STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not conduct a comprehensive assessment of a resident not less than once every 12 months while a resident. This was identified for one (Resident #78) of one resident reviewed for the Resident Assessment Task. Specifically, Resident #1's Admission Minimum Data Set assessment was completed on 2/7/2024. The Annual Minimum Data Set (MDS) assessment was completed on 2/10/2025, which was 369 days from the previous comprehensive assessment. Additionally, the Assessment Reference Date for the Annual Minimum Data Set was 1/20/2025 and the assessment was not completed until 21 days after the Assessment Reference date. The finding is: The facility's policy and procedure titled Resident Assessment Instrument (MDS 3.0), last revised on 10/1/2023, documented that the Annual (Comprehensive Assessment) is completed within 366 days of the previous Comprehensive Assessment reference date and within 92 days of the previous Quarterly Assessment reference date. Resident #78 was admitted with diagnoses including Cellulitis (bacterial skin infection) of the Right Lower Limb, Hypertension, and Dysuria (painful or uncomfortable urination). The Annual Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #78 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident #78 had mild cognitive impairment. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented Section Z (Assessment Administration) was not completed until 2/20/2025, 21 days after the assessment reference date. During an interview on 2/25/2025 at 1:51 PM, the Minimum Data Set (MDS) Director stated that Resident #78's Annual Minimum Data Set assessment was just completed and submitted today (2/25/2025) at 1:39 PM. The Minimum Data Set Director stated that the Minimum Data Set should have been completed on 2/3/2025, which was 14 days after the assessment reference date. The Minimum Data Set Director stated they were on vacation at the time the assessment was due, and any Registered Nurse could have completed the Minimum Data Set assessment. During an interview on 2/27/2025 at 8:53 AM, the Director of Nursing Services stated the staff have five days to complete the assigned section of the Minimum Data Set. The Director of Nursing Services stated that the Minimum Data Set Coordinator should ensure that the Minimum Data Set assessment is completed timely. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/27/2025 at 12:19 PM, the Administrator stated all Minimum Data Set assessments should be completed on time. The Administrator stated that a backup Minimum Data Set (MDS) assessor should be in place to ensure the timely completion and transmission of the Minimum Data Set (MDS) assessment. 10 NYCRR 415.11(a)(3)(i)

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure that all completed Minimum Data Set (MDS) assessments were electronically transmitted to the Center for Medicare and Medicaid Services (CMS) within 14 days of the resident assessment completion. This was identified for one (Resident #78) of one resident reviewed for the Resident Assessment Task. Specifically, Resident #78's Annual Minimum Data Set (MDS) assessment was completed on 2/10/2025; however, the assessment was not electronically submitted to the Center for Medicare and Medicaid Services (CMS) until 2/25/2025, 15 days after the completion date. The finding is: The facility's policy and procedure titled Resident Assessment Instrument (MDS 3.0), last revised on 10/1/2023, documented that the Minimum Data Set (MDS) process requires input from the health care team to complete the designated areas in a timely and accurate fashion in accordance with State and Federal regulations. The Minimum Data Set (MDS) Coordinator is responsible for the electronic transmission process. The transmission will occur as dictated by the Resident Assessment Instrument Manual. Resident #78 was admitted with diagnoses including Cellulitis (bacterial skin infection) of the Right Lower Limb, Hypertension, and Dysuria (painful or uncomfortable urination). The Annual Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #78 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident #78 had mild cognitive impairment. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report provided by the facility revealed the following: Resident #78's Annual Minimum Data Set (MDS) assessment with the reference date of 1/20/2025 was completed on 2/10/2025; however, the assessment was not electronically submitted to the Center for Medicare and Medicaid Services (CMS) until 2/25/2025, 15 days after the completion date. During an interview on 2/25/2025 at 1:51 PM, the Minimum Data Set (MDS) Director stated Resident #78's Minimum Data Set assessment was transmitted today (2/25/2025) at 1:39 PM. The Minimum Data Set Director stated that the Minimum Data Set assessment should have been transmitted on 2/17/2025. The Minimum Data Set Director stated they were on vacation at the time the assessment was due for transmission and any Registered Nurse could have completed and transmitted the Minimum Data Set assessment. During an interview on 2/27/2025 at 8:53 AM, the Director of Nursing Services stated the staff have five days to complete the assigned section of the Minimum Data Set. The Director of Nursing Services stated that the Minimum Data Set Coordinator should transmit the completed Minimum Data Set assessment timely. (continued on next page)

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/27/2025 at 12:19 PM, the Administrator stated all Minimum Data Set assessments should be completed and transmitted to the Centers for Medicare and Medicaid Services on time. The Administrator stated that a backup Minimum Data Set (MDS) assessor should be in place to ensure the timeliness of the completion and transmission of the Minimum Data Set (MDS) assessment. 10 NYCRR 415.11(a)(3)(i)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey, initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for two (Resident #90 and Resident #237) of three residents reviewed for Pressure Ulcers. Specifically, 1) during a wound care observation of Resident #90's left buttock Stage 2 Pressure ulcer (wound with partial thickness loss of skin) on 2/26/2025, another stage Stage 2 Pressure Ulcer was observed on the right buttock. There was no documented evidence of an assessment or a Physician's order for treatment for the right buttock pressure ulcer. The wound care nurse administered treatment on Resident #90's right buttock wound without any Physician's Order 2) Resident #237 was assessed with a Stage 3 pressure ulcer to the sacrum. There was no documented evidence that Resident #237 was turned and positioned every two hours as required by the comprehensive care plan. Additionally, treatment recommendations made by the Wound Care team were not followed. The finding is: The facility's policy titled Pressure Ulcer Care, last revised on 9/27/2023, documented that Registered Nurses (RN) and Licensed Practical Nurses (LPN) are responsible for identifying the presence of and the risk for skin ulcers, document the presence of skin ulcer, initiate Comprehensive Care Plan (CCP), notify wound care nurse of skin risk and presence of ulcers and notify Physician of skin ulcer and obtain treatment orders. To identify residents at risk for the development of Pressure ulcers and to monitor the condition of the resident's skin, report any skin problem, and/or follow-up treatment. Physician Orders are obtained for wound care treatments. All wound care treatments are to specify the frequency of the treatment as well as the duration of the treatment period. Resident #90 was admitted with diagnoses including Hemiplegia (paralysis or weakness on one side of the body), left non-dominant side, Asthma, and Type 2 Diabetes. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #90 had moderately impaired cognition. The Quarterly Minimum Data Set (MDS) assessment documented that Resident #90 had an unhealed pressure ulcer, was at risk for developing pressure ulcers and used pressure-reducing devices for chair and bed. A review of the Comprehensive Care Plan (CCP) indicated the resident had multiple pressure ulcers including the left buttock, right heel, right medical foot, right distal foot, and sacrum. The interventions included applying treatment as ordered by the Physician, maintaining turning and positioning every 2 hours as recommended, and monitoring for pain. The Comprehensive Care Plan did not include the presence of a pressure ulcer on the right buttock. A Physician's order dated 2/19/2025 documented treatment orders for the left buttock, sacrum, right heel, and right foot wounds. There was no physician's order for a treatment of the right buttock wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order dated 2/19/2025 documented Medihoney (medication that supports the removal of damaged tissue and aids in wound healing). Apply to the left buttock wound after cleaning with normal saline, and cover with a dry protective dressing. A review of the Wound Care Consultation Note dated 2/19/2025 documented the resident had a left buttock unstageable pressure ulcer; Stage 3 sacral pressure ulcer; Stage 3 right heel pressure ulcer; and a Deep Tissue Injury (purple localized area of discolored intact skin or blood-filled blister) to the right foot with treatment recommendations. The note did not indicate a pressure ulcer to the right buttock area. During a wound care observation dated 2/26/2025 at 10:15 AM, Licensed Practical Nurse#2 removed the dressing on Resident #90's left buttock. Licensed Practical Nurse #2 cleansed the left buttock wound with normal saline and applied Medihoney (medication that supports the removal of damaged tissue and aids in wound healing) as per the Physician's order. Licensed Practical Nurse #2 covered the wound with a dry protective dressing. A dressing was observed on Resident #90's right buttock. Licensed Practical Nurse #2 took off the dressing and a Stage 2 pressure ulcer wound was observed on the right buttock. Licensed Practical Nurse #2 cleansed the right buttock wound with normal saline, applied Medihoney to the right buttock wound, and covered the wound with a dry protective dressing without a Physician's order. During an interview on 2/26/2025 at 10:59 AM, Licensed Practical Nurse #2 stated they got confused when they saw the dressing on Resident #90's right buttock. Licensed Practical Nurse #2 stated they recalled Resident #90 had a wound on the right buttock that had healed. Licensed Practical Nurse #2 stated they did not know that the resident had another pressure ulcer on the right buttock. Licensed Practical Nurse #2 stated they should have checked the Physician's Order before putting the treatment on Resident #90's right buttock. During an interview on 2/26/2025 at 1:45 AM, Registered Nurse #1, Unit Manager, stated the wound on Resident #90's right buttock had reopened on 2/25/2025. Registered Nurse #1 stated the Nurse from the day before (2/25/2025) just put a dry dressing on Resident #90's right buttock but forgot to document their findings and did not communicate with the Unit Supervisor. Registered Nurse #1 stated they became aware of the wound after the wound care observation on 2/26/2025. They started an investigation and found out that the Licensed Practical Nurse #3 from the day before knew about the wound but forgot to tell anyone. Registered Nurse #1 stated that Licensed Practical Nurse #2 should have checked the order first before doing the treatment on the right buttock. Registered Nurse #1 stated that if there were no treatment orders for the right buttock wound, then they (Licensed Practical Nurse #2) should have told the Unit Supervisor. During an interview on 2/27/2025 at 8:30 AM, the Wound Care Nurse stated they were not aware that Resident #90's right buttock wound had reopened. The Wound Care Nurse stated that any skin changes must be reported to the Unit Supervisor. The Wound Care Nurse stated that all wound care treatments need a Physician's Order. During an interview on 2/27/2025 at 9:00 AM, the Wound Care Physician stated they had received a notification from the Wound Care Nurse on 2/26/2027 at 11:51 AM regarding Resident #90's right buttock wound that reopened. The Wound Care Physician stated they had ordered to clean Resident #90's right buttock wound with normal saline and applied Medihoney (medication that supports the removal of damaged tissue and aids in wound healing). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 10:15 AM, Licensed Practical Nurse #3 stated they had worked as a Medication Nurse on 2/25/2025 and had gotten a report from a Certified Nursing Assistant (CNA) (could not recall who) that Resident #90's right buttock wound had reopened. Licensed Practical Nurse #3 stated that they had checked the wound and put a dry sterile dressing on the area. Licensed Practical Nurse #3 stated they forgot to document and report the wound to the Unit Supervisor. Licensed Practical Nurse #3 stated they should have documented Resident #90's reopened wound in the Progress Note, but they got busy with their medication pass. During an interview on 2/27/2025 at 10:45 AM, the Director of Nursing Services stated that Licensed Practical Nurse #2 should not have administered any treatment without a Physician's Order. The Director of Nursing Services stated the expectation is for the Nurses to be able to communicate any skin changes to their Unit Supervisor. The Director of Nursing Services stated that the Unit supervisor can call the Physician and get an order for any treatment needed by the resident. The Director of Nursing Services stated that they (The Director of Nursing Services) expect the Nurses to document any changes in the resident's skin condition. 34798 2) Resident #237 was admitted with diagnoses including Compression Fracture of First Lumbar Vertebra (Spine), Diabetes Mellitus, and Spinal Stenosis. The 1/22/2025 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented that the resident had one Stage 2 pressure ulcer present on admission, the resident was at risk for developing pressure ulcers, and the resident was dependent on staff members for bed mobility and turning. The Nursing Admission Assessment, dated 1/16/2025, documented a Braden Score (scale for determining pressure ulcer risk) of 17, indicating the resident was at mild risk for developing pressure ulcers. The assessment documented that the resident's skin was intact. The 1/17/2025 wound care nursing skin assessment documented the resident had a Stage 2 Pressure Ulcer on the Sacrum measuring 3 centimeters in length, 2 centimeters in width, and 0.1 centimeters in depth. The wound appeared red and had no drainage. A Physician's order dated 1/17/2025 documented Silvadene 1 % topical cream, cleansing sacral pressure ulcer with normal saline, applying Silvadene, and covering with dry protective dressing once a day. A Wound Physician visit note dated 1/22/2025 documented sacral Stage 2 present on admission, measuring 0.5 centimeters in length, 0.5 centimeters in width, and 0.1 centimeters in depth. The recommendation was to cleanse with normal saline, apply Silvadene twice a day, and turn and position. A review of the January 2025 Treatment Administration Record revealed that the Silvadene treatment was not changed to twice a day as recommended by the Wound Physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan titled Presence of Skin Breakdown-Sacrum, effective 1/16/2025, had no interventions or notes entered until 1/30/2025. Maintain Turning and Positioning every two hours as recommended was entered on 1/30/2025 by the Assistant Director of Nursing/Wound Care Nurse #1. In addition, the Assistant Director of Nursing/Wound Care Nurse #1 entered the treatment recommendation for Silvadene twice a day into the Care Plan but there was no corresponding Physician order. A Physician's order dated 1/29/2025 documented cleansing the sacral pressure ulcer with normal saline, apply Medihoney, and covering with a dry protective dressing twice a day for the Pressure Ulcer of the Sacral Region. A subsequent visit note by the Wound Physician dated 2/5/2025 documented sacral ulcer Stage 3, 1.5 centimeters in length, 1.2 centimeters in width, and 0.1 centimeters in depth. The wound had scant serous drainage, with 50% slough (dead tissue). Recommendations were to cleanse the wound with Normal Saline, apply Medihoney, cover with gauze, and secure with a bordered gauze; change daily, turn, and position every 2 hours. A review of the February 2025 Treatment Administration Record revealed that the Medihoney treatment was not changed from twice a day to daily treatment as per the Wound Physician's recommendation until 2/19/2025. A review of the Resident Nursing Instructions (care instructions for Certified Nursing Assistants) effective 1/16/2025 revealed an entry on 1/30/2025 by the Assistant Director of Nursing/Wound Care Nurse #1 to Turn and Position every two hours as recommended. Bed mobility, entered by the Registered Nurse Admission Nurse #3, documented bed mobility of partial/moderate assist entered on 1/16/2025 (admission). A review of the Certified Nursing Assistant Accountability Records for January and February 2025 revealed no documented evidence that the resident was turned and positioned every two hours. During an interview on 2/28/2025 at 8:55 AM, Certified Nursing Assistant #2 (7:00 AM-3:00 PM shift) stated the resident was not able to turn and position themselves and required assistance. Certified Nursing Assistant #2 stated they turned the resident to place the resident on a bedpan. During the day shift the resident did not stay in bed and was always out of bed. During an interview on 2/28/2025 at 9:07 AM, Rehabilitation Director #1 stated that initially, the resident was dependent on one person for bed mobility and turning and positioning, and with therapy, the resident's bed mobility status improved and the resident required supervision and touching assistance of one person for rolling. During an interview on 2/28/2025 at 10:00 AM, Certified Nursing Assistant #3 (11:00 PM-7:00 AM shift) stated the resident was very alert and would call staff by using the call bell when they needed something, for instance, water, pain medication, or ask to use the bedpan. Certified Nursing Assistant #3 stated they turned and positioned the resident maybe two times during the night. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025 at 10:09 AM, Certified Nursing Assistant #4 (3:00 PM-11:00 PM shift) stated the resident was alert. The resident usually went back to bed at 8:00 PM and requested to use the bedpan. Certified Nursing Assistant #4 stated they could not remember if there was a spot in the accountability to document turning and positioning. Being that the resident was alert, they would let me know if they were uncomfortable; the resident was just fine. During an interview on 2/28/2025 at 12:19 PM, Assistant Director of Nursing/Wound Care Nurse #1 stated they could not explain why the turning and positioning every two hours intervention was not in place in the Nursing Care Instructions since the resident's admission and why the turning and positioning intervention was first added on 1/30/2025. Assistant Director of Nursing/Wound Care Nurse #1 stated they did not know where the Certified Nursing Assistants would document the turning and positioning every two hours but said turning. During an interview on 2/28/2025 at 12:30 PM, Registered Nurse Admission Nurse #3 stated during the admission assessment the resident was able to turn and position themselves, therefore turning and positioning was not added to the resident's care profile. Registered Nurse Admission Nurse #3 stated the resident must have deteriorated which is why turning and positioning was added on 1/30/2025. During an interview on 2/28/2025 at 1:35 PM, the Director of Nursing Services stated if the admission nurse did an assessment and turning and positioning was not necessary, then that is why turning and positioning was not put in the care profile initially. It is the facility's general policy that turning and positioning is completed every two hours. The Director of Nursing Services stated stated they were not sure if that is in writing in a policy. 10 NYC RR 415.12(c)(1)(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** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure that each resident's environment remained free of accident hazards. This was identified for one (Resident #21) of four residents reviewed for Accidents. Specifically, an oxygen E-Cylinder tank (portable oxygen tank) was observed on the right side of Resident #21's bed. The E-Cylinder tank was not secured in a rolling safety stand or a metal rack. The finding is: The facility's policy, titled Oxygen Closet last revised on 9/2024, documented the facility would maintain an adequate supply of oxygen needed for the administration of oxygen. A minimum of two small E-Cylinder tanks will be maintained on each unit for emergency purposes. Oxygen tanks not secured on tank dollies or the E-tank rack, will be secured to the wall with chains. Resident #21 was admitted with diagnoses including Acute Renal Failure with Hypoxia (absence of enough oxygen in the tissues) and Chronic Obstructive Pulmonary Disease (COPD). The Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident #21 had moderate cognitive impairment. Resident #21 had shortness of breath when lying flat. A Physician's Order dated 1/16/2025 documented continuous oxygen therapy to Resident #21 at 2 liters per minute via nasal cannula. The order was discontinued on 1/29/2025. A Comprehensive Care Plan (CCP) titled Respiratory Disorder dated 9/5/2023 documented interventions including elevating the head of the bed at 45 degrees and administering oxygen therapy as per the Physician's Order. During an observation on 2/24/2025 at 10:59 AM, Resident #21 was sitting in their wheelchair receiving oxygen therapy from an oxygen concentrator at 2 liters per minute via nasal cannula. A free-standing E-Cylinder (portable tank) tank was on the side of Resident #21's bed. During an interview on 2/24/2025 at 10:59 AM, Certified Nursing Assistant #1, who was present in the resident's room during the observation, stated they did not notice the oxygen tank on the side of the bed during morning care. Certified Nursing Assistant #1 stated that they did not know who put the tank on the side of the bed. Certified Nursing Assistant #1 stated that the oxygen tank should be in an oxygen caddy or metal rack. During an interview on 2/24/2025 at 11:06 AM, Licensed Practical Nurse #1 stated Resident #21 did not have a Physician's Order for Oxygen treatment. Resident #21's oxygen order was discontinued on 1/29/2025. Licensed Practical Nurse #1 stated that they did not know who left the oxygen tank without the rolling cart in the resident's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/2025 at 1:46 PM, Registered Nurse #1, Unit Manager, stated Resident #21 did not have a Physician's Order for Oxygen treatment. Resident #21's oxygen order was discontinued on 1/29/2025. Registered Nurse #1 stated that the town had a power outage the day before (2/23/2025), and an oxygen tank must have been brought to Resident #21. Registered Nurse #1 stated that the oxygen tank should have been secured on a rolling cart or caddy. During an interview on 2/27/2025 at 9:00 AM, the Director of Nursing Services stated if a resident is having shortness of breath or an anxiety attack, the facility can start oxygen therapy at a maximum of 2 liters via nasal cannula. The Director of Nursing Services stated that the oxygen tank should have been on a rolling cart or a caddy due to the danger of the oxygen tank falling or exploding if left unsecured. 10 NYCRR 415.12(h)(1)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure that the staff implemented and provided care and services according to the resident's needs and professional standard of practice for each resident with a feeding tube. This was identified for one (Resident #27) of one resident reviewed for Tube Feeding, specifically, on 2/24/2025 at 11:30 AM and 1:00 PM. Resident #27 was observed receiving enteral tube feeding (a method of providing nutrition directly into the gastrointestinal (GI) tract through a tube); the enteral tube feeding bottle and the water bag was observed hanging on a feeding tube stand without a label including the resident's name and the time the tube feeding was started. The finding is: The facility's policy titled Tube Feedings: Gastrostomy Feedings, last revised on 11/12/2024, documented that Gastrostomy tube feedings will be administered by licensed nursing staff in accordance with written physician orders. To maximize each resident's quality of life, tube feedings will be provided during the evening and overnight hours. Resident #27 was admitted with diagnoses that included Multiple Sclerosis (a disease in which the immune system eats away the protective covering of nerves), Quadriplegia (loss of movement and sensation in all four limbs- arms and legs), and Chronic Obstructive Pulmonary Disorder (COPD). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #27 had a Brief Interview for Mental Status (BIMS) score of 0. Resident #27 was rarely and was never understood. Resident #27 had severe cognitive impairment. Resident #27 had a swallowing disorder, including holding food in their mouth and cheek. Resident #27 had a feeding tube (nasogastric or abdominal) and received an average fluid intake per day by intravenous or tube feeding. The Comprehensive Care Plan (CCP) titled Tube Feeding, dated 10/17/2024, documented interventions to administer the feeding formula with the required amount of water as prescribed by the Physician. Monitor for signs and symptoms of aspiration precaution. Ensure the head of the bed is elevated at 30-45 degrees or more during feeding and one hour after the feeding. The Physician's order dated 11/9/2024 documented Jevity1.5, 1000 cubic centimeters per 1500 kilocalories per day with a flow rate of 50 milliliters per hour for 20 hours per day. Start the feeding at 5:00 PM. Water Flushes with 250 milliliters of water bolus (single large dose) before and after each feeding using a syringe kit. Automatic water flush of 600 milliliters at 30 milliliters per hour for 20 hours every day at 11:00 PM-7:00 AM shift, 7:00 AM-3:00 PM shift, and 3:00 PM-11:00 PM shift. During an observation on 2/24/2025 at 11:30 AM, Resident #27 was observed receiving enteral tube feeding via a feeding pump. In their room. The enteral feeding bottle and a water bag were observed hanging from the feeding tube stand. The enteral tube feeding bottle and the water bag did not have a label to identify the resident's name, the time feeding was started, and the feeding directions as prescribed by the Physician. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent observation on 2/24/2025 at 1:00 PM, Resident #27 was observed receiving enteral tube feeding via a feeding pump. In their room. The enteral feeding bottle and a water bag were observed hanging from the feeding tube stand. The enteral tube feeding bottle and the water bag did not have a label to identify the resident's name, the time feeding was started, and the feeding directions as prescribed by the Physician. During an interview on 2/24/2025 at 1:06 PM, Licensed Practical Nurse #1 stated they did not notice that the enteral tube feeding bottle and water bag did not have any label on them. The Licensed Practical Nurse #1 stated that the evening nurse should have labeled both the enteral tube feeding bottle and the water bag. Licensed Practical Nurse #1 stated they also should have checked the enteral tube feeding bottle and water bag for the labels during the morning medication pass. During an interview on 2/24/2025 at 3:03 PM, Licensed Practical Nurse #4, who worked during the 3:00 PM-11:00 PM shift on 2/23/2025, stated they had forgotten to label the enteral tube feeding bottle and the water bag. Licensed Practical Nurse #4 stated they did not have a marker or pen to label the enteral tube feeding bottle and water bag. Licensed Practical Nurse #4 stated that they become busy with the medication pass and had forgotten about labeling the enteral feeding bottle and water bag. During an interview on 2/26/2025 at 2:42 PM, Registered Nurse #1, Unit Manager, stated the enteral tube feeding bottle and water bag should have a label with the resident's name, the time the feeding was started, and instructions about the enteral order by the Physician. During an interview on 2/27/2025 at 10:00 AM, the Director of Nursing Services stated Resident #27's enteral feeding bottle and water bag should have been labeled. The Director of Nursing Services stated that all Nurses on each shift are responsible for ensuring that proper labeling is in place for both enteral feeding bottles and water bags. 10 NYCRR 415.12(g)(2)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure the Physician documented in the resident's medical record that the irregularity identified by the Pharmacist has been reviewed and what action has been taken to address it. This was identified for two (Resident #121 and Resident #116) of five residents reviewed for Unnecessary Medications. Specifically, Nurse Practitioner #1 disagreed with recommendations provided by the Consultant Pharmacist for Resident # 121 and Resident #116; however, the reason for the disagreement was not documented. The findings are: The facility's undated policy titled, Drug Regimen Review-Monthly documented that the Prescriber/Licensed Designee shall document on the Drug Regimen Review form whether they agree or disagree with the recommendations and provide a brief clinical rationale if no change is to be made. 1) Resident #121 had diagnoses including Atrial Fibrillation and Orthostatic Hypotension (blood pressure drops significantly when a person stands up from a sitting or lying position). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderately impaired cognition. The Physician's Order dated 10/25/2024 last renewed on 2/9/2025 documented for the resident to receive Fludrocortisone (a steroid medication that helps reduce inflammation and treat adrenal insufficiency) 0.1 milligram tablet - give 1 tablet (0.1 milligrams) by oral route twice daily for Orthostatic Hypotension. The Physician's Order dated 10/25/2024 documented for the resident to receive Midodrine (a medication used to treat low blood pressure) 10-milligram tablet - give 1 tablet by oral route three times per day for Orthostatic Hypotension. The medication was discontinued on 2/4/2025. The Physician's Order dated 2/4/2025 last renewed on 2/9/2025 documented for the resident to receive Midodrine 5 milligram tablet - give 1 tablet by oral route three times per day for Orthostatic Hypotension. The Drug Regimen Review dated 1/28/2025 documented the resident was currently receiving both Midodrine and Fludrocortisone with diagnoses of Orthostatic Hypotension. The Consultant Pharmacist recommended evaluating the need for both medications and considering discontinuing one of the medication orders, if appropriate. The Physician/Prescriber Response made by Nurse Practitioner #1 on 1/31/2025 documented Disagree; however, there was no clinical rationale indicated on the form or in the resident's Electronic Medical Record. 28173 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #116 had diagnoses including Benign Prostatic Hyperplasia, Insomnia, and Multiple Myeloma. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating the resident had severely impaired cognition. The Physician's Order dated 12/12/2024 last renewed on 2/25/2025 documented Haloperidol 1 milligram (an antipsychotic medication) tablet - give 1 tablet by oral route twice daily for Metabolic Encephalopathy. The Physician's Order dated 12/13/2024 last renewed on 2/25/2025 documented Melatonin 5 milligram (a hormone that aids in sleep) tablet - give 1 tablet by oral route once daily at bedtime for Vitamin Deficiency, unspecified, and Melatonin 3 milligram tablet - give 1 tablet by oral route once daily at bedtime for Vitamin deficiency, unspecified. The Physician's Order dated 12/12/2024 last renewed on 2/25/2025 documented Pomalyst 3 milligram (medication to treat Multiple Myeloma) capsule - give 1 capsule (3 milligrams) by oral route once daily for 21 days for Multiple Myeloma in relapse. The Physician's Order dated 12/12/2024 last renewed on 2/25/2025 documented Tamsulosin 0.4 milligram (smooth muscle relaxer) capsule - give 1 capsule (0.4 milligrams) by oral route once daily half an hour following the same meal each day for Benign Prostatic Hyperplasia with lower urinary tract symptoms. The Drug Regimen review dated 1/10/2025 documented: -The resident was currently receiving Haloperidol 1 milligram twice daily for behaviors associated with Dementia. No recent behavior problems were noted. The Consultant Pharmacist recommended evaluating the current dosing and to consider tapering Haldol to 1 milligram daily dosing or documenting the reason for the inability to do so. The Physician/Prescriber Response made by Nurse Practitioner #1 on 1/14/2025 was Disagree; however, no clinical rationale was documented on the form or in the resident's Electronic Medical Record. -The resident was currently receiving both Melatonin 5 milligrams and Melatonin 3 milligrams. The Consultant Pharmacist recommended evaluating the need for two medications in the same drug class and considering discontinuing one order, if appropriate. The Physician/Prescriber Response made by Nurse Practitioner #1 on 1/14/2025 was Disagree; however, no clinical rationale was documented on the form or in the resident's Electronic Medical Record. -The resident was currently receiving Pomalidomide (Pomalyst) once a day for 21 days. Typically dosed cyclically once a day for 21 days of a repeated 28-day cycle. No follow-up cycle is scheduled. The recommendations were to evaluate and consider ordering follow-up cycles to ensure continuity of care, if appropriate. The Physician/Prescriber Response made by Nurse Practitioner #1 on 1/14/2025 was Disagree; however, no clinical rationale was documented on the form or in the resident's Electronic Medical Record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was currently receiving Tamsulosin (Flomax) 0.4 milligram with an order to crush the medication. This medication should not be crushed, chewed, or opened. The recommendations were to evaluate the continued need. Consider either discontinuing if no longer needed or switching to Silodosin (Rapaflo) 8 milligrams (medication used for enlarged prostate) once daily after dinner which may be opened and the powder sprinkled whole in applesauce, if appropriate. The Physician/Prescriber Response made by Nurse Practitioner #1 on 1/14/2025 was Disagree; however, no clinical rationale was documented on the form or in the resident's Electronic Medical Record. During an interview on 2/26/2025 at 12:00 PM, Nurse Practitioner #1 stated they have been a Nurse Practitioner for only approximately six months. Nurse Practitioner #1 stated they were not aware that they have to write an explanation when they disagree with a Pharmacist's recommendation. Nurse Practitioner #1 stated Primary Physician #1 did not educate them about documenting the rationale for disagreeing with the recommendations made by the Pharmacist. During an interview on 2/26/2025 at 12:45 PM, Primary Physician #1 stated Nurse Practitioner #1 should have written a response when they disagreed with a Pharmacist's recommendations. One can disagree with the recommendations; however, the rationale for disagreement must be documented in the resident's medical record. Primary Physician #1 stated Nurse Practitioner #1 was trained first before they were allowed to work by themselves. 10 NYCRR 415.18(c)(2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025 the facility did not ensure each resident was free of any significant medication errors. This was identified for one (Resident #284) of six residents observed during medication administration. Specifically, Resident #284 had a do not crush physician's order for Metoprolol extended-release medication tablet (a blood pressure medication). During the medication administration observation, Licensed Practical Nurse #5 crushed and administered the Metoprolol extended-release medication tablet to Resident #284. The finding is: The facility's policy titled Medication Administration: General Policies and Practices, effective 11/12/2024, documented that prior to administering any medication the staff nurse reads the order in its entirety carefully, noting the name, dosage, route, and time of administration, making certain that the dosages, frequency, and schedules correspond with the physician's order; reads the medication label before pouring the medication; reviews the electronic medication record for accuracy after all medications for a specific resident have been prepared. The policy did not specifically address extended-release medications or crushing medications. Resident #284 was admitted with diagnoses including Joint Replacement Surgery, Diabetes Mellitus, and Hypertensive Heart Disease. The Minimum Data Set assessment was not available because the resident was recently admitted to the facility. The Nursing Admission assessment dated [DATE] documented the resident was oriented to person, place, and time. A Physician's order dated 2/17/2025 documented Metoprolol Succinate Extended Release (ER) 25-milligram tablet, extended-release 24 hours, by oral route once daily at 9:00 AM; Do Not Crush or Chew, for diagnosis of Essential Hypertension. The accessdata.fda.gov website for Metoprolol Succinate extended-release tablets documented that the Metoprolol Succinate extended-release tablets are scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed. A Physician's order dated 2/18/2025 documented a regular-consistency diet. During a medication administration observation on 2/25/2025 at 8:18 AM, Licensed Practical Nurse #5 prepared Resident #284's medications. Licensed Practical Nurse #5 crushed and mixed each of the following medications individually in apple sauce, and administered the medications to the resident: -Finasteride 5 milligrams for enlarged prostate, -Entresto 24 milligrams-26 milligrams for Heart Failure, -Metoprolol Succinate Extended Release 25 milligrams for Hypertension, -Furosemide 20 milligrams for Hypertension, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Aspirin 81 milligrams for Coronary Artery Disease and, During an interview on 2/25/2025 at 9:00 AM, Licensed Practical Nurse #5 reviewed the physician's order for the extended-release Metoprolol Succinate, which the nurse had crushed and administered to the resident. The order documented Do Not Crush. Licensed Practical Nurse stated the medication blister pack label did not indicate to not crush, therefore they crushed the extended-release Metoprolol Succinate medication. Licensed Practical Nurse #5 questioned the surveyor Was I not supposed to crush the Metoprolol? A review of Licensed Practical Nurse #5's Medication Pass Audit Tool (competency), dated 10/22/2024, revealed the nurse passed the medication pass technique assessment under the category. The audit tool included that products suitable for crushing were crushed (enteric-coated, sustained release and sublingual products are not to be crushed). During an interview on 2/26/2025 at 8:50 AM, the Medical Director (the resident's Primary Physician) stated Licensed Practical Nurse #5 should not have crushed the Metoprolol Succinate Extended-Release tablet because crushing an extended-release tablet releases all the medication at once and creates the possibility of a drop in blood pressure. During an interview on 2/26/2025 at 10:46 AM, Pharmacist #1 stated crushing the extended-release medication releases all the medication at once. Crushing the medication disrupts the medication release mechanism because the medication in the extended-release tablet is formulated to be released throughout the day. There could be side effects from crushing the medication like low blood pressure. Monitoring of the resident's blood pressure would be needed if the extended-release medication was crushed. During an interview on 2/27/2025 at 9:13 AM, Registered Nurse #2, the unit manager, stated nurses are not supposed to crush extended-release medications; this is a part of their education. If a nurse crushes an extended-release medication, they have to reach out to the doctor for further direction. During an interview on 2/27/2025 at 10:06 AM, the Director of Nursing Services stated an extended-release medication should not be crushed. If the nurse crushed the extended-release medication, they have to reach out to the doctor on how to proceed and the resident should be closely monitored for the next 24 hours. The progress note dated 2/25/2025 documented Resident #284'2 blood pressure was obtained on 2/25/2025 at 12:54 PM due to the resident having blood in the urine. The blood pressure was 124/57 millimeters of Mercury (normal range 120/80). There was no documentation regarding monitoring the residents related to administering a crushed extended-release Metoprolol Succinate medication. 10 NYCRR 415.12(m)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and staff interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure that drugs and biologicals were stored in a locked compartment. This was identified for one (Resident #1) of four residents reviewed for Accident Hazards. Specifically, Resident #1 was observed with an Albuterol inhaler (medication used to treat difficulty breathing) on top of their bed and there was no nursing staff in the vicinity. There was no Physician's order for Albuterol inhaler and the resident was not assessed to self-administer their medication. The finding is: The facility's policy titled Medications: Storage and Handling last revised on 12/12/2024, documented medications are stored according to procedures established in compliance with State and Federal regulations. Medications and biologicals are stored in locked compartments under proper temperature controls, and only authorized personnel have access to the keys. Residents participating in a self-administration program are to have a locked medication cabinet in their room. Resident #1 was admitted with diagnoses including Chronic Obstructive Pulmonary Disorder, Malignant Neoplasm (Cancer) of the lung, and Emphysema (chronic lung disease that permanently damages the lungs' air sacs). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 3, which indicated that Resident #1 had severe cognitive impairment. The Minimum Data Set assessment documented Resident #1 had shortness of breath when lying flat. A review of Resident #1's electronic medical record revealed no Physician Orders for an Albuterol 90 microgram inhaler. A Physician's Order dated 12/27/2024 documented Breo Ellipta (an inhaler that treats asthma and Chronic Obstructive Pulmonary Disease) 100 micrograms per 25 micrograms dose powder by inhalation of puff by oral route once daily. A Comprehensive Care Plan titled Respiratory Disorder: Chronic Obstructive Pulmonary Disorder dated 9/26/2024, documented interventions including to administer medications and oxygen therapy as per the Physician's Orders. During an observation on 2/24/2025 at 10:29 AM, Resident #1 was sitting in a wheelchair in their room. An unlabeled Albuterol 90 micrograms inhaler was observed on top of Resident #1's bed with an expiration date of 3/6/2025. There was no nurse in the room or within the vicinity of Resident #1's room. Resident #1 stated they did not remember where the inhaler came from and that they used that inhaler all the time. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/2025 at 10:43 AM, Licensed Practical Nurse #2 stated Resident #1 did not have an order for an Albuterol inhaler. Licensed Practical Nurse #2 stated Resident #1 had an order for a Breo-Ellipta inhaler that the Nurses administer once a day. Licensed Practical Nurse #2 stated the resident is confused and they had never seen Resident #1 use the Albuterol inhaler. During an interview on 2/24/2025 at 1:41 PM, Registered Nurse#1, the Unit Manager, stated they had never seen Resident #1 use the Albuterol inhaler. Registered Nurse #1 stated Resident #1 had confusion and would not be able to self-administer the medication. Registered Nurse #1 stated they did not know how Resident #1 obtained the inhaler medication. During an interview on 2/27/2025 at 10:33 AM, the Director of Nursing Services stated Resident #1 should not have had any medications without the nurse's supervision. The Director of Nursing Services stated Nurses should be aware of any unsecured medications. 10 NYCRR 415.18(e)(1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure it maintained an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #283) of one resident reviewed for Respiratory Infection. Specifically, Resident #283 was readmitted to the facility on [DATE] from the hospital with a diagnosis of Influenza. The resident was placed on Contact and Droplet Precautions. During two separate observations, [NAME] #1 and [NAME] #2 were cleaning the resident's room without wearing appropriate Personal Protective Equipment. [NAME] #1 put on the Personal Protective Equipment after the observation and then exited the room without removing the Personal Protective Equipment to retrieve a garbage pail from the hallway. The finding is: The facility's policy titled Infection Control-Droplet Precautions, effective 10/30/2023, documented droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Infectious agents for which droplet precautions are indicated include Influenza virus. The facility's policy titled Infection Control-Contact Precautions, effective 10/30/2023 documented that contact precautions are intended to prevent transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment. Healthcare personnel wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient environment. Putting on the Personal Protective Equipment upon room entry and discarding before exiting the room is done to contain pathogens. Resident #283 was admitted to the facility with diagnoses of Muscle Wasting and Atrophy (muscle shrinkage), Diabetes Mellitus, and Major Depressive Disorder. The Minimum Data Set assessment was not available due to the resident's recent admission to the facility. The Nursing Admission assessment dated [DATE] documented the resident was oriented to person, place, and time. A review of nursing progress notes revealed the resident was transferred to the hospital on 2/17/2025 due to low hemoglobin and was readmitted to the facility on [DATE] with a positive diagnosis of Influenza. A Comprehensive Care Plan titled, Isolation Precautions for Influenza A, effective 2/20/2025, documented resident has an active infection requiring isolation precautions. The goal was for staff to prevent the spread of infection. The intervention included to maintain an isolation cart outside of the resident's room and to maintain Contact Precautions. The care plan did not include Droplet Precautions. A Physician's order dated 2/24/2025 documented Contact/Droplet precautions until (Influenza) symptoms resolve. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/24/2025 at 10:26 AM, Resident #283 was lying in bed in their room. A pink sign outside the resident's room documented: Isolation, Droplet/Contact Precautions, Staff and Providers must clean their hands when entering and exiting, wear a gown, an N95 Respirator (facemask acceptable if an N95 not available); eye protection, and gloves. [NAME] #1 was observed inside the resident's room not wearing a gown, eye protection, or an N95 mask and was sweeping the floor and moving furniture around. [NAME] #1 was wearing a surgical mask and gloves. [NAME] #1 stated they knew they were supposed to wear all appropriate Personal Protective Equipment and were not able to state why they were not wearing the appropriate Personal Protective Equipment. The porter then sanitized their hands, put on a gown, gloves, an N95 mask, and eye shield, and re-entered the room. After continuing to sweep the room, the porter exited the room with all the Personal Protective Equipment still on, including the gloves, and retrieved a garbage pail that was outside of Resident #283's room across the hallway. During an interview on 2/24/2025 at 2:17 PM, Operations Manager #1 stated the porters are supposed to follow the instructions on the isolation precautions sign at the doorway; they are supposed to wear full Personal Protective Equipment for Contact and Droplet rooms and then remove the Personal Protective Equipment before leaving the room. During an interview on 2/26/2025 at 8:02 AM, the Assistant Director of Nursing/Infection Preventionist #1 stated [NAME] #1 was expected to follow the directions on the isolation precaution sign. Assistant Director of Nursing/Infection Preventionist #1 stated the resident should have been placed on Contact and Droplet precautions on 2/20/2025 when the resident was readmitted and a Physician's order for Contact and Droplet Precautions should have been obtained on 2/20/2025 and the care plan should have also included the Droplet Precautions. Assistant Director of Nursing/Infection Preventionist #1 stated this was an oversight. During an interview on 2/27/2025 at 10:06 AM, the Director of Nursing Services stated the staff are expected to follow the isolation precaution directions provided on the signage. During an observation on 2/27/2025 at 11:57 AM, [NAME] #2 was observed inside Resident #283's room cleaning while the resident was in bed. The isolation Contact and Droplet signage was still at the doorway. The porter was wearing gloves, a gown, and a surgical mask, but no N95 mask and no eye protection. The surveyor brought the signage to the attention of the porter, who then reached out of the room to the isolation cart, which was placed in the hallway outside of the resident's room, wearing the same gloves, and took out a face shield from the isolation cart and put on the face shield. 10 NYC RR 415.19(a)(1-3)