STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335231	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel at Woodbury for Rehab and Nursing, L L C	8533 Jericho Tpke Woodbury, NY 11797

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observation, interview, and record review during the Recertification Survey and Abbreviated Survey (Complaint # NY00319453) completed on 4/23/2024, the facility did not ensure resident rights to be free from abuse. This was identified for one (Resident #311) of two Residents reviewed for Abuse. Specifically, Resident #311 who had a history of verbally disruptive and intrusive behavior such as attempts to enter other resident rooms, antagonize residents, excessive talking, inappropriate outbursts, and mocking other residents, was transferred to Resident #310's unit on 5/3/2023 after returning from emergency room status post verbal altercation with a resident on the previous unit. Resident #311 continued to have disruptive behaviors including paranoia, agitation, incessant speaking, and being accusatory toward others on the newly assigned unit. On 7/3/2023 Resident #310 punched Resident #311 on the face. Resident #310 stated they hit Resident #311 because they (Resident #311) used foul language toward them. Resident #311 sustained a three-centimeter linear scratch to the right face and an open area to the right upper ear. The finding is: The facility policy entitled Abuse Identification and Investigation, Prevention, and Reporting dated 10/31/2022 documented that the Federal definition of abuse is the willful infliction of injury with resulting physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The New York State definition of abuse is inappropriate physical contact with a resident of a residential health care facility while the resident is under the supervision of the facility, which harms or is likely to harm the resident. The facility will be cognizant to identify trends in the behaviors of residents that are likely to provoke situations that could lead to abuse and to care plan those behaviors with individualized and appropriate interventions. -Resident #310 was admitted to the facility with the diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #310 had a Brief Interview for Mental Status score of 5, indicating severely impaired cognition. Resident #310 was independent in bed mobility, transfers, and walking. Resident #310 had no behaviors noted on the minimum data set assessment. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Medical Note dated 6/1/2023 documented Resident #310 was noted to be hallucinating therefore urine culture was done along with a psychiatric evaluation. Resident #310 was noted with a history of Anxiety, Depression, and previous psychiatric hospitalization in 2020. Resident #310 with a negative work-up for infection, remains calm, and cooperative with no further Psychosis. Resident #310 is to continue with Risperdal (an antipsychotic medication) 3 milligrams, monitor, and supportive care for now. The Behavior care plan for Resident #310 dated 7/4/2023 documented that Resident #310 was at risk for resident-to-resident altercation related to confusion, impaired judgment, and mood disorder. Interventions included to keep Resident #310 away from other residents exhibiting physical/verbal behavioral symptoms directed towards others, Redirect/Refocus attention by offering alternatives, keep engaged in varied activities to reduce the possible chance of wandering into the space or room of residents exhibiting physical/verbal behavioral symptoms directed towards others, 1:1 observation for 48 hours. Resident #310's medical record lacked documented evidence of an altercation on 7/2/2023 between Resident #310 and Resident #311. The Resident Accident and Incident Report dated 7/3/2023 for Resident #310 documented that at 6:10 PM a Resident-to-Resident incident occurred. Registered Nurse Supervisor # 5 was called to Unit B by Certified Nurse Aide #7 for an altercation between Resident #310 and Resident #311. Certified Nurse Aide #7 reported that Resident #310 punched Resident #311 in the face after Resident #311 cursed at Resident #310. Resident #310 was alert, confused, calm, and cooperative. Resident #310's statement documented I hit [Resident #311] because [they] said F you. -Resident #311 was admitted to the facility with the diagnoses of Coronary Artery Disease, Depression, and bipolar disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #311 had a Brief Interview for Mental Status score of 15, indicating intact cognition. The Minimum Data Set assessment documented that Resident #311 had verbal behaviors directed towards others. Resident #311 also rejected care and wandered. Resident #311 had impairment on one side at the lower extremity. Resident #311 used a walker and wheelchair for mobility. The Behavior care plan for Resident #311 dated 7/16/2022 and last revised on 5/17/2023 documented that Resident #311 exhibited disruptive behavior including verbal symptoms directed toward others (threatening others, screaming at others, and cursing), cursing and screaming at nursing staff, as well as rolling their (Resident #311) wheelchair around the nursing station to disturb nurses during their med passes. The interventions included to keep Resident #311 within viewing distance for observation as much as possible, redirect and refocus the resident's attention by offering alternatives (comfort foods or engaging in individual therapy). A review of progress notes from 4/5/2023 to 5/2/2023 revealed that Resident #311 presented with paranoid and disruptive behaviors. Resident #311 was noted with intrusive behavior such as attempts to enter other resident rooms, antagonizing other residents, excessive talking, inappropriate outbursts, and mocking other residents. On 5/2/2023, Resident #311 was noted screaming at another resident while sitting outside of the resident's room. Resident #311 made accusations against the resident and was not responsive to redirection. Resident #311 was sent to the emergency room for evaluation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Social Work progress note dated 5/3/2023 documented that Resident #311 continued to present with increased behavioral symptoms as evidenced by verbal disruption, intrusiveness, and threatening and accusatory behaviors. It was difficult to redirect the resident. The resident is provided with ongoing reminders/cueing/re-direction/reality orientation; however, behaviors persisted. As per the interdisciplinary team's recommendation Resident #311 will be temporarily moved to another unit today. Staff will continue to observe the resident for changes in mood and/or behavior and validate concerns. A review of progress notes from 5/4/2023 to 6/27/2023 (after the resident was moved to Resident #310's unit) revealed that Resident #311 continued to present with disruptive behaviors including paranoia, agitation, incessant speaking, and accusatory towards others. Resident #311 was also noted to be interruptive to other people's conversations while wheeling themselves around the facility. The Resident Accident and Incident Report dated 7/3/2023 for Resident #311 documented that at 6:10 PM a Resident-to-Resident incident occurred. Registered Nurse Supervisor #5 was called to Unit B by Certified Nurse Aide #7 for an altercation between Resident #310 and Resident #311. Certified Nurse Aide #7 reported that Resident #311 was punched by Resident #310 while passing each other in the hallway. Resident #311 was found in the wheelchair in the hallway agitated and uncooperative. Resident #311 had an approximately 3-centimeter linear scratch to the right side of the face and a pinpoint open area to the right upper ear. Resident #310's statement documented [Resident #310] punched me for no reason. The updated Investigative Summary concluded Resident #310 did have intentional contact with Resident #311. The investigation revealed that there is no cause to believe abuse has occurred. Certified Nurse Aide #7 was interviewed on 4/19/2024 at 3:29 PM. Certified Nurse Aide #7 stated they were the regularly assigned Certified Nurse Aide for Resident #311 on the 3:00 PM to 11:00 PM shift since the resident moved to Unit B on 5/3/2023. Certified Nurse Aide #7 stated that Resident #311 had episodes of screaming at others and would sometimes be in a bad mood. Certified Nurse Aide #7 stated that on 7/3/2023 at about 6:00 PM, they (Certified Nurse Aide #7) were serving dinner and heard Resident #310 and Resident #311 yelling back and forth. Certified Nurse Aide #7 overheard Resident #311 say F-you very loudly. Certified Nurse Aide #7 then observed Resident #310 and Resident #311 throwing fists at each other. Certified Nurse Aide #7 stated they (Certified Nurse Aide) immediately separated the residents and called for help. Certified Nurse Aide #7 confirmed that Resident #311 was punched in the face by Resident #310. Registered Nurse Supervisor #5 was interviewed on 4/22/2024 at 10:51 AM and stated that they responded to the incident on 7/3/2023. Registered Nurse Supervisor #5 stated that Resident #311 was struck by Resident #310. Resident #310 told Registered Nurse Supervisor #5 that Resident #311 was always bothering Resident #310 and that is why Resident #310 reacted by punching Resident #311. Registered Nurse Supervisor #5 stated that Resident #311 had a history of behavioral issues and was very persistent and difficult to redirect. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Director of Nursing Services was interviewed on 4/22/2024 at 1:50 PM and stated that on 7/3/2023, they got a call from the Administrator that Resident #310 and Resident #311 had an altercation. When the Director of Nursing Services arrived at the facility, the Administrator had already called the local police for assistance. The Director of Nursing Services stated Resident #311 had a scratch on the right side of their head. Resident #311 was encouraged to go to the hospital but refused. Resident #311 was upset about the situation, saying [Resident #310] punched me for no reason. The Director of Nursing Services stated that Resident #310 admitted to punching Resident #311 because Resident #311 cursed at Resident #310. The Director of Social Work was interviewed on 4/22/2024 at 3:35 PM. The Director of Social Work stated that Resident #311 had consistent behavior of interjecting in other people's conversations and boisterousness with other residents. Resident #311 was difficult to redirect and required to be kept within viewing distance to help avoid potential conflicts with other residents. The Director of Nursing Services was re-interviewed on 4/22/2024 at 3:55 PM. The Director of Nursing Services stated Resident #310 did abuse Resident #311 when Resident #310 hit Resident #311 on 7/3/2023. The Director of Nursing Services stated that in the Incident Report summary dated 7/3/2023, they erroneously documented that the altercation between Resident #310 and Resident #311 was not abuse. The Director of Nursing Services stated that when they reported the incident to the New York State Department of Health they indicated the altercation between Resident #310 and Resident #311 resulted in abuse for Resident #311. The Director of Nursing Services further stated that the incident between Resident #310 and Resident #311 resulted in abuse for Resident #311. 415.4(b)(1)(ii)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/16/2024 and completed on 4/23/2024, the facility did not ensure that a comprehensive person-centered care plan was implemented for each resident that includes measurable objectives and timeframes to meet resident's medical and nursing needs. This was identified for one (Resident #16) of one resident reviewed for position and mobility. Specifically, Resident #16 had a physician's order for a hip abduction flexion contracture cushion (abduction pillow) to be worn at all times. During observations on 4/17/2024 at 9:00 AM and on 4/19/2024 at 9:00 AM Resident #16 was observed in bed without a hip abduction flexion contracture cushion. The finding is: The facility's policy titled, Assistive Devices last revised 11/2022 documented nursing staff is responsible for ensuring the wearing schedule for assistive devices is followed. Conduct skin inspection at a minimum every shift unless otherwise ordered. Nursing or any other clinical discipline shall report any adverse reaction from the assistive device such as redness, discomfort, discoloration, excoriation, etc to the Occupational or Physical Therapist. Resident #16 was admitted with diagnoses including a Fracture of the Left Femur, Dementia, and Cardiomyopathy. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 3, indicating the resident had severe cognitive impairment. The Minimum Data Set documented the resident had functional limitations in the range of motion to both lower extremities. The Comprehensive Care Plan (CCP) titled, Fracture of Left Hip dated 6/02/2023 documented interventions including a hip abduction pillow to be worn as tolerated for positioning and to prevent contractures. The hip abduction pillow is to be removed for skin checks and hygiene. The Physical Therapist's Evaluation and Plan of Treatment dated 8/11/2023 documented the resident maintains their hip in an adducted and flexed position requiring the need for a hip abduction wedge for positioning. The Physical Therapist's Discharge Summary dated 8/31/2023 documented a recommendation for a hip abduction flexion contracture cushion while in bed and to remove it for skin checks and hygiene. The Comprehensive Care Plan titled, Activities of Daily Living effective 9/01/2023 documented an intervention for the placement of a pillow between knees when in bed for comfort as tolerated. A Physician's order dated 2/20/2024 and last renewed on 4/05/2024 documented the hip abduction flexion contracture cushion to be worn at all times in bed and the Geri chair; remove for skin checks/hygiene. On 4/17/2024 at 9:00 AM, Resident #16 was observed curled up in bed. The resident was not wearing the hip abduction flexion contracture cushion. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/19/2024 at 9:00 AM, Resident #16 was observed in bed with no hip abduction flexion contracture cushion in place. Certified Nursing Assistant #2 was interviewed on 04/19/2024 at 9:04 AM and stated that Resident #16 often removes and puts the hip abduction flexion contracture cushion on the floor. The Certified Nursing Assistant located the hip abduction flexion contracture cushion in Resident #16's closet. The Certified Nursing Assistant stated the hip abduction flexion contracture cushion was on the floor when they came in to provide care and they put the hip abduction flexion contracture cushion in the closet. Certified Nursing Assistant #2 stated they did not notify anyone regarding the resident's behavior of removing the abduction pillow. Certified Nursing Assistant #2 then asked the resident if they (Certified Nursing Assistant #2) could place the hip abduction flexion contracture cushion on them and the resident refused. Certified Nursing Assistant #2 stated they would notify the nurse that Resident #16 refused their hip abduction flexion contracture cushion. Registered Nurse #4, the Unit Manager, was interviewed on 4/19/2024 at 9:06 AM and stated they were not aware that Resident #16 refused the hip abduction flexion contracture cushion. Registered Nurse #4 stated the Certified Nursing Assistants should have notified them of the resident's refusal to use the abduction pillow. They would have then notified the Rehabilitation department to re-evaluate the resident. The Occupational Therapy Evaluation and Plan of Treatment dated 4/19/2024 documented Splint /Orthotic Recommendations: It is recommended the [resident] continue to wear the current device with current orders as [resident] was able to tolerate today without [complaint of] pain or discomfort. Physical Therapist #1 was interviewed on 4/22/2024 at 9:30 AM and stated Resident #16 has both hips and leg contractures and was recommended by the Rehabilitation Therapy Department to use the hip abduction flexion contracture cushion upon discharge from therapy on 8/31/2023. The cushion is utilized to keep the hips from rotating and the legs from contracting. If Resident #16 was refusing the hip abduction flexion contracture cushion, the nursing staff should have notified the Physical Therapy department to re-evaluate the resident for alternate devices. The Director of Nursing Services was interviewed on 4/23/2024 at 9:22 AM and stated Resident #16 had been refusing the hip abduction flexion contracture cushion; the Physical Therapy Department was alerted on 4/19/2024. The Director of Nursing Services stated the nurses were expected to notify the resident's Physician and/or Physical Therapist to re-evaluate Resident #16 for alternative devices. 10 NYCRR 415.11(c)(1)

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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. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/16/2024 and completed on 4/23/2024, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles. This was identified for one (Resident #312) of four residents reviewed for medication administration. Specifically, during the medication pass observation on 4/17/2024 for Resident #312, the labels on the medication blister packs, for physician-prescribed Allopurinol (a medication to reduce uric acid to treat gout and kidney stones) and Torsemide (a diuretic to help reduce fluid in the body), did not match the physician orders. The finding is: The facility's policy titled, Pharmacy, dated June 2018, documented the facility utilizes its pharmaceutical services system to ensure the safe and effective use of medications for all our residents; this facility does not have an in-house pharmacy; this facility uses a blister pack system; Medications no longer in use shall be returned for credit or destroyed in accordance with established policies and procedures. The facility's policy titled, Medication: Administration-General dated December 2021, documented the nurse will review the physician's orders and compare them against the medication administration record. Compare the medication name, strength, and dosage schedule on the medication administration record against the prescription label. Resident #312 was admitted with diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Peripheral Vascular Disease. The 4/9/2024 nursing admission assessment documented that the resident was alert to person, place, time, and situation. A physician's order dated 4/11/2024 documented Allopurinol, 100 milligrams tablet, give 2 tablets (200 milligrams) by oral route once daily at 8:00 AM for a diagnosis of Gout. A physician's order dated 4/11/2024 documented Torsemide 20 milligrams tablet, give 1 tablet (20 milligrams) by oral route once daily at 8:00 AM for diagnosis of Hypertension. During the medication pass observation for Resident #312, performed by Licensed Practical Nurse #1, on 4/17/2024 at 8:34 AM, the blister pack label for Allopurinol documented 100 milligrams tablet, give one tablet every 12 hours. The delivery date on the blister pack was 4/9/2024. The blister pack label for Torsemide documented 20 milligrams tablet, give two tablets by mouth daily. The delivery date on the blister pack was 4/10/2024. Licensed Practical Nurse #1 acknowledged the blister pack labels did not match the physician's orders and would report this to the supervisor. Licensed Practical Nurse #1 administered the medications as per the physician's order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #1 was re-interviewed on 4/17/2024 at 10:48 AM and stated if there was a discrepancy between the physician's order and the medication label, they would report the discrepancy to the nursing supervisor and the supervisor would contact the pharmacy. Licensed Practical Nurse #1 stated they have not reported the discrepancy to the supervisor yet. Registered Nurse Supervisor #1 was interviewed on 4/17/2024 at 10:50 AM regarding the observed discrepancy between the physician order and the blister pack labels. Registered Nurse Supervisor #1 stated when there is an order change, the pharmacy is supposed to send a new blister pack; when there is a change in the physician's orders the facility does not use see the medication administration record labels to be put on a blister pack to indicate changes in the physician's orders. Registered Nurse Supervisor #1 stated if the pharmacy does not send the new blister pack, the facility staff should follow up with the pharmacy. Registered Nurse Supervisor #1 stated the medication nurses have to bring the discrepancy to their attention and they would then call the pharmacy. An email correspondence with pharmacy representative #1 dated 4/17/2024 at 1:10 PM documented, an every-12-hour Allopurinol order blister pack was last provided on 4/9/2024; the order was changed to once a day on 4/11/2024 and the facility was expected to use the supply on hand. A new supply blister pack of Torsemide was delivered on 4/12/2024 that matched the physician's order. Registered Nurse Supervisor #1 was re-interviewed on 4/17/2024 at 2:01 PM and stated the facility just received stickers to put on the medication label that document: see the medication administration record. Registered Nurse Supervisor #1 stated Putting stickers on a blister pack is new to me. Registered Nurse Supervisor #1 stated the sticker will be placed on the Allopurinol blister pack. Regarding the Torsemide, Registered Nurse Supervisor #1 stated they were not aware that a new supply for Torsemide was delivered on 4/12/2024. Registered Nurse Supervisor #1 and Licensed Practical Nurse #1 checked the medication cart and found the not-yet-started Torsemide blister pack that was delivered on 4/12/2024. The Director of Nursing Services was interviewed on 4/18/2024 at 8:04 AM and stated they were not sure of the facility's policy regarding when there is a discrepancy between the physician's order and the medication label; however, they thought the nurses should put a see the medication administration record label on the medication when a physician's order is changed and the medication supply on hand has to be utilized or reach out to the pharmacy to rectify the discrepancy. 10 NYCRR 415.18(e) (1-4)