STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335196	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Lake Specialized Rehab and Care Center	275 Castleton Avenue Staten Island, NY 10301

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, to the State Survey Agency. This was evident for one (1) (Residents #105) of four (4) residents reviewed for accidents out of 35 total sampled residents. Specifically, Resident #105 had an unwitnessed fall on 06/04/2025 when they were observed on the floor with a laceration to the right eyebrow. The resident was transferred to the hospital and was diagnosed with a cervical fracture. Resident #105 was cognitively impaired and was unable to explain how the injury was sustained. This incident was not reported to the New York State Department of Health. See F-689. The findings include:The facility policy titled Abuse Investigations with a reviewed date of 01/2023 documented that all reports of injury of unknown source shall be promptly and thoroughly investigated by the facility management. The policy did not include protocols for reporting injuries of unknown source to the State Survey Agency.Resident #105 had diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities), syncope (fainting or passing out) and collapse, and gait and mobility abnormalities.The Minimum Data Set (a resident assessment tool) assessment dated [DATE] documented that Resident #105 had severe cognitive impairment.A nurse's progress note dated 06/04/2025 at 6:40 AM by Licensed Practical Nurse #5, documented that at about 5:50 AM, they were in the medication room when they heard an alarm. They ran to the hallway, observed Resident #105 on the floor, and called the nursing supervisor.A nurse's progress notes dated 06/04/2025 at 6:36 AM by Registered Nurse #11, documented that they were called to the unit at approximately 5:50 AM to assess Resident #105 who fell in the hallway. The resident was assessed with a visible laceration above the right eyebrow.The hospital information and transfer form dated 06/06/2025 documented Resident #105's primary diagnosis as fracture to the second cervical vertebra (neck bone). The hospital radiology (imaging tests to create pictures of the inside of your body) report dated 06/04/2025 documented acute fracture of odontoid process (a bone on the spine that helps in head rotation and stability to the upper spine). The hospital recommended neurosurgery (medical specialty focusing on spinal cords) follow up in two (2) weeks.The Accident/Incident Report form dated 06/07/2025 completed by Registered Nurse #11 documented that on 06/04/2025 at about 5:50 AM, Registered Nurse #11 was notified by the floor nurse that Resident #105 fell from the wheelchair. The event was unwitnessed, and the resident was unable to state how the incident occurred. The report documented instructions and was confused, had impaired judgment, unable to understand and follow instructions, and required consistent redirection. The floor nurse was in the medication room, and the certified nursing assistants were providing care to other residents.There was no documented evidence that the facility reported Resident #105's unwitnessed fall incident, resulting in major injury, to the New York State Department of Health.On 04/14/2026 at 10:51 AM, Assistant Director of Nursing #2 was interviewed and stated they completed the investigation for Resident #105's fall occurrence on 06/04/2025. They stated that the fall was (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unwitnessed and that the resident sustained a cervical fracture. Assistant Director of Nursing #2 stated they were not sure if this incident was reported to the New York State Department of Health and was not sure of the facility's policy on reporting incidents.On 04/16/2026 at 10:47 AM, the Director of Nursing was interviewed and stated that the regulation does not state that they have to report a major injury of unknown origin.10 New York Codes, Rules and Regulations 415.4(b)(2)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, record review and interviews, the facility failed to ensure that residents' Comprehensive Care Plans were reviewed and revised by the interdisciplinary team after each assessment, and revised based on changing goals, preferences, and needs of the resident. This was evident for one (1) of four (4) residents reviewed for Respiratory Care, and one (1) of two (2) residents reviewed for Falls out of 35 total sampled residents. Specifically, 1.) Resident #91's Respiratory Care Comprehensive Care Plan was not updated after their Quarterly Minimum Data Set Assessment, and 2.) Resident #105's Falls Comprehensive Care Plan interventions were not reviewed and updated after enduring multiple falls in the facility. See F-689.The findings include: The facility's policy and procedure titled Care Plans-Comprehensive with a last reviewed date of 01/2026 documented that it is the facility's policy to develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs. Each resident's care plan is designed to aid in preventing or reducing declines in the resident's functional status. The plan of care is evaluated in response to a significant change in the resident's physical, communicative, psychosocial, functional, or emotional status, or at least every 90 days. 1. Resident #91 had diagnoses including Chronic Obstructive Pulmonary Disease and Non-Alzheimer's Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #91 received oxygen therapy in the facility. The Respiratory Conditions Comprehensive Care Plan established 06/19/2023 documented that Resident #91 had a goal to be free from signs and symptoms of respiratory distress for 90 days. Interventions included administering oxygen as needed, and elevating Resident #91's head of bed due to their shortness of breath when lying flat. The Respiratory Conditions Comprehensive Care Plan was documented as being last updated on 12/30/2025 and was not updated following Resident #91's quarterly assessment on 03/18/2025. On 04/14/2026 at 12:20 PM, Licensed Practical Nurse #1 who was the Unit Manager on Resident #91's unit was interviewed and stated that Resident #91 utilizes oxygen therapy. Licensed Practical Nurse #1 stated that they are responsible for updating Resident #91's Respiratory Conditions care plan on a quarterly basis and that it should have been updated by 03/20/2026 following Resident #91's quarterly Minimum Data Set assessment. Licensed Practical Nurse #1 stated that they were not sure why it had not been updated. On 04/15/2026 at 09:44 AM, Assistant Director of Nursing #2 was interviewed and stated that Nurse Supervisors are responsible for updating care plans every three months and they were not aware that Resident #91's Respiratory Conditions care plan had not been updated on a quarterly basis. On 04/16/2026 at 10:52 AM, the Director of Nursing stated that the Nurse Managers are responsible for updating care plans for residents on their unit. The Director of Nursing stated they did not know why Resident #91's Respiratory Conditions care plan had not been updated on a quarterly basis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #105 had diagnoses that included Dementia (loss of memory, language, problem-solving and other thinking abilities), Syncope (fainting or passing out) and Collapse, and gait and mobility abnormalities. The Minimum Data Set (a resident assessment tool) assessment dated [DATE] documented that Resident #105 had severe cognitive impairment and had a fall history and had a fracture related to the fall. A comprehensive care plan for falls/injury was initiated on 01/25/2022 for Resident #105 related to physical performance limitations. The facility interventions dated 01/26/2022 included anticipating needs, monitoring activities of the resident, and monitoring risk factors. The care plan notes documented that Resident #105 had prior falls on 05/26/2022, 03/19/2023, 04/12/2023, 05/13/2023, 10/29/2023, and 01/26/2024. The care plan interventions were not updated in response to these incidents. A nurse's progress notes dated 06/04/2025 at 6:36 AM by Registered Nurse #11 documented that they were called to the unit at approximately 5:50 AM to assess Resident #105 who fell in the hallway. The resident was assessed with a visible laceration above the right eyebrow. The comprehensive care plans documented that the resident was leaning forward and sustained a fall from the wheelchair in the hallway on 06/04/2025. There was no documented evidence that the care plan interventions were reviewed and revised following the fall incident on 06/04/2025. The Certified Nursing Assistant Clinical Accountability and Record Assignment (contains care instructions for Certified Nursing Assistants) dated 04/2025 indicated that Resident #1 required extensive assistance of 2 staff for transfers. There was no documented fall prevention instructions except for the use of tab alarm on chair and bed. On 04/14/2026 at 12:45 PM, Licensed Practical Nurse #6 was interviewed and stated that their responsibility is to make sure the care plans are updated quarterly, annually, when there is a significant change, and as needed with the supervision of the Director of Nursing and Assistant Director of Nursing. They stated that Resident #105's fall interventions need not be updated because these are the intervention being used to prevent Resident #105 from falling. On 04/14/2026 at 10:51 AM, Assistant Director of Nursing #2 was interviewed and stated that the fall care plan is updated by adding the fall incident on the problem section of the care plan. They stated that there were no new interventions added to Resident #105's care plan for falls. Assistant Director of Nursing #2 stated it is the responsibility of the Registered Nurse to update the care plan. On 04/14/2026 at 3:27 PM, the Director of Nursing was interviewed and stated that the unit managers, Licensed Practical Nurses, and Registered Nurses are responsible for updating the residents' care plans. New York Codes, Rules, Regulations 415.11(c)(2) (i-iii)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interviews, the facility failed to ensure each resident received treatment and care in accordance with professional standards of practice. This was evident for one (1) (Resident #191) of one (1) resident reviewed for change in condition. Specifically, Resident #191 who had a documented allergy to Vancomycin was prescribed and administered Vancomycin for the treatment of pneumonia placing the risk at risk for an adverse allergic reaction.See F-755.The findings include:The facility's policy titled Medication Administration dated 12/2023 documented that medications shall be administered in a safe and timely manner, and as prescribed by the physician. The policy also documented that medication nurses must check and verify medication allergies prior to administering medications. Resident #191 had diagnoses that included Heart Failure, Seizure Disorder, Respiratory Failure, and Ventilator Dependence.On 04/09/26 at 11:33 AM, Resident #191 was observed in bed. The resident was on a ventilator and had a red allergy bracelet alert on the left wrist .The Quarterly Minimum Data Set (a resident assessment tool) dated 02/03/2026 documented that Resident #191 was severely cognitively impaired, dependent on ventilator, and was dependent on performing activities of daily living. A comprehensive care plan for medication allergy was initiated for Resident #191 on 04/09/2024. The care plan documented that the resident had allergy to mucomyst. The care plan was updated on 05/09/2025 to document an allergy to Vancomycin. The facility interventions included monitoring any allergic reaction and use of red charm bracelet for allergy alert.A physician's order dated 05/09/2025 documented that Resident #191 had allergy to Vancomycin.A physician's order dated 06/30/2025 included an order for Vancomycin 1 gram via intravenous piggyback every 12 hours for 10 days for cocci in cluster (types of bacteria that are grouped together). The Medication Administration Record documented that Registered Nurse #1 administered the ordered Vancomycin on 06/30/2025 at 9:00 AM. A progress note by Respiratory Therapist #1 dated 06/30/2025 at 1:55 PM documented that Resident #191 had scattered rhonchi (course rattling lung sounds usually caused by secretions), wheezing, and had an oxygen saturation of 96%. The resident was suctioned with large amount of thick yellowish secretions, albuterol was administered. Solumedrol (a medication used to treat certain allergies) was also administered.A nurse's progress note by Licensed Practical Nurse #2 dated 06/30/2025 at 3:33 PM documented that Resident #191's family member was made aware of antibiotic allergy and of the resident's increased work of breathing from this morning and expressed understanding of Solumedrol. The physician assistant was made aware and discontinued the order for Vancomycin.A medication error report dated 06/30/2025 documented that Licensed Practical Nurse #2 discovered that Resident #191 was administered Vancomycin to which the resident was allergic to. Resident #191 had increased work of breathing and was wheezing. Solumedrol was given with good effect. The reason for the medication error was failure to check the resident's allergy.On 04/14/2026 at 12:56 PM, an interview was conducted with Registered Nurse #1 who administered Vancomycin to Resident #191. They stated they do not recall the incident. They stated that resident with known allergies wear an allergy bracelet and that nurses must check first if a resident has allergies to the medication before administration.On 04/13/26 at 11:43 AM, an interview was conducted with License Practical Nurse #2 who stated that on the day of the incident, they observed Resident #191 in bed at around 10:30 AM with increased breathing that was higher than their baseline and had swollen face and lips. They stated they noticed that the resident was receiving intravenous Vancomycin at that time, and they quickly informed the physician that this resident was allergic to Vancomycin. Licensed practical Nure #2 stated the physician ordered to stop the infusion and to administer Solumedrol. They stated that the resident was not transferred to the hospital and that they closely monitored the resident who did not have any further complication after administering Solumedrol.On 04/13/2026 at 11:59 AM, an interview was conducted with Respiratory Therapist #1 who stated that they noted Resident #191 was wheezing and that the ventilator peak pressure (pressure reached in a resident's airway during (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the inspiratory phase of mechanical ventilation) was at 50 centimeters water (cm H2O) which was higher than their baseline of 30. Respiratory Therapist #1 stated that they were not aware that the resident received Vancomycin to which they were allergic to and that the resident's condition at that time was not something very unusual, especially for resident on ventilator and with all their medical conditions. On 04/15/2026 at 11:47 AM, an interview was conducted with Medical Doctor #1, who prescribed Vancomycin for Resident #191. They stated that they could not recall the incident. They stated that this could have been prevented if someone, from either the nursing home or the pharmacy, realized that Resident #191 was allergic to Vancomycin.On 04/15/2026 at 11:33 AM, an interview was conducted with Assistant Director of Nursing #1, who was also the Infection Preventionist, who stated that Resident #191 received Vancomycin despite being allergic to it. They stated that License Practical Nurse #2 observed Resident 191 with swollen face and lips and was wheezing; the physician was made aware and ordered to administer Solumedrol. Assistant Director of Nursing #1 stated that Resident #191 did not have any further complication after that. They stated that residents with known allergies wear allergy alert bracelets to serve as a warning and that the allergy is also documented on the resident's profile in the electronic medical record.10 New York Codes, Rules and Regulations 415.12

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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 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to ensure each residents received adequate supervision to prevent accidents. This was evident for one (1) (Resident #105) of four (4) residents reviewed for accidents out of 35 total sampled residents. Specifically, on 06/04/2025, Resident #105, who had severe cognitive impairment and had a history of multiple falls, had an unwitnessed fall from a wheelchair when the resident was left in the hallway without supervision. Resident #105 sustained a head laceration and was transported to the hospital and subsequently diagnosed with a cervical fracture. This deficient practice resulted in actual harm to Resident #105 that was not Immediate Jeopardy.The findings include:The facility policy titled Accident-Incident with a reviewed date of 01/2023 documented that accidents and incidents are to be written in a clear and concise manner describing the facts, equipment, hazardous conditions, deviant behavior and/or other factors involved pertaining to a specific situation. All accidents will be reviewed within 24 hours to ensure event was not related to abuse, neglect, or mistreatment.Resident #105 had diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities), syncope (fainting or passing out) and collapse, and gait and mobility abnormalities.The Minimum Data Set (a resident assessment tool) assessment dated [DATE] documented that Resident #105 had severe cognitive impairment, required substantial/maximal assistance (staff lifts or holds trunk or limbs and provides more than half the effort) for activities of daily living including sit to stand and transfers. The facility was unable to provide documented evidence of a fall risk assessment prior to Resident #105's fall occurrence on 06/04/2025.A Comprehensive Care Plan for falls/injury was initiated on 01/25/2022 for Resident #105 related to physical performance limitations. The facility interventions dated 01/26/2022 included anticipating needs, monitoring activities of the resident, and monitoring risk factors. The care plan notes documented that Resident #105 sustained falls on 05/26/2022, 03/19/2023, 04/12/2023, 05/13/2023, 10/29/2023, and 01/26/2024. The care plan was modified to add a wheelchair tab alarm (a device used to alert caregivers when an elderly or at-risk individual attempts to leave a bed or chair) on 01/24/2024.A nursing assessment form dated 10/08/2024 documented that Resident #105 had history of falls.A care plan evaluation was documented on 10/15/2024 and there was no documented evidence that interventions were updated in response to the resident's repeated falls.The Certified Nursing Assistant Clinical Accountability and Record Assignment (contains care instructions for certified nursing assistants) dated 04/2025 indicated that Resident #1 required extensive assistance of two (2) staff for transfers. There were no fall prevention instructions except for the use of tab alarm on chair and bed.A nurse's progress note dated 06/04/2025 at 6:40 AM by Licensed Practical Nurse #5, documented that at about 5:50 AM, they were in the medication room when they heard an alarm. They ran to the hallway, observed Resident #105 on the floor, and called the nursing supervisor.A nurse's progress notes dated 06/04/2025 at 6:36 AM by Registered Nurse #11, documented that they were called to the unit at approximately 5:50 AM to assess Resident #105 who fell in the hallway. The resident was assessed with a visible laceration above the right eyebrow.A medical progress note dated 06/04/2025 at 7:52 AM by Medical Doctor #1 documented that Resident #105 had a fall in the hallway while trying to stand up from the wheelchair. The resident sustained a laceration to the right eyebrow with edema and active bleeding and was sent to the emergency room for evaluation.A nurse's progress note dated 06/04/2025 at 3:54 PM documented that Resident #105 was admitted to the hospital.The hospital information and transfer form dated 06/06/2025 documented Resident #105's primary diagnosis as fracture to the second cervical vertebra (neck bone). The hospital radiology (imaging tests to create pictures of the inside of your body) report dated 06/04/2025 documented acute fracture of odontoid process (a bone on the spine that helps in head rotation and stability to the upper spine). The hospital recommended (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	neurosurgery (medical specialty focusing on spinal cords) follow up in two (2) weeks.The Accident/Incident Report form dated 06/07/2025 completed by Registered Nurse #11 documented that on 06/04/2025 at about 5:50 AM, Registered Nurse #11 was notified by the floor nurse that Resident #105 fell from the wheelchair. The event was unwitnessed, and the resident was unable to state how the incident occurred. The report documented that Resident #105 was confused, had impaired judgment, unable to understand and follow instructions, and required consistent redirection. The floor nurse was in the medication room, and the certified nursing assistants were providing care to other residents.The undated facility investigative summary completed by Assistant Director of Nursing #2 documented that Resident #105 sustained an unexpected fall. The summary documented that the resident stated they leaned forward attempting to reach something on the floor. The staff were summoned by the tab alarm and found the resident on the floor bleeding.During an interview on 04/14/2026 at 12:13 PM, Certified Nursing Assistant #6, who was assigned to Resident #105 on the date and time of the incident, stated on 06/04/2025 at around 6:00 AM, they took Resident #105 out of bed to wheelchair to sit in the hallway and went to other residents' rooms to provide morning care. Certified Nursing Assistant #6 stated they responded to Resident #105's chair alarm and observed the resident lying on the floor. Certified Nursing Assistant #6 stated Resident #105 was not on any monitoring. They were not aware if Resident #105 had previous falls and were not aware of any interventions or assistance that is required for Resident #105 to prevent falls. During an interview on 04/14/2026 at 9:55 AM, Certified Nursing Assistant #7 stated they were on duty at the date and time of the incident but were not assigned to Resident #105. They stated they started providing morning care to other residents at about 4:30 AM. They stated they were inside a resident's room between 6:15 AM and 6:30 AM and were about to start morning care when they heard a loud thump and saw Resident #105 on the floor, face down and bleeding from their forehead. Certified Nursing Assistant #7 stated Resident #105 needs a lot of redirection, does not try to get up from the wheelchair but would always bend forward as if reaching for something on the floor. They stated they remember Resident #105 falling once and that the resident was not on any supervision or monitoring schedule. They stated they are not aware if Resident #105 had a wheelchair or bed alarm.During an interview on 04/14/2026 at 8:55 AM, Licensed Practical Nurse #5 stated on the date of the incident, morning care was provided to Resident #105 between 4:30 AM and 5:00 AM. The resident was then taken out of bed to wheelchair and was left sitting in the hallway. They stated they do not remember why the resident was left in the hallway. They stated they could not remember the time of the incident, but they were at the nursing station when they heard a loud thump and observed Resident #105 on the floor. They stated they did not witness the fall and that they called Registered Nurse #11 to assess the resident. Licensed Practical Nurse #5 stated the resident was not on any monitoring or supervision and this was the first time Resident #105 fell on their shift. Licensed Practical Nurse #5 stated that Resident #105 had a chair alarm and that they rely on that alarm for supervision.During an interview on 04/14/2026 at 10:51 AM, Assistant Director of Nursing #2 stated they were the one who completed the investigation for Resident #105's fall occurrence on 06/04/2025. They stated they reviewed the surveillance footage and at about 5:50 AM, they observed Resident #105 in a wheelchair in the hallway leaning forward to reach for something and fall. They stated that the staff did not witness the fall and that Licensed Practical Nurse #5 was in the hallway by the medication cart, further away from Resident #105. The Assistant Director of Nursing stated the resident sustained cervical fracture as a result of the fall.During an interview on 04/14/2026 at 3:27 PM, the Director of Nursing stated that Resident #105 sustained a cervical fracture from a fall that occurred on 06/04/2025. They stated they viewed the surveillance footage and observed Resident #105 sitting in a wheelchair at the nurses' station between 5:00 AM and 7:00 AM. The Director of Nursing stated that the resident was left by the nursing station which was a high visibility area because the resident wakes up early and climbs out of bed. They stated that the surveillance footage showed Resident #105 eating and tried to pick up something that dropped on the floor and fell forward. They stated they do not remember if (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	there were staff in the hallway but stated there are usually two (2) certified nursing assistants and a nurse on the unit.10 New York Codes, Rules and Regulations 415.12(h)(2)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interviews, the facility failed to ensure that medications were dispensed in a safe manner and in accordance with professional standards of practice. This was evident for one (1) (Resident #191) of one (1) resident reviewed for change in condition. Specifically, the facility failed to ensure that the pharmacy identified and acted upon Resident #191's documented drug allergy to Vancomycin prior to dispensing, resulting in the delivery and administration of Vancomycin to Resident #191 with a known allergy to the medication.See F-684.The findings include:The facility failed to provide a policy related to pharmacy services.Resident #191 had diagnoses that included Heart Failure, Seizure Disorder, Respiratory Failure, and Ventilator Dependence. The Quarterly Minimum Data Set (a resident assessment tool) dated 02/03/2026 documented that Resident #191 was severely cognitively impaired, dependent on ventilator, and was dependent on performing activities of daily living. A comprehensive care plan for medication allergy was initiated for Resident #191 on 04/09/2024. The care plan documented that the resident had allergy to mucomyst. The care plan was updated on 05/09/2025 to document an allergy to Vancomycin. The facility interventions included monitoring any allergic reaction and use of red charm bracelet for allergy alert.A physician's order dated 05/09/2025 documented that Resident #191 had allergy to Vancomycin.A physician's order dated 06/30/2025 included an order for Vancomycin 1 gram via intravenous piggyback every 12 hours for 10 days for cocci in cluster (types of bacteria that are grouped together). The Medication Administration Record documented that Registered Nurse #1 administered the ordered Vancomycin on 06/30/2025 at 9:00 AM.A medication error report dated 06/30/2025 documented that Licensed Practical Nurse #2 discovered that Resident #191 was administered Vancomycin to which the resident was allergic to. Resident #191 had increased work of breathing and was wheezing. Solumedrol was given with good effect. The reason for the medication error was failure to check the resident's allergy.On 04/13/26 at 11:43 AM, an interview was conducted with License Practical Nurse #2 who stated that on the day of the incident, they observed Resident #191 in bed at around 10:30 AM with increased breathing that was higher than their baseline and had swollen face and lips. They stated they noticed that the resident was receiving intravenous Vancomycin at that time, and they quickly informed the physician that this resident was allergic to Vancomycin. Licensed practical Nure #2 stated the physician ordered to stop the infusion and to administer Solumedrol. They stated that the resident was not transferred to the hospital and that they closely monitored the resident who did not have any further complication after administering Solumedrol.On 04/15/2026 at 11:47 AM, an interview was conducted with Medical Doctor #1, who prescribed Vancomycin for Resident #191. They stated that they could not recall the incident. They stated that this could have been prevented if someone, from either the nursing home or the pharmacy, realized that Resident #191 was allergic to Vancomycin.On 04/14/2026 at 11:58 AM, an interview was conducted with Registered Pharmacist #1, the Pharmacy General Manager, who stated that Resident #191's medical profile dated 05/09/2025 showed that Resident #191 was allergic to Vancomycin, but the pharmacy system did not prevent them from dispensing the medication. They stated this was a system error in both the nursing home and the pharmacy that should have been prevented. They stated that the Vancomycin allergy was listed on the electronic physician order that was received by the pharmacy, abut since it was a new allergy for Resident #191, it was not updated in the dispensing system, and was not flagged when they were filling the prescription.On 04/15/2026 at 11:33 AM, an interview was conducted with Assistant Director of Nursing #1, who was also the Infection Preventionist, who stated that Resident #191 received Vancomycin despite being allergic to it. 10 New York Codes, Rules and Regulations 415.18(a)