a resident on psychotropic medications. On 04/02/2024 at 01:07 PM, the Director of Nursing was interviewed and stated a resident's behaviors and nonpharmacological interventions must be documented in the medical record prior to placing a resident on psychotropic medications. On 04/02/2024 at 11:18 AM, the Psychiatrist was interviewed and stated Resident #190 was admitted to the facility on Seroquel because they displayed hallucinations. The Seroquel was discontinued, and Resident #190 began hallucinating again due to their diagnosis of dementia. Resident #190 cried and screamed and was ordered Risperdal. The Psychiatrist stated the dose of Risperdal was too low to cause cardiac issues. Resident #190 began pointing and talking to someone that was not there during the Psychiatry consult in 1/2024 and the Psychiatrist decided to place the resident on Risperdal to address the hallucinations. On 04/02/2024 at 01:26 PM, Medical Doctor #1 was interviewed and stated Resident #190 was prescribed Risperdal because they were agitated, cursing, and screaming daily claiming their family abandoned them in the facility. Medical Doctor #1 agreed with the Psychiatrist and ordered Resident #190 to receive Risperdal to address their hallucinations. Gradual dose reductions of psychotropic medications were only attempted with residents receiving high doses of medication for at least 6 months. 49081 2) Resident #141 was admitted to the facility with diagnoses that included Heart Failure, Atrial Fibrillation, Malnutrition and Osteoporosis. The Admission Assessment 5 Day Scheduled Minimum Data Set, dated dated dated [DATE] documented resident was moderately impaired cognition, had no behavioral symptoms and no antipsychotic medications were received. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Assessment Minimum Data Set, dated dated dated [DATE] documented resident was severely cognitively impaired and had no behavioral symptoms. Diagnoses included Non-Alzheimer's Dementia, and Psychotic Disorder. The Minimum Data Set documented resident received antipsychotic, gradual dose reduction was clinically contraindicated, and date physician documented was 11/24/2023. A Comprehensive Care Plan Titled Dementia Cognitive Loss dated 10/05/2023 and revised 01/17/2024 had a goal of sustain current level of cognitive functioning. Interventions included anticipate needs, maintain calm environment, and use direct/simple instructions and cues. A Comprehensive Care Plan Title Psychoactive drug use with diagnosis of Psychosis and Depression dated 01/09/2024 had interventions which included evaluate behavior pattern daily, evaluate effectiveness of medications, monitor for changes in behavior or moods and psychiatry consultation. On 03/28/2024 at 09:54 AM, Resident #141 was observed in bed with bilateral floormats on both sides of bed. Resident #141 observed with calm mood. On 04/01/2024 at 09:41 AM, Resident #141 was observed in bed eating breakfast. Resident #141 mood was pleasant and answered simple questions. Resident #141 displayed no behaviors. On 04/02/2024 at 09:06 AM, Resident #141 was observed eating breakfast, replied to surveyor when asked with simple questions but with some confusion. No restless or agitation observed. Resident #141 observed in good mood. At 11:47 AM, Resident #141 observed sleeping in bed with the television on and bilateral floormats observed on both sides of bed. From 03/28/2024 through 04/02/2024 during multiple observations, Resident #141 was observed in bed, no activities being provided. Resident #141 displayed no behaviors. A Medical progress note dated 10/05/2023 documented Resident #141 was alert, awake, frail looks with chronological age. Psychiatry: normal mood and affect Resident #141 with anorexia to continue with Remeron 30 mg at bedtime. A Psychiatry progress note dated 10/19/2023 documented Resident #141 was for psychiatric evaluation with history of Aphasia and Subsequent Dementia with Depression, on psychotropic medications. As per staff Resident #141 had been without behavioral disturbances, no significant agitation, although recent reported Resident #141 with restlessness and agitation. Resident #141 denied Depression, no signs, and symptoms of Depression and positive confusion. Resident #141 denied psychotic signs and symptoms but recent reported of visual hallucinations. Resident #141 had positive memory deficits. Resident #141 was on psychotropic medications of Remeron 15 mg at bedtime and Melatonin 10 mg at bedtime. Diagnoses included Vascular Dementia with Depression. No gradual dose reduction was attempted, Resident #141 was unstable. A Psychiatry progress note dated 10/25/2023 documented for follow up, Resident #141's history of present illness with severe memory deficit, behavioral problem-periodic restlessness and agitation, labile and depressed mood, psychosis- visual hallucinations and insomnia. Psychotropic medications were Remeron 15 mg by oral route at bedtime and Melatonin 10 mg by oral route at bedtime. Resident #141 mental status documented awake, alert and calmed, mood depressed, hallucinations visual type, affect full/labile. Plan: please start Risperdal 0.25 mg by oral route at bedtime for Visual Hallucinations/Psychosis, support provided, monitor behavior and mood. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medical progress notes dated 10/31/2023 documented Resident #141 was seen by psychiatrist had some visual hallucination and psychiatrist consult recommended Risperdal in low dose. Resident #141 with anxiety with visual hallucinations and adding Risperdal 0.25 mg at bedtime. A Nursing progress note dated 11/25/2023 at 02:41 AM documented Resident #141 had behavior of crawling onto the floor mats attempting to go to the bathroom. A Nursing progress notes dated 11/25/2023 at 10:32 PM documented Resident #141 had behavior of crawling onto the floor mats attempting to go to the bathroom. A Nursing progress note dated 01/10/2024 at 10:32 PM documented Resident #141 was monitored for insomnia. Received Resident #141 in chair awake, alert and verbal at 11:30 PM. At 12:35 AM Resident #141 observed dozing in chair. Certified Nursing Assistant put Resident #141 back to bed and floor mats placed on floor for safety as Resident #141 had a habit of coming out from bed. At 12:45 AM, Resident #141 observed crawling from mattress on the floor and shifted Resident #141 back to chair with assistance of two staff, and placed Resident #141 in front of nurse's station for constant observation and safety. There were no other nursing notes documented for Resident #141's behavior. The Medication Administration Record dated 10/01/2023 to 10/31/2023, documented Resident #141 was started on Risperdal (Risperidone) 0.5 mg tablet once daily for Generalized Anxiety Disorder on 10/31/2023. The Medication Administration Record dated from 10/01/2023 to 03/31/2024, documented no tapering or discontinuation of the medication Risperidone 0.25 mg once daily. Review of Physician's order dated 11/13/2023 Risperidone 0.25 mg tablet order for diagnosis of Generalized Anxiety Disorder, observed changed diagnosis to Unspecified Psychosis not due to a substance or known physiologic condition and Visual Hallucinations. The Medication Regimen Review progress note dated 11/25/2023 documented Resident #141 currently receiving Risperidone (Risperdal) 0.25 mg at bedtime which can increase risk for falls. Evaluate considering tapering dose or implementing alternative treatment if necessary. Currently receiving low dose Risperidone (Risperdal) for a diagnosis other than an approved chronic psychiatric condition, please evaluate continued need and efficacy and consider discontinue, if appropriate. Physician responded disagreed, Resident #141 with psychosis with hallucinations. The Medications Regimen Review progress note dated 02/25/2024 documented Resident #141 currently receiving Risperidone. Per order, use is for diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis is inaccurate and the resident currently is using this medication for an approved use such as Schizophrenia, Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reductions and discontinuing currently. Physician responded and disagreed with note that Resident #141 had dementia with psychotic disturbance including hallucinations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Certified Nursing Assistant Documentation History Detail documented that on 10/08/2023 and 10/18/2023 Resident #141 had 1 occasion of intrusive wandering and 1 occasion of repetitive physical movements, on 11/23/2023 and 11/25/2023 1 occasion of repetitive physical movements, 1 occasion of wandering and 1 occasion of abusive language. There was no documented evidence that Resident #141 displayed signs of psychosis prior to being prescribed antipsychotic medication. There was no documented evidence of a medical workup to rule out underlying medical conditions before Resident #141 was prescribed antipsychotic medication. There was no documented evidence that non-pharmacological interventions were attempted for Resident #141 prior to the administration of antipsychotic medications. During an interview on 04/02/2024 at 09:04 AM, Certified Nursing Assistant #4 stated that Resident #141 would try to get up and walk to go to the bathroom or go outside the room. Resident #141 sometimes would scream when they were in the hallway because Resident #141 wanted to get up and then they would try to hit the staff. To keep Resident #141 calm, we give food that Resident #141 likes, and try to divert their attention. Certified Nursing Assistant #4 also stated that now that Resident #141 is on contact isolation, they do not take them out of bed but when Resident #141 starts to get up, they take them out of bed because Resident #141 was high risk for fall and had an incident before. During an interview on 04/01/2024 at 09:45 AM, Registered Nurse #21 stated that Resident #141 was alert and confused and sometimes they get upset, argue with other staff, become restless and agitated if staff would give them a bath. Resident #141 would chase the staff away but did not scream or yell. Registered Nurse #21 also stated that the only behavior Resident #141 had was that they tried to get up from bed without calling for assistance. Resident #141 was provided with recreational activities and liked coloring, painting, watching television especially the Spanish channel. During an interview on 04/02/2024 at 11:56 AM, the Director of Nursing stated that they provided nonpharmacological intervention such as redirection, recreation activities and they explore the background of residents. The Director of Nursing also stated that Resident #141 had a few falls and at some point, they placed Resident #141 on one to one because of behavior like restlessness, kicking, and constant getting up and was not easily redirected. The Director of Nursing further stated that they would assess if the medication was effective by showing that Resident #141 had experienced fewer behavioral symptoms. The Director of Nursing stated that they had behavior notes and the Certified Nursing Assistants document behaviors also. The Director of Nursing was only able to provide 3 behavior nursing notes dated 11/25/2023 (2 notes) and 01/10/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/02/2024 at 03:06 PM, the Psychiatrist stated that the medication Risperidone 0.25 mg tablet was ordered because Resident #141 had Dementia with Psychotic behavior features with hallucinations. The Psychiatrist said that Resident #141's hallucinations were like hearing somebody in their room and hearing their daughter's voices. The Psychiatrist said that Resident #141 was bothered by these hallucinations, but now, Resident #141 was better, there was no behavior, no agitation and there were no hallucinations anymore. The Psychiatrist said that they tried to discontinue the medication twice but was not successful and could not recall when they discontinued the medication. Hallucinations came back, and they started the medication again. The Psychiatrist said that usually they follow up with Resident #141 every eight weeks and Risperidone 0.25 mg tab was the right medication because it was only a small dose and that would not affect Resident #141's heart or cause a heart attack. During an interview on 04/02/24 at 03:12 PM, Medical Doctor #1 stated that Resident #141 hallucinated but cannot tell exactly when this occurred and they would have to check the medical record. Medical Doctor #1 also stated that they saw Resident #141 on the unit and they knew that Resident #141 with an episode of intermittent depression, lack of appetite and weight loss. Medical Doctor #1 further stated that Resident #141 hallucinated in the past and Risperdal was recommended by the psychiatrist. 10 NYCRR 415.12(1)(2)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335100	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isabella Geriatric Center Inc	515 Audubon Avenue New York, NY 10040

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on observations, interviews, and record review conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure food was stored in accordance with professional standards for food service safety. This was evident during kitchen observation and in 1 (9th floor) of 18 pantries. Specifically, 1) the kitchen walk-in refrigerator contained expired, opened, and undated food and drink items, 2) the 9th floor pantry refrigerator was 44 degrees Fahrenheit and contained undated, unlabeled food, and 3) Dietary staff were observed not wearing head coverings in the food preparation area of the kitchen The findings are: The facility policy titled Food Storage from Deliveries dated ,d+[DATE] documented opened, stored leftover food should be labeled and dated. Opened items should be discarded after 48 hours. Expired food should be discarded immediately. The Food Service supervisor ensures foods are labeled, dated, and not expired. The facility policy titled Food Storage on Units dated ,d+[DATE] documented all items to be stored on the units are to be labeled with resident name, room number, dated, and stored at a refrigerator temperature of 40 degrees Fahrenheit or less. The charge nurse, Nursing supervisor or designee ensures that food items are labeled, dated, and stored appropriately and discarded per policy. 1) On [DATE] at 09:23 AM, Food Service Director #1 was present when the kitchen walk-in refrigerator was observed with 4 facility-prepared 4-ounce containers labeled diced pineapples with a use-by date of [DATE], 1 undated and unlabeled bag containing 6 wheat tortillas with no expiration date, 1 undated plastic bag containing 6 slices of white bread with no expiration date, an open and undated 64-ounce container of orange juice, and a quarter-sheet pan of sliced corned beef dated [DATE]. 2) On [DATE] at 09:22 AM, Registered Nurse #1 was present during observation of the 9th Floor pantry refrigerator. The refrigerator was observed with an unlabeled and undated bag containing 1 bowl of rice and noodles and half of a cucumber. The refrigerator thermometer was observed at a temperature of 44 degrees Fahrenheit. 3) On [DATE] at 11:28 AM, Dietary Worker #1 and Food Service Director #2 were observed without hair nets or head coverings and were in the kitchen preparing the lunch meal. On [DATE] at 05:45 PM, Dietary Worker #2 and Dietary Worker #3 were observed on the tray line in the kitchen during dinner service and were not wearing hair nets or head coverings. On [DATE], Food Service Director #1 was interviewed and stated the kitchen walk-in refrigerator contained expired food items because of inconsistent food dating and that staff were supposed to label food with the preparation date and a date the food should be discarded. Food Service Director #1 stated all Dietary staff should label food with a discard date that is 48 hours after the food was prepared and/or opened. Dietary staff were not responsible for the food kept in the pantry refrigerators on the resident units. (continued on next page)

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	335100	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isabella Geriatric Center Inc	515 Audubon Avenue New York, NY 10040

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 09:30 AM, Registered Nurse #1 was interviewed and stated all resident food kept in the pantry refrigerators should be labeled and dated by staff that place the food in the refrigerator. The unit staff were responsible were checking the refrigerator temperatures daily to ensure they remain below 40 degrees Fahrenheit. 10 NYCRR 415.14(h)

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	335100	A. Building B. Wing	04/02/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48711 Based on observation, record review, and staff interviews conducted during the recertification survey from 3/26/2024 to 4/2/2024, the facility did not ensure infection control practices and procedures were maintained. This was evident for 1 (Unit 10W) of 18 resident units during medication pass and during infection control review. Specifically, 1) infection control policies were not reviewed annually, and 2) License Practical Nurse #4 did not sanitize a blood pressure cuff in between resident use or perform hand hygiene during medication administration. The findings are: 1) The facility policy titled Operating Procedures - Infection Control was dated 12/2022, Influenza Vaccination Requirements - Health Care Workers was dated 4/12/2017, Mandatory COVID-19 Vaccination Program was dated 12/14/2021, and Antibiotic Stewardship Program was dated 09/2022. There was no documented evidence the policies related to infection control were reviewed and revised annually. On 04/02/2024 at 01:45 PM, the Director of Nursing was interviewed and stated the Infection Control Preventionist was not available for interview. Infection control policies were supposed to be updated annually and the Nursing department was not responsible for reviewing and updating the polices. 41709 2) The facility policy titled Equipment - Cleaning/Disinfection of Instruments/Equipment dated 5/2023 documented equipment used for more than one resident is cleaned and disinfected after use and prior to use on another resident according to manufacturer guidelines. The facility policy titled Hand Hygiene dated 1/2024 documented hands must be washed before and after contacts with residents and when handling contaminated equipment and supplies. On 03/27/2024 at 09:39 AM, Licensed Practical Nurse #4 was observed on Unit 10W applying a blood pressure cuff to Resident #785's arm without sanitizing the blood pressure cuff prior to application. Licensed Practical Nurse #4 did not sanitize the blood pressure cuff, entered Resident #339's room, and placed the blood pressure cuff on Resident #339's right arm. Licensed Practical Nurse #4 did not sanitize the blood pressure cuff and placed the blood pressure cuff of Resident #308's arm. On 03/27/24 at 09:53 AM, Licensed Practical Nurse was observed on Unit 10W at the medication cart and touched the medication cart, grabbed a pen to document a resident's vital signs, handled the computer mouse to check Physician Orders, grabbed keys to open the medication cart, did not perform hand hygiene and dispensed medication from blister packs, grabbed a bottle of cranberry juice to pour into a cup, entered Resident #785's room and administered medication to the resident without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/2024 at 10:42 AM, an interview was conducted with Licensed Practical Nurse #4 who stated they should have sanitized the blood pressure cuff in between each resident use but forgot. Licensed Practical Nurse #4 stated they also should have performed hand hygiene when administering medications to residents and was unable to provide a reason they did not perform hand hygiene before administering medications to Resident #785. On 03/27/2024 at 10:43 AM, an interview was conducted with Registered Nurse #7 who stated blood pressure cuffs were sanitized in between each resident use to promote infection control. Sanitizing wipes were available on the units for nurses to wipe down the cuffs before and after resident use. Registered Nurse #7 monitored the Licensed Practical Nurses by performing rounds on the units to ensure they follow infection control practices and reminded nurses during morning report to adhere to infection control policies. Registered Nurse #7 was unable to explain Licensed Practical Nurse #4's failure to sanitize blood pressure cuffs in between each use and perform hand hygiene when administering medications. On 03/29/2024 at 03:42 PM, an interview was conducted with the Infection Control Preventionist who stated all staff were provided with ongoing education regarding appropriate infection control practice. Competency evaluations were also performed to ensure staff were knowledgeable and practicing infection control. The Infection Control Preventionist stated sanitizing wipes, hand sanitizers, and soap were readily available on all units to ensure staff performed hand hygiene and sanitized equipment in between each resident use. The Infection Control Preventionist performed rounds on the units and has not observed any infection control breaches. NYCRR 415.19(b)(4)