STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER: Ross Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 839 Suffolk Avenue Brentwood, NY 11717	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observation, record review, and interviews during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure that all residents had the right to request, refuse, and/or discontinue treatment, and to formulate an advance directive (medical interventions in the event of a life-threatening episode) that would be honored and the written description of the facility policy to implement advance directives were followed. This was identified for one (Resident #18) of two residents reviewed for advance directives. Specifically, Specifically, the facility did not ensure that Resident #18's advance directives (their preferred code status in the event of cardiac or pulmonary arrest) were accurately identified per their wishes. The finding is: The facility's policy titled Identification of Residents with Advanced Directive dated [DATE], documented the staff should identify the resident's advanced directives status by utilizing the electronic medical record and residents' hard (paper) chart. Medical Orders for Life-Sustaining Treatment (MOLST) is a medical order form that tells others the resident's wishes regarding life-sustaining treatment. It is designed to communicate the individual's wishes about a range of life-sustaining and resuscitative measures. Residents who are already in a facility who have their advanced directives changed by request of self or representative will have the updated information entered on the electronic medical record, physicians' orders, and form placed in the appropriate section of the hard chart. Medical Orders for Life-Sustaining Treatment (MOLST) healthcare workers such as social workers, nurses, medical doctors, nurse practitioners, and physician assistants will identify a resident who has an advanced directive by checking the emergency medical record for residents order that states advanced directive, checking the hard chart for the pink or white copy of Medical Orders for Life-Sustaining Treatment (MOLST) that identifies the resident or the Health Care Proxy's wishes for advance directive form placed in the appropriate section of the hard chart. Resident #18 was admitted to the facility with diagnoses including Lymphedema (swelling due to built-up of lymph fluid), Atrial Fibrillation, and Heart Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #18 had a Brief Interview for Mental Status of 12, which indicated the resident had moderately impaired cognition. A Comprehensive Care Plan titled Advanced Directives dated [DATE] documented both the Do Not Resuscitate and the Cardiopulmonary Resuscitation (CPR) as Resident#18's advanced directives. (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: 335159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ross Center for Nursing and Rehabilitation	839 Suffolk Avenue Brentwood, NY 11717

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order for advance directive dated [DATE] documented Full Code (Cardiopulmonary Resuscitation). A Medical Orders for Life-Sustaining Treatment (MOLST) form dated [DATE] documented Full Code (Cardiopulmonary Resuscitation). Resident#18 was observed on [DATE] at 1:37 PM in their room sitting in a wheelchair. The resident was not wearing an identification band. There were two identification bands attached to the left side of Resident #18's wheelchair. One of the Identification Bands had a red dot and the second Identification band had no dots. During an interview on [DATE] at 1:37 PM, Resident #18 stated they did not like to wear an identification band and that is why there were identification bands on their wheelchair and walker. Resident #18 stated they wished for Do Not Resuscitate and then changed their wishes in [DATE] and wanted to be resuscitated if their heart stopped. During an interview on [DATE] at 2:00 PM, Licensed Practical Nurse #4 confirmed Resident #18 was not wearing an identification band and had two different identification bands attached to Resident #18's wheelchair. Licensed Practical Nurse #4 stated the resident refuses to wear their Identification band. Licensed Practical Nurse #4 stated the red dot on the identification band indicated that Resident#18 wished for Do Not Resuscitate. Licensed Practical Nurse #4 stated they check for Resident#18's identification band every shift and sign for it on the Medication Administration Record to indicate the presence of the identification band. Licensed Practical Nurse #4 stated they did not realize the resident had two different identification bands attached to the wheelchair. During an interview on [DATE] at 3:40 PM, Social Worker #2 stated when a resident's advance directive status is changed they are responsible for ensuring correctly identified advance directive status is reflected on the resident's identification band. For Do Not Resuscitate, the identifier is a red dot that is placed on the resident's identification band. When a resident rescinds their Do Not Resuscitate status, then the Identification band should be replaced and should not have a red dot. During an interview on ,d+[DATE]//2024 at 3:45 PM, the Director of Nursing Services stated it was not acceptable that Resident #18 had two identification bands on Resident #18's wheelchair. The Director of Nursing Services stated the facility does not use the red dots on the identification band to indicate the resident's advance directive status. They stated none of the facility policies include using the red dots as an identifier for the resident's advance directive status. The Director of Nursing Services stated if a nurse found a resident unresponsive they must confirm the resident's advanced directive status by checking the physician orders and the Medical Orders for Life-Sustaining Treatment (MOLST) form. 10 NYCRR 415.3 (e) (2)(iii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 17585 Based on observation, record review, and interviews during the Recertification Survey initiated on 10/29/2024 and completed on 11/1/2024, the facility did not ensure that each resident was provided with a comfortable and homelike environment. This was identified on one (East Unit) of three resident units during the environmental tour. Specifically, the hot water temperatures were not maintained within an acceptable range and were noted below the required range of 90 degrees-110 degrees Fahrenheit in the resident areas. The finding is: 42 CFR 483.470 (d)(3) PART 483-REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES 483.470 Condition of Participation: Physical environment. (d) Standard: Client bathrooms. The facility must ensure: (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 Fahrenheit. New York State Rules and Regulations, Article 2 Medical Facility Construction, Part 713- Standards of Construction for Nursing home facilities, Section 713-1.9- Mechanical requirements, (m) Domestic hot water systems shall provide adequate hot water at each outlet at all times. Hot water temperature at fixtures used by residents shall not exceed 110 degrees Fahrenheit. The facility's Policy and Procedure for Hot Water dated 7/2013 documented that each resident's sink/faucet is tested for a proper temperature of 90-113 degrees Fahrenheit. Each faucet is checked on a daily basis during the Maintenance Department's preventive maintenance room checks. This includes testing of hot water, with the range noted above. If the temperature is not within the correct range, the Maintenance Department staff immediately adjusts the temperature to be within the appropriate range. During the initial tour of the facility on 10/29/2024 between 10:00 AM to 11:00 AM, on the East unit, Residents # 102 and Resident # 39 complained the water in their rooms and showers were cold the last few weeks. This has been brought to the Maintenance Department's attention and nothing has been done. Resident # 102 stated they had to take showers on another unit because the shower in their room did not have hot water. The hot water was felt by touch and found to be cool. On 10/30/2024 at 12:52 PM, the hot water temperature for the sink was tested in Resident # 102's and Resident #39's rooms. The Director of Environmental Services was present during the observations. The sink water temperature in Resident # 102's and Resident #39's rooms was found to be cool to the touch. The water temperature was measured at 79 degrees Fahrenheit. The hot water in both resident room sinks was running for at least four minutes before the temperature reading was obtained. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 12:52 PM, the Director of Environmental Services stated hot water temperatures are checked daily and a water temperature log is maintained on each unit. The Director of Environmental Services stated they were not aware of any hot water temperature issues, if they were made aware of any temp below 90 degrees Fahrenheit, they would have adjusted the boiler temperature. During an observation on 10/30/2024 at 3:00 PM, the hot water temperature for the East unit shower room was measured. The water temperature was 81 degrees Fahrenheit. The hot water in the shower room was running for at least four minutes before the temperature reading was obtained. During an interview on 10/31/2024 at 3:28 PM, Certified Nurse Assistants #1 and # 2 who were assigned to the East unit were interviewed and stated before showering a resident, they have to run the water for more than 1 hour for the water to get warm and still, the water temperature is not hot enough. Both Certified Nurse Assistants #1 and # 2 stated that the maintenance department was aware of the water temperature issues. Maintenance Personnel #1 was interviewed on 10/30/2024 at 03:11 PM and stated they monitor hot water temperatures daily on each unit by checking the water temperature of each shower room and two resident rooms. Maintenance Personnel #1 tested the hot water this morning and all temperatures were just barely above 90 degrees Fahrenheit in the East unit shower rooms. Maintenance Personnel #1 stated they were not made aware of any cold water temperature issues and there was no request to adjust the water temperatures. The Administrator was interviewed on 10/30/24 at 03:39 PM and stated they were aware of the problem with the mixing valve since 10/15/2024. We were sending residents who required showers to other units because of the problems with the hot water on the east unit showers. The Administrator further stated they were trying to get the mixing valve sooner; however, the supply company did not have the part available for the last 2-3 weeks. 10 NYCRR 415.5 (h)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on record review and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/1/2024, the facility did not ensure the Minimum Data Set assessment was completed to accurately reflect each resident's status. This was identified for one (Resident #27) of two residents reviewed for Advanced Directives. Specifically, the Quarterly Minimum Data Set assessment dated [DATE] did not reflect Resident #27 had an advanced directive of Do Not Hospitalize. The finding is: The facility's policy titled Comprehensive MDS Policy last revised on 9/2024 documented the Minimum Data Set provides an assessment that is comprehensive, accurate, standardized, and reproducible for each resident's functional capabilities. Therapeutic Recreation, Social Services, Nutrition, and Minimum Data Set assessment staff are responsible for their specific area on the Minimum Data Set assessment. Each discipline that completes a section of the Minimum Data Set assessment signs, and dates the Minimum Data Set assessment for sections completed. Resident #27 was admitted with diagnoses including Metabolic Encephalopathy (a type of brain disorder), Moderate Protein-Calorie Malnutrition, and Type 2 Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] did not include a Brief Interview for Mental Status because the resident was rarely or never understood and had severely impaired skills for daily decision-making. The Minimum Data Set assessment Section S documented the resident had advanced directives including Do Not Resuscitate, Do Not Intubate, and feeding restrictions. The Minimum Data Set did not document the resident had an advanced directive of Do Not Hospitalize. A Comprehensive Care Plan titled Advanced Directives effective 1/22/2019 and last revised on 4/24/2024 documented Resident #27's advanced directives included the following: Do Not Resuscitate, Do Not Intubate, and limited medical interventions. The comprehensive care plan documented an advanced directive to send the resident to the hospital. A Physician's Order effective 8/15/2024 and renewed 10/9/2024 documented an advanced directive of Do Not Hospitalize. A Medical Orders for Life-Sustaining Treatment (MOLST) form for Resident #27 dated 8/15/2024 documented do not send the resident to the hospital unless pain or symptoms cannot be otherwise controlled. During an interview on 10/31/2024 at 12:45 PM, the Minimum Data Set Coordinator stated the staff who completes and signs for sections in the Minimum Data Set assessment are responsible for assuring accuracy for the designated section. The Minimum Data Set Coordinator stated they sign the Minimum Data Set assessment once it is entirely completed. They stated the Quarterly Minimum Data Set for Resident #27 did not accurately reflect the resident's advanced directive status and should have indicated the resident had an advanced directive of Do Not Hospitalize. The Minimum Data Set Coordinator further stated the social workers were responsible for ensuring the accuracy of advanced directives on the Minimum Data Set assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 1:12 PM, Social Worker #1 stated they were responsible for completing and ensuring the accuracy of the advanced directives for Resident #27 on the Quarterly Minimum Data Set assessment dated [DATE]. Social Worker #1 stated the Minimum Data Set assessment should have reflected that Resident #27 had an advanced directive of Do Not Hospitalize and this was an oversight. During an interview on 11/1/2024 at 3:45 PM, the Director of Nursing Services stated the social workers were responsible for ensuring the accuracy of advanced directives on the Minimum Data Set assessment for each resident. The Quarterly Minimum Data Set assessment dated [DATE] should have accurately reflected Resident #27's advanced directives in accordance with Resident #27's Medical Orders for Life-Sustaining Treatment (MOLST) form and the Physician's Orders for advanced directives. 10 NYCRR 415.11(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on interviews and record review during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for each resident. This was identified for two (Resident #27 and Resident #18) of two residents reviewed for Advanced Directives. Specifically, 1) on [DATE], Resident#18 advanced directive wishes changed from Do Not Resuscitate to Cardiopulmonary Resuscitation. The comprehensive care plan was not updated to accurately reflect changes in the resident's advance directives until [DATE]. 2) Resident #27's comprehensive care plan was not updated to accurately reflect the resident's advance directives for Do Not Hospitalize as per the physician's orders and the resident's wishes. The findings are : The facility's policy titled Comprehensive Care Plan last revised on ,d+[DATE] documented the comprehensive Care Plan will be reviewed and revised on a quarterly basis, with a significant change in condition, annual basis, on re-admission from an inpatient hospital stay, and as requested by the resident/representatives. The care plan shall be periodically reviewed and revised by a team of qualified persons after each assessment. The facility's policy titled Advanced Directives-MOLST, POLST last revised on ,d+[DATE] documented that residents will have their advanced directives honored and these will be reviewed during admission and throughout their stay. When a resident is initiating or revising a Medical Orders for Life-Sustaining Treatment (MOLST) form or Physician Orders for Life-Sustaining Treatment form while residing at the facility, the Medical Orders for Life-Sustaining Treatment (MOLST) form or Physician Orders for Life-Sustaining Treatment form will be executed as part of the care planning process and advanced care planning conversations. If the resident decides to revoke a Medical Orders for Life-Sustaining Treatment (MOLST) form or Physician Orders for Life-Sustaining Treatment form, the resident's clinician will be notified and changes to the medical orders will be obtained as soon as possible to ensure that the resident's wishes are accurately reflected in the plan of care. 1) Resident #18 was admitted to the facility with diagnoses including Lymphedema (swelling due to built-up of lymph fluid), Atrial Fibrillation, and Heart Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #18 had a Brief Interview for Mental Status of 12, which indicated the resident had moderately impaired cognition. A Comprehensive Care Plan titled Advanced Directives dated [DATE] documented both the Do Not Resuscitate and the Cardiopulmonary Resuscitation (CPR) as Resident#18's advanced directives. The physician's order for advance directive dated [DATE] documented Full Code (Cardiopulmonary Resuscitation). A Medical Orders for Life-Sustaining Treatment (MOLST) form for Resident #18 dated [DATE] Full Code(Cardiopulmonary Resuscitation). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:00 PM, Registered Nurse Manager #2 stated the social workers were responsible for the advanced directive care plans. Registered Nurse Manager #2 stated they do not update the care plans for advanced directives. During an interview on [DATE] at 1:15 PM, Social Worker#1 stated the Social Work Department is responsible for the advanced directive care plans. Social Worker#1 stated Resident#18 changed their advance directive wishes on [DATE] from Do Not Resuscitate to a full code. Social Worker#1 stated they forgot to update the advanced directive care plan, and it was just a clerical error. During an interview on ,d+[DATE]//2024 at 3:45 PM, the Director of Nursing Services stated the comprehensive care plans should accurately reflect the resident's advance directive status and it is not acceptable that Resident#18's advanced directive care plan was not updated to accurately reflect the resident's wishes for a full code. 50423 2) Resident #27 was admitted with diagnoses including Metabolic Encephalopathy (a type of brain disorder), Moderate Protein-Calorie Malnutrition, and Type 2 Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] did not include a Brief Interview for Mental Status because the resident was rarely or never understood and had severely impaired skills for daily decision-making. The Minimum Data Set documented the resident had advanced directives including Do Not Resuscitate, Do Not Intubate, and feeding restrictions. A Comprehensive Care Plan titled Advanced Directives, effective [DATE] and last revised on [DATE] documented advanced directives including to send the resident to the hospital. A physician's order effective [DATE] and renewed on [DATE] documented an advanced directive of Do Not Hospitalize. A Medical Orders for Life-Sustaining Treatment (MOLST) form dated [DATE] included do not send the resident to the hospital unless pain or symptoms cannot be otherwise controlled. The comprehensive care plan for the Advance Directive was not updated to reflect the new advance directive order for Do Not Hospitalize. During an interview on [DATE] at 10:48 AM, Social Worker #1 stated they were responsible for initiating and updating the comprehensive care plan for advanced directives. Social Worker #1 stated they did not know why the advance directive comprehensive care plan did not reflect Resident #27's wish and the physician's order for Do Not Hospitalize. During an interview on [DATE] at 3:45 PM, the Director of Nursing Services stated the comprehensive care plan for advanced directives should be updated as soon as there are any changes in advanced directives for each resident. The Director of Nursing Services stated the comprehensive care plan for Resident #27 should have been updated to reflect the resident's wish and the physician's orders for advanced directives. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44925 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/01/2024, the facility did not ensure medications were properly stored in medication carts. This was identified for one (Unit North Medication Cart 1), of 2 units reviewed during the Medication Storage Task. Specifically, Unit North Medication Cart#1 was utilized for storing items other than the resident medications such as the hearing aids, dirty measuring tape, three rolls of surgical tape, seven hearing aid batteries, and a small box of loose rubber bands. The findings are: The Medication Storage policy dated 4/2019 documented that Medications will be stored in a manner that maintains product integrity; ensures residents' safety; and complies with the New York State Department of Health guidelines. The policy documented that with the exception of emergency drug kits, all medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, as defined by facility policy. The Medication Carts policy dated 12/2023 documented that items other than the medications that may be utilized and needed during medication administration will be stored separately in the cart away from the medications. North Unit Medication Cart #1 was observed on 10/30/2024 at 7:14 AM, in the presence of Unit Registered Nurse Manager#1. The top drawer of the medication cart had a tape measure with dried brown stains folded and secured with a rubber band, seven hearing aids batteries, three rolls of paper treatment tape, small boxes of used, loose rubber bands, and a scanning thermometer stored along with the eye drops and over the counter medications. During an interview on 10/30/2024 at 7:14 AM, Registered Nurse Manager #1 stated the items that were observed in the medication cart had to stay in the medication cart in the top drawer because these items are related to medical needs. Registered Nurse Manager #1 stated they use the thermometer to monitor the residents' temperatures, therefore the thermometer needed to stay in the first drawer of the medication cart. During an interview on 10/30/2024 at 7:19 AM, Licensed Practical Nurse #2 stated the observed items have to stay in the medication cart since they were all health-related items. During an interview on 11/1/2024 at 3:41 PM, the Director of Nursing Services stated that medical tape, hearing aids, rubber bands, and thermometers should not be stored in the medication cart. The medication carts should include only medications and items related to the medication administration. 10 NYCRR 415.18(e)(1-4)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on observations, interviews, and record review during the Recertification Survey initiated on 10/28/2024 and completed on 11/1/2024, the facility did not ensure each resident was served food and drink that was palatable, attractive, and at a safe and appetizing temperature. This was identified for ten (Resident #9, Resident #10, Resident # 14, Resident # 39, Resident #50, Resident #72, Resident #77, Resident #91, Resident #94, and Resident #103) of eleven residents during the Resident Council meeting; one (Resident #102) of four residents reviewed for food, and one (Resident #48) of sixteen residents reviewed during the dining task. Specifically, during the resident council meeting held on 10/28/2024 ten of eleven residents in attendance complained the hot meals were served cold. On 10/30/2024 during the lunch meal service observations, the lunch meal temperatures for the hot food items were observed to be below 135 degrees Fahrenheit. The finding is: The undated facility policy titled Food Temperatures documented temperatures of all food items will be taken and properly recorded prior to service each meal. All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Hot food items may not fall below 135 degrees Fahrenheit after cooking unless it is an item that is to be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit prior to serving. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures such as hot or cold carts, pellet systems, insulated plate bases, domes, etc. Food sent to the units for distribution will be transported and delivered to the unit storage areas to maintain temperatures at or above 135 degrees Fahrenheit for hot foods. Resident #102 was admitted with diagnoses that included status post left hip Periprosthetic Fracture (around the internal prosthetic). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #48 was admitted with diagnoses including a Left Clavicle (the collar bone) Fracture, Type 2 Diabetes Mellitus, and Protein-Calorie Malnutrition. The Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact. The Resident Council meeting was conducted on 10/28/2024 at 11:15 AM. Ten of eleven residents during the group interview complained that they were served cold food during meals that should have been served hot. A review of the Resident Council minutes from 4/2024 to 10/2024 revealed during the Resident Council meeting on 5/2024 there was a concern with meal trucks arriving on the units and the staff not handing out meal trays. No concerns were documented in the Resident Council minutes regarding hot foods that were served cold during meals. During an interview on 10/28/2024 at 11:31 AM, Resident #48 stated the hot foods were served cold and that the food was lousy. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/28/2024 at 11:05 AM, Resident #102 stated they received cold food that should have been served hot during meals. On 10/30/2024 during the lunch meal service, three test trays were requested for three of three units in the facility (Unit North, Unit East, and Unit West): The last unit meal truck of two meal trucks for Unit [NAME] arrived on the unit at 12:20 PM. The last meal tray was observed to be served at 12:30 PM. The test tray temperatures were taken at 12:20 PM in the presence of the Dietician. The temperature readings for both the vegetables and noodles were 122 degrees Fahrenheit. The last lunch meal truck of two meal trucks for Unit East arrived on the unit at 12:29 PM. The last meal tray was served at 12:44 PM. The test tray temperatures were taken at 12:44 PM in the presence of Licensed Practical Nurse #3. The temperature readings for both the noodles and the carrots were 113 degrees Fahrenheit, and the temperature reading for the Chicken meal was 128 degrees Fahrenheit. The lunch meal truck for Unit North arrived on the unit at 12:35 PM. The last meal tray was served at 12:41 PM. The test tray food temperatures were taken at 12:41 PM in the presence of the Dietician. The temperature reading for carrots was 115 degrees Fahrenheit, and the temperature reading for the noodles was 95 degrees Fahrenheit. During an interview on 11/1/2024 at 9:28 AM, the Ombudsman stated the residents had complained about cold food for about two or three months during the Resident Council meetings and they spoke with the Director of Recreation to determine if there was a plan to address the residents' concerns. The Ombudsman stated the Director of Recreation told them they (the Director of Recreation) would speak with the Director of Nursing Services regarding the concerns. The Ombudsman did not realize the residents' concerns regarding the food temperatures were not included in the Resident Council minutes because they did not request or receive a copy of the Resident Council minutes. During an interview on 11/1/2024 at 3:55 PM, the Food Service Director stated they knew the Resident Council's concerns about hot meals being served cold. The Food Service Director stated they monitor the hot food temperatures on the tray line in the kitchen for every meal; however, the food temperatures were not monitored on the units during meals. The meal temperature concern was discussed during the morning meetings with the administrative staff (Department Heads). The Food Service Director stated they brought up helpful solutions during these morning meetings such as closed, insulated food trucks and a pellet system but nothing was done. The Food Service Director stated they could not recall the last time Quality Assurance was completed regarding food temperatures. During an interview on 11/1/2024 at 4:04 PM, the Director of Recreation stated they attended Resident Council meetings and were responsible for recording the meeting minutes. The cold food concern was discussed during the Resident Council meetings for the past three months. The Director of Recreation stated this concern should have been documented in the Resident Council minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Ross Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 839 Suffolk Avenue Brentwood, NY 11717	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/1/2024 at 4:14 PM, the Dietician stated they were aware of the residents' concern regarding receiving hot food at cold temperatures during meal services. The Dietician stated they recommended distributing meal trays before distributing coffee to shorten the distribution time. The Dietician stated they also recommended utilizing methods such as insulated food trucks or a pellet system as these would be helpful to maintain hot food temperatures of at least 135 degrees Fahrenheit; however, these recommendations were never implemented. During an interview on 11/1/2024 at 4:19 PM, the Director of Nursing Services stated they were aware of the Resident Council members' concerns related to hot food items being served cold. This concern was also discussed during morning meetings. The Director of Nursing Services stated they completed multiple observations of the nursing staff during breakfast and lunch meals on different units and they did not identify concerns regarding the length of time the staff distributes meal trays on the units. 415.14(d)(1)(2)

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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. 17732 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/1/2024, the facility did not follow proper sanitation practices to prevent the outbreak of foodborne illness and did not distribute and serve food in accordance with professional standards for food service safety. This was identified during the kitchen facility task; for ten (Resident #9, Resident #10, Resident # 14, Resident # 39, Resident #50, Resident #72, Resident #77, Resident #91, Resident #94, and Resident #103) of eleven residents during the Resident Council meeting; for one (Resident #102) of four residents reviewed for food, and for one (Resident #48) of sixteen residents reviewed during the dining task. Specifically, 1) The cold water dishmachine used for dishwashing did not hold the proper temperature of 140 degrees Fahrenheit as recommended by the manufacturer. 2) during the resident council meeting held on 10/28/2024 ten of eleven residents in attendance complained about the meal temperature and were served cold food that should have been served hot. On 10/30/2024 during the lunch meal service, three (Unit North, Unit East, Unit West) of three units meals temperatures for the hot food items were below 135 degrees Fahrenheit. The findings are: 1) The facility's undated policy titled Dishwashing Procedures documented that all dishes, utensils, and trays are to be washed and sanitized appropriately. Procedures include but are not limited to: Running a test tray through the machine; and checking the wash and the rinse temperature gauges. The wash temperature-120 degrees Fahrenheit or above and the rinse temperature-140 degrees Fahrenheit or above. If the temperature [reading] is not appropriate, notify the Food Service Director and/or Maintenance. When the [dishwashing] machine is not working appropriately, disposables will be used. Under the General Operating Instructions for the dishmachine, the policy documented that the water temperature should be 140 degrees Fahrenheit and to report to the Supervisor if the temperature is lower or higher than 140 degrees Fahrenheit. The facility's undated policy titled Dish Machine Log documented that the water temperature of the dishmachine should be at 120 degrees Fahrenheit. Check the temperature at each meal and record on the log sheet. Report any discrepancies to the Food Service Director immediately. The dishmachine was observed being operated by Dietary Aide #1 on 10/29/2024 at 10:20 AM, in the presence of the Food Service Director. The temperature gauge on the dishmachine read 110 degrees Fahrenheit for the Wash and 110 degrees Fahrenheit for the Rinse cycle. During an interview on 10/29/2024 at 10:20 AM, the Food Service Director stated the dishmachine used by the facility was a low-temperature dishmachine. The chemical sanitizer is used each time the dishmachine is run. With the chemical sanitizer, the low-temperature machine's Wash and Rinse temperature had to be 120 degrees Fahrenheit to sanitize effectively. During an interview on 10/29/2024 at 10:20 AM, Dietary Aide #1 stated they were using the dishmachine to wash the dishes from the facility's Breakfast meal. Dietary Aide #1 stated when they started the dishmachine that morning, the temperature gauge was at 120 degrees Fahrenheit for Wash and Rinse cycle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dishmachine Temperature Log sheet for October 2024 was reviewed on 10/29/2024 at 10:30 AM. For the entire month of October, the breakfast, lunch, and dinner, the dishmachine temperature readings were 120 degrees Fahrenheit including the temperature reading for the Breakfast meal on 10/29/2024. The dishmachine was observed being operated by Dietary Aide #1 on 10/29/2024 at 10:50 AM, in the presence of the Food Service Director. The temperature gauge on the dishmachine read 95 degrees Fahrenheit for the Wash and 95 degrees Fahrenheit for the Rinse cycle. During an interview on 10/30/2024 at 12:25 PM, the Director of Environmental Services stated they were aware that sometimes the water supplied to the dishmachine runs at a low temperature and the hot water mixing valve had to be adjusted. During an additional interview on 10/30/2024 at 12:35 PM, the Food Service Director stated they would periodically check the temperature of the dishmachine themselves. The Food Service Director stated that when the temperature of the dishmachine did not reach the desired temperature, the residents would be served their meals on disposable plates, cups, and utensils or all plates, cups, and utensils would be washed by hand in the three-compartment sink. During an interview on 10/30/2024 at 3:35 PM, the President of the vendor company that supplied the sanitizing solution for the dishmachine stated the Wash temperature of the dishmachine should be at 120 degrees Fahrenheit and the Rinse temperature at 140 degrees Fahrenheit for the chemical to effectively sanitize the dishes. During an interview on 11/1/2024 at 3:40 PM, the Administrator stated they knew there were temperature issues with the dishmachine but for the most part, the temperature of the dishmachine was hitting 120 degrees Fahrenheit. The Administrator stated that the facility had used disposable plates, cups, and utensils when the the dishmachine water temperature was too low. 17585 2) The undated facility policy titled Food Temperatures documented temperatures of all food items will be taken and properly recorded prior to service each meal. All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures such as hot or cold carts, pellet systems, insulated plate bases, domes, etc. Food sent to the units for distribution will be transported and delivered to the unit storage areas to maintain temperatures at or above 135 degrees Fahrenheit for hot foods. The Resident Council meeting was conducted on 10/28/2024 at 11:15 AM. Ten of eleven residents during the group interview complained that they were served cold food during meals that should have been served hot. During an interview on 10/28/2024 at 11:31 AM, Resident #48 stated the hot foods were served cold and that the food was lousy. During an interview on 10/28/2024 at 11:05 AM, Resident #102 stated they received cold food that should have been served hot during meals. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/2024 during the lunch meal service, three test trays were requested for three of three units in the facility (Unit North, Unit East, and Unit West): The last unit meal truck of two meal trucks for Unit [NAME] arrived on the unit at 12:20 PM. The last meal tray was observed to be served at 12:30 PM. The test tray temperatures were taken at 12:20 PM in the presence of the Dietician. The temperature readings for both the vegetables and noodles were 122 degrees Fahrenheit. The last lunch meal truck of two meal trucks for Unit East arrived on the unit at 12:29 PM. The last meal tray was served at 12:44 PM. The test tray temperatures were taken at 12:44 PM in the presence of Licensed Practical Nurse #3. The temperature readings for both the noodles and the carrots were 113 degrees Fahrenheit, and the temperature reading for the Chicken meal was 128 degrees Fahrenheit. The lunch meal truck for Unit North arrived on the unit at 12:35 PM. The last meal tray was served at 12:41 PM. The test tray food temperatures were taken at 12:41 PM in the presence of the Dietician. The temperature reading for carrots was 115 degrees Fahrenheit, and the temperature reading for the noodles was 95 degrees Fahrenheit. During an interview on 11/1/2024 at 3:55 PM, the Food Service Director stated they knew the Resident Council's concerns about hot meals being served cold. The Food Service Director stated they monitor the hot food temperatures on the tray line in the kitchen for every meal; however, the food temperatures were not monitored on the units during meals. The meal temperature concern was discussed during the morning meetings with the administrative staff (Department Heads). The Food Service Director stated they brought up helpful solutions during these morning meetings such as closed, insulated food trucks and a pellet system but nothing was done. The Food Service Director stated they could not recall the last time Quality Assurance was completed regarding food temperatures. During an interview on 11/1/2024 at 4:14 PM, the Dietician stated they were aware of the residents' concern regarding receiving hot food at cold temperatures during meal services. The Dietician stated they recommended distributing meal trays before distributing coffee to shorten the distribution time. The Dietician stated they also recommended utilizing methods such as insulated food trucks or a pellet system as these would be helpful to maintain hot food temperatures of at least 135 degrees Fahrenheit; however, these recommendations were never implemented. During an interview on 11/1/2024 at 4:19 PM, the Director of Nursing Services stated they were aware of the Resident Council members' concerns related to hot food items being served cold. The Director of Nursing Services stated they completed multiple observations of the nursing staff during breakfast and lunch meals on different units and they did not identify concerns regarding the length of time the staff distributes meal trays on the units. 10 NYCRR 415.14(h)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 17585 Based on record review and staff interviews, during the re-certification survey initiated on 10/29/2024 and completed on 11/1/2024, the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility was not effectively administered to ensure food served to the residents was at acceptable temperature parameters for three of the three resident units. Cross Reference F 804 Food and Nutrition Services F 812 Food and Nutrition Services The finding is: The undated facility policy titled Food Temperatures documented temperatures of all food items will be taken and properly recorded prior to service each meal. All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Hot food items may not fall below 135 degrees Fahrenheit after cooking unless it is an item that is to be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit prior to serving. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures such as hot or cold carts, pellet systems, insulated plate bases, domes, etc. Food sent to the units for distribution will be transported and delivered to the unit storage areas to maintain temperatures at or above 135 degrees Fahrenheit for hot foods. The Resident Council meeting was conducted on 10/28/2024 at 11:15 AM. Ten of eleven residents during the group interview complained that they were served cold food during meals that should have been served hot. A review of the Resident Council minutes from 4/2024 to 10/2024 revealed during the Resident Council meeting on 5/2024 there was a concern with meal trucks arriving on the units and the staff not handing out meal trays. No concerns were documented in the Resident Council minutes regarding hot foods that were served cold during meals. On 10/30/2024 during the lunch meal service, three test trays were requested for three of three units in the facility (Unit North, Unit East, and Unit West): The last unit meal truck of two meal trucks for Unit [NAME] arrived on the unit at 12:20 PM. The last meal tray was observed to be served at 12:30 PM. The test tray temperatures were taken at 12:20 PM in the presence of the Dietician. The temperature readings for both the vegetables and noodles were 122 degrees Fahrenheit. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The last lunch meal truck of two meal trucks for Unit East arrived on the unit at 12:29 PM. The last meal tray was served at 12:44 PM. The test tray temperatures were taken at 12:44 PM in the presence of Licensed Practical Nurse #3. The temperature readings for both the noodles and the carrots were 113 degrees Fahrenheit, and the temperature reading for the Chicken meal was 128 degrees Fahrenheit. The lunch meal truck for Unit North arrived on the unit at 12:35 PM. The last meal tray was served at 12:41 PM. The test tray food temperatures were taken at 12:41 PM in the presence of the Dietician. The temperature reading for carrots was 115 degrees Fahrenheit, and the temperature reading for the noodles was 95 degrees Fahrenheit. During an interview on 11/1/2024 at 9:28 AM, the Ombudsman stated the residents had complained about cold food for about two or three months during the Resident Council meetings and they spoke with the Director of Recreation to determine if there was a plan to address the residents' concerns. The Ombudsman stated the Director of Recreation told them they (the Director of Recreation) would speak with the Director of Nursing Services regarding the concerns. The Ombudsman did not realize the residents' concerns regarding the food temperatures were not included in the Resident Council minutes because they did not request or receive a copy of the Resident Council minutes. During an interview on 11/1/2024 at 3:55 PM, the Food Service Director stated they knew the Resident Council's concerns about hot meals being served cold. The Food Service Director stated they monitor the hot food temperatures on the tray line in the kitchen for every meal; however, the food temperatures were not monitored on the units during meals. The meal temperature concern was discussed during the morning meetings with the administrative staff. The Food Service Director stated they brought up helpful solutions during these morning meetings such as closed, insulated food trucks and a pellet system but nothing was done. The Food Service Director stated they could not recall the last time Quality Assurance was completed regarding food temperatures. During an interview on 11/1/2024 at 4:04 PM, the Director of Recreation stated they attended Resident Council meetings and were responsible for recording the meeting minutes. The cold food concern was discussed during the Resident Council meetings for the past three months. The Director of Recreation stated this concern should have been documented in the Resident Council minutes. An Interview was conducted on 11/1/2024 at 3:00 PM with the Administrator and they stated they were doing the best they could with serving residents food at an acceptable temperature. 10 NYCRR 415.26

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 17585 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/29/2024 and completed on 11/1/2024, the facility did not ensure the Quality Assurance Performance Improvement (QAPI) committee developed and implemented appropriate plans of action to correct identified issues with the facility's cold food concern identified on three of three units observed during the dining task. Specifically, multiple complaints were brought up during Resident Council meetings that hot meals were being served cold; however, the Quality Assurance Performance Improvement Committee did not address, review, analyze, and act on available data on the identified issue to make improvements and to ensure improvements are sustained. Cross Reference: F 804 Food and Nutrition Services F 812 Food and Nutrition Services The finding is: The facility's undated Quality Assurance Performance Improvement Plan documented that the purpose of the Quality Assurance Performance Improvement is to provide quality care and cost-effective services to meet the individual needs of the residents they serve, through innovation and continuous improvement in the delivery of care. The purpose of the Quality Assurance Performance Improvement (QAPI) is to evaluate resident experiences of the services provided to determine how the experience can be improved. Quality Assurance Performance Improvement includes all members of each service. Decisions are made based on the evaluation of all input from residents, families, healthcare practitioners, caregivers, and other stakeholders. A Review of the Quality Assurance and Performance Improvement (QAPI) meeting agenda for 8/21/2024 revealed no documented attempts to address, review, analyze, and act on complaints regarding the hot meals being served cold, to make improvements, and to ensure improvements are sustained. A review of the Resident Council Meeting Minutes dated 8/2024 to October 2024 revealed that the residents' complaints about cold food were not reflected in the minutes. During an interview on 11/1/2024 at 3:55 PM, the Food Service Director stated they were aware of the concerns of hot meals being served cold. The concerns were brought up during the Resident Council meetings within the past three months. The Food Service Director stated that the food temperatures were not monitored on the units during meals. The concern of cold food was discussed during the morning meetings with the administrative staff (Department Heads). The Food Service Director stated they could not recall the last time Quality Assurance was completed regarding food temperatures. During an interview on 11/1/2024 at 4:04 PM, the Director of Recreation stated they attended Resident Council meetings and were responsible for recording the meeting minutes. The cold food concern was discussed during the Resident Council meetings for the past three months. The Director of Recreation stated this concern should have been documented in the Resident Council minutes. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 11/01/2024 at 5:52 PM, the Director of Nursing Services stated they were part of the Quality Assurance and Improvement Program (QAPI) Committee, and attended the meetings on a quarterly. They were aware of the complaints related to the hot meals being served cold. These complaints were brought up during multiple Resident Council Meetings. The Director of Nursing Services stated food temperature complaints were not discussed in the Quality Assurance and Process Improvement Committee meetings because the issue was addressed in morning reports. 10 NYCRR 483.75 (a)(2)(h)(i)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observations, record review, and interviews conducted during the Recertification Survey initiated on 10/29/2024 and completed on 11/1/2024, the facility did not ensure all portions of the resident call system were functioning to allow each resident to call for staff assistance. This was identified for one (Unit East) of three resident units. Specifically on 10/22/2024, Resident # 102 was placed by staff on the toilet and was instructed to use the call bell to call for assistance when they were ready. The resident tried to use the call bell for staff assistance; however, the call bell was not functioning. Subsequently, the resident attempted to transfer from the toilet on their own, resulting in a fall with injury. The findings are: The facility's policy and procedure for Call Bells, revised in December 2022 documented the purpose is to provide residents with a method of communication to assist in meeting needs. The policy did not document a process to routinely ensure the residents' call bells were operational. Resident #102 was admitted with a diagnosis that included status post Periprosthetic Fracture (fracture around the internal prosthetic) of the Left Hip joint. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The resident exhibited no behaviors and was dependent on staff for transfer. The resident was occasionally incontinent of bowel and bladder. The Minimum Data Set also documented that the resident had a history of falls with injuries. The resident had impairment to one side of the lower extremities due to Functional Limitation in Range of Motion. The resident used a wheelchair for mobility. The Comprehensive Care Plan (CCP) for Falls dated 9/17/2024 documented the resident was at risk for falls with injury secondary to a fall in the last month prior to admission and fracture related to a fall in the last 6 months prior to admission. The interventions included educating the resident to use the call bell for assistance and having Physical Therapy reinforce education, placing the bed in the lowest position, and placing the call bell within easy reach at all times. The Accident/Incident report dated 10/21/2024 documented the resident was observed on the floor in their bathroom. The resident was transferred from the wheelchair to the toilet on 10/21/2024 at 7:15 AM by the Occupational Therapy Assistant. The resident was instructed to use the call bell to request assistance after they completed toileting. The resident stated they tried to clean themselves after bowel movement then resident stood up from the toilet lost their balance and fell . The call bell in the resident's bathroom was not working. A nursing progress note dated 10/22/2024 at 2:54 PM documented the resident was transferred to the Hospital for a probable fracture of the left wrist. During an interview on 10/31/2024 at 12:52 PM, the Director of Environmental Services stated the Call bells are not checked on a routine basis and there were no audits available for review. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 1:05 PM, Maintenance Personnel #1 stated the call bell in Resident #102's bathroom was not lighting up in the hallway nor was it lighting up at the nursing station. There was no audible call bell sound present. Only the light on the bathroom call bell box was working. They had to replace the call bell switch with a whole new box. During an interview on 10/31/2024 at 12:30 PM, Resident #102 stated the Occupational Therapy Assistant placed them on the toilet and told them to press the call bell after they completed toileting. The resident pressed the call bell and waited for more than 20 minutes. When they could no longer tolerate sitting on the toilet, they attempted to transfer themselves from the toilet and fell . Resident #102 stated they fractured their arm because of the fall. During an interview on 10/31/2024 at 1:23 PM, Licensed Practical Nurse #1 stated on 10/21/2024, Resident #102 fell while attempting to get up from the toilet. The resident used the call bell to call for staff assistance; however, they (Licensed Practical Nurse #1) did not see or hear the call bell. The call bell light or sound was not working in the hallway or at the nursing station. After the resident was assessed and removed from the bathroom floor, they notified the Maintenance Department to fix the call bell. During an interview on 10/31/2024 at 01:33 PM, the Director of Nursing Services stated on 10/21/2024, the call bell in Resident #102's bathroom was not functioning. The resident attempted to get up from the toilet and fell . The Director of Nursing Services stated the staff were not aware of the call bell malfunction before the resident's fall. 10 NYCRR 415.29