STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335199	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resort Nursing Home	430 Beach 68th Street Arverne, NY 11692

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** 44472 Based on record reviews and interviews, during the Recertification and Complaint Survey (NY00331563) from 05/21/2024 to 05/29/2024, the facility did not ensure that all alleged violations involving abuse and neglect, were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency. Additionally, the facility did not ensure the results of all investigations were reported to the State Survey Agency within 5 working days of the incident. This was evident for 3 (Resident #126, #136, and #195) of 7 residents reviewed for Abuse out of 36 sampled residents. Specifically, 1.) On 01/13/2024 at approximately 2:30 PM, the facility was made aware that Registered Nurse #3 administered the wrong medication to Resident #126. An initial report was made to the New York State Department of Health on 01/14/2024 at 9:01 AM. A Follow-up Investigation Report was not submitted by the facility within 5 working days of the incident. 2.) On 05/06/2024, Resident #136 had a physical altercation with Resident #195 that was not reported to the New York State Department of Health. The findings include: The facility policy titled Abuse Prohibition dated 12/2023 documented all alleged or suspected incidents of abuse, neglect, or mistreatment will be thoroughly investigated. Any case in which abuse, neglect, or mistreatment has been identified via the investigation will be reported promptly to the New York State Department of Health. A Dear Nursing Home Administrator Letter (DAL: NH 22-20) dated 10/18/2022 regarding Facility Incident Reporting System stated that the notice was to inform the Administrator of changes in reporting of nursing home facility incidents as detailed in QSO-22-19-NH and effective on 10/24/2022. The guidance stated that in addition to an initial facility incident report that must be submitted following reporting timelines, nursing homes must submit to the New York State Department of Health the results of the facility investigation. Within 5 business days of the incident, the facility must provide, in its report, sufficient information to describe the results of the investigation, and must indicate any corrective action(s) taken if the allegation was verified. The facility should include any updates to information provided in the initial report and the following additional information, including, but are not limited to, the following: 1. Additional/Updated information related to the reported incident, 2. Steps taken to investigate the allegation, 3. A conclusion, 4. Corrective action(s) taken, and 5. The name of the facility investigator. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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	1. Resident #126 had diagnoses of Traumatic Spine Injury with Quadriplegia, prior Opioid Abuse, and Bipolar Disorder. The Minimum Data Set assessment dated [DATE] documented Resident #126 had intact cognition. A Report of Accident / Incident form with date of occurrence 01/13/2024 at 3:00 PM documented that towards the end of the shift, the medication nurse reported they accidentally gave 12 tablets of Percocet 10-325 milligrams to Resident #126 instead of 12 tablets of Methadone 10 milligrams. The facility summary of investigation dated 01/13/2024 documented the incident as medication error. The summary of investigation documented that the medication nurse discovered their own medication error when they were completing the narcotic count. The nurse immediately reported the error to the Registered Nurse Supervisor. Resident #126 was transferred to the hospital to rule out Tylenol toxicity and returned to the facility without signs and symptoms of adverse effects. The summary documented the investigation revealed no evidence of narcotic diversion. A Nursing Home Facility Incident Report documented that the incident report was submitted to the New York State Department of Health on 01/14/2024 at 9:01 AM. During an interview on 05/29/2024 at 2:10 PM, the Director of Nursing stated they completed the investigation of the medication error. The Director of Nursing stated they do not have to report the medication error incident within 2 hours and that they have 5 days to report the incident. They stated it was an error on their part for not complying with the 2 hour time frame for reporting. During an interview on 05/29/2024 at 3:11 PM, the Administrator stated they were not aware that the incident was not reported to the State Agency within the required time frame which was no later than 2 hours. 44864 2. Resident #136 was admitted to the facility with diagnoses of Non-Alzheimer's Dementia, Impulse Disorder, and Hyperlipidemia. The Minimum Data Set assessment dated [DATE] documented Resident #136 had intact cognition and had no behavior symptoms. Resident #195 was admitted to the facility with diagnoses of Alzheimer's Disease and Difficulty Walking. The Minimum Data Set assessment dated [DATE] documented Resident #195 had severely impaired cognition and had no behaviors. A staff statement by a Certified Nursing Assistant dated 05/06/2024 documented that they heard 4 loud bangs on the wall and heard a loud argument coming from Residents #136 and #195's room. Resident #136 had Resident #195 against the wall. Resident #136's both hands were wrapped around Resident #195's shirt, while Resident #195's hand was holding onto Resident #136's shirt. The Certified Nursing Assistant separated the residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Accident Investigation Report dated 05/07/2024 documented that on 05/06/2024 at around 10:00 AM, the staff heard shouting and yelling coming from Residents #136 and #195's room. The staff immediately responded and noted Resident #136 was grabbing Resident #195's shirt. Both were separated. Resident #136 continued to curse as they were redirected outside of their room. The facility summary of investigation concluded that abuse had not occurred because the plan of care was followed, and safety interventions were in place. There was no documented evidence that the resident to resident physical abuse involving Resident #136 and Resident #195 that occurred on 05/06/24 was reported to the New York Department of Health. During an interview on 05/28/2024 at 3:43 PM, the Director of Nursing stated the incident was not reported because the residents did not sustain any injury as a result of the altercation. The Director of Nursing stated there was no need to report the incident since there was no harm and the residents were immediately separated. During an interview on 05/29/2024 at 2:37 PM, the Administrator stated they did not feel that there was a need to report the incident because there was no harm on either residents. 10 NYCRR 415.4(b) (2)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 18881 Based on observation and interview conducted during the Recertification Survey from 05/21/2024 to 05/29/2024 , the facility did not ensure that the nurse staffing information was posted in a prominent place readily accessible to residents and visitors. Specifically, there was no available posting of daily nurse staffing information. The findings are: The facility did not have a policy on Posting Daily Nurse Staffing Information. During observations conducted on 05/21/2024, 05/22/2024, 05/23/2024, and 05/24/2024, the State Surveyor was unable to locate the postings of the daily nurse staffing levels for each shift or any signage instructing residents or visitors where it was located. On 05/24/2024 at 3:45 PM , the State Surveyor asked the Director of Nursing where the staffing information was located and was shown the staffing schedule for the day. During an interview on 05/24/2024 at 2:45 PM, the Director of Nursing stated they do not have the daily nursing staffing posted and they had no policy for it. They stated they read the guidelines and saw that the daily nursing staffing posting was required and they started posting it. 10 NYCRR 415.13

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44472 Based on interview and record review during the Recertification and Complaint Survey (NY00331563) from 05/21/2024 through 05/29/2024, the facility failed to ensure that residents were free of significant medication errors. This was evident for 1 (Resident #126) of 1 resident reviewed for medication administration. Specifically, Resident #126 had a physician's order for 12 tablets of Methadone 10 milligram by oral route once daily. On 01/13/2024, the Resident was administered 12 tablets of Percocet 10-325 milligrams instead of Methadone. Cross Reference: F658 - Services Meet Professional Standards The findings include: The facility policy titled Medication Administration with a revision date of 10/2023 documented the purpose of the policy was to ensure safe administration of medication for residents. The policy stated that medication and strength are verified with physician's order as transcribed on the medication administration record. Controlled substance record is signed immediately after a narcotic has been administered. During an interview on 05/29/2024 at 1:00 PM, Registered Nurse #3 stated they gave Resident #126 12 tablets of Percocet instead of the prescribed 12 tablets of Methadone. They stated they discovered their error when they were counting the controlled drugs before the end of their shift. They stated they immediately reported the incident to the nursing supervisor, and they were told not to come back to work while investigation was in progress. During an interview on 05/29/2024 at 2:10 PM, the Director of Nursing stated they completed the investigation of the incident, and that Registered Nurse #3 committed a medication error and was immediately terminated. During an interview on 05/29/2024 at 3:11 PM, the Administrator stated the medication error incident was a big shock to the facility and had not happened before. 415.12(m)(2)