STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335239	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clove Lakes Health Care and Rehab Center, Inc	25 Fanning Street Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on observation, record reviews, and interviews conducted during survey, the facility failed to ensure that resident was free from neglect. This was evident for one (1) of five (5) residents (Resident #1) sampled. Specifically, the facility failed to ensure Registered Nurse #1 or other direct care service providers (Certified Nursing Assistant #1) provided Resident #1 with goods, services and care that were necessary to prevent physical harm. On [DATE], Registered Nurse #1 neglected to ensure that Resident #1, who had an order for continuous oxygen, received significant medications and treatments that were scheduled for 4:00 PM, 8:00 PM and 9:00 PM. In addition, Certified Nursing Assistant #1 neglected to provide hourly monitoring of Resident #1 who was assessed as at risk for falls and to ensure the resident had received and ate dinner. At 9:49 PM on [DATE], Resident #1 was found unresponsive on the floor face down with no pulse and no breathing. Cardiopulmonary resuscitation was initiated until Emergency Medical Services(911) arrived at 10:07 PM and assumed care. Resident #1 expired at 10:24 PM. This resulted in actual harm to Resident #1 that was Immediate Jeopardy. The findings are: A review of the facility's policy, Prevention/Identification and Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident's Property with a review date [DATE], documented residents must not be subjected to abuse, neglect, exploitation, mistreatment and misappropriation of residents' property by anyone. It is the policy of the facility to report any suspected patient verbal and/or physical abuse, neglect, exploitation, mistreatment and misappropriation of resident's property occurring within the facility. The term neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A review of the facility's policy, Accident Prevention Program with a review date of [DATE], documented an accident is defined as an event which results in serious bodily harm, such as fractures, lacerations which require closure, second- or third-degree burns or any other requiring admission to a hospital. The Licensed Nurse and/or Nursing Supervisor reviews/revises resident's plan of care as needed. Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, (poor air flow to the lung), diabetes mellitus, (high sugar in the blood), and heart failure (heart muscle does not pump enough blood). The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #1's cognition was intact. Resident #1 required supervision/touching assistance with activities of daily living care. Resident #1 required continuous oxygen therapy. A review of Fall Risk Evaluation dated [DATE] identified Resident #1 at high risk for falls. Resident #1 had a history of falls in the facility.A review of the Comprehensive Care Plan for At Risk of Abuse, Neglect, with a review date of [DATE] documented interventions to allow Resident #1 to express feelings of being fearful and anxious, as necessary. Provide physical and emotional support for resident safety. A review of the Comprehensive Care Plan for At Risk of Falls, with a review date of [DATE] documented interventions for staff to anticipate and meet resident's needs, ensure resident's call light is within reach and encourage to use it for assistance as needed. Ensure a clean and dry environment. A review of the Order Summary Report (Physician's orders) from [DATE] (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	through [DATE] revealed Resident #1 had orders for Fluticasone-Salmeterol inhalation aerosol two (2) times daily and Incruse Ellipta inhalation aerosol one (1) time a day for chronic obstructive pulmonary disease, Metformin 500 milligram tablet two (2) times daily for diabetes mellitus, and Sertraline 100 milligram two (2) times daily for major depressive disorder, Varenicline Tartrate 1 milligram every 12 hours for smoking cessation, Atorvastatin 20 milligram one (1) tablet at bedtime for high fat level in the blood Quetiapine Fumarate (antipsychotic medication) 300 milligram 1 tablet at bedtime for major depressive disorder, Trazodone 100 milligram tablet at bedtime for depression, and oxygen at 3-liters per minute via nasal cannula continuously every shift for chronic obstructive pulmonary disease. A review of the Medication Administration Record dated [DATE] for the evening shift (3:00 PM-11:00 PM) showed Resident #1 was scheduled to receive the above medications at 4:00 PM, 8:00 PM, and 9:00 PM. There was no documented evidence Resident #1 received any medications or treatment during the evening shift on [DATE]. A review of a Task List Report (instructions for certified nursing assistants) dated [DATE] revealed Resident #1 was placed on hourly visual checks for safety. This plan was in place until the date of the incident ([DATE]). There was no documented evidence Resident #1 was provided hourly monitoring from 2:45 PM to 9:40 PM on [DATE].A review of the nutritional intake form dated [DATE] revealed no documented evidence that Resident #1 had been served a meal or snack from 2:45 PM to 9:40 PM on [DATE].A review of the visitor's log dated [DATE] revealed there was no documented evidence that a visitor had visited Resident #1. The nursing progress note by Registered Nurse #1 dated [DATE] at 11:53 PM documented at 9:49 PM Resident #1 was found on the floor unresponsive with no pulse, no breathing, called STAT (an action must be taken immediately) at 9:50 PM and cardiopulmonary resuscitation initiated right away, nonrebreather mask attached to run at 15 liters per minute. At 9:51 PM 911 was called, intravenous line inserted at right peripheral arm and normal saline 0.9 bolus started. At 10:07 PM, 911 arrived and took over. At 10:24 PM, Resident #1 was pronounced expired by Emergency Medical Services. Registered Nurse #1 notified Adult Child #1.A review of the Accident/Incident Investigation form dated [DATE] at 9:49 PM incident revealed after the investigation, the incident appears to have been related to a medical event. Resident #1 was found lying on the floor beside their bed unresponsive. No measurable vital signs were obtained. Stat was called and cardiopulmonary resuscitation initiated, and Emergency Medical Services arrived. Resident #1 was pronounced by Emergency Medical Services at 10:24 PM. On initial assessment Resident #1 had no visible injuries and skin was intact. During postmortem care a large skin tear was observed to Resident #1's right cheek. On investigation the call bell was found to be within reach but had not been activated. Bed was in lowest and locked position. Floor of the room was clean and dry, free of clutter. After investigation the interdisciplinary team determined that there is no cause to believe an alleged abuse, mistreatment, or neglect regarding this resident had occurred. There was no documentation in the incident report that from 4:15 PM to 9:48 PM Resident #1 was missing, staff were unaware of Resident #1's whereabouts until the resident was found unresponsive, Resident #1 did not receive any medications on the evening shift, and when the resident was found, they were not connected to any oxygen. There was no documentation the nursing supervisor and medical doctor were notified. During an interview on [DATE] at 3:52 PM, Adult Child #1 (complainant) stated Registered Nurse #1 called them at 9:43 PM and stated Resident #1 was missing and was asked if they had taken Resident #1 with them and they said no. Adult Child #1 stated Registered Nurse #1 called them again (unsure of time) and stated they found Resident #1 unresponsive beside their bed. Adult Child #1 stated they arrived in the facility, and they stated Resident #1 expired at 10:24 PM. Adult Child #1 stated they observed skin peeled off Resident #1's right side of face that looked like a burned skin injury. Adult Child #1 stated they asked Registered Nurse Supervisor #1 about the facial injury, and they stated that the Emergency Medical Services had caused the injury. During an interview on [DATE] at 2:37 PM, Registered Nurse #1 stated they arrived on the unit on [DATE] at 4:15 PM and did not see Resident #1 on the unit during their rounds. Registered Nurse #1 stated they received information (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(unsure of staff to whom they received it) that Resident #1 had a visitor. Registered Nurse #1 stated they did not look for Resident #1 (thinking they were with visitor) and continued to work. Registered Nurse #1 stated they were not sure if Resident #1 came back in the unit and started looking for them at 9:40 PM and briefly looked in Resident #1's room and did not see them. Registered Nurse #1 stated that at approximately 9:43 PM, they called the Adult Child #1 and asked if they had taken Resident #1 with them and was told no. Registered Nurse #1 stated they immediately contacted Registered Nurse Supervisor #1 to inform them that they could not locate Resident #1. Registered Nurse #1 stated they started the search in Resident #1's room again and at 9:49 PM, they found Resident #1 unresponsive beside their bed face down on the floor. During an interview on [DATE] at 6:02 PM, Certified Nursing Assistant #1 stated they worked on [DATE] from 3:00 PM-11:00 PM and was assigned to the care of Resident #1. Certified Nursing Assistant #1 stated when they received their assignment at 3:30 PM, they observed Resident #1 in their room sitting on their bed. Certified Nursing Assistant #1 stated they did not see a visitor for Resident #1 in the room. Certified Nursing Assistant #1 stated Resident #1 used the call light when they needed assistance. Certified Nursing Assistant #1 stated they did not serve a dinner tray to Resident #1 because they were serving residents on the other side of the unit. They stated that they did not know if Resident #1 ate or not. Certified Nursing Assistant #1 stated they did not ask the other certified nursing assistant if Resident #1 ate. Certified Nursing Assistant #1 stated they are supposed to check Resident #1 during meals and document. Certified Nursing Assistant #1 stated they did not perform hourly checks on Resident #1. They stated that the second time they checked Resident #1 was at approximately 8:30 PM in their room. They stated that they asked Resident #1 if they needed anything and they said they were okay. Certified Nursing Assistant #1 stated Registered Nurse #1 did not communicate with them that Resident #1 was missing and never had communication with Registered Nurse #1 during their shift. During an interview on [DATE] at 5:43 PM, Registered Nurse Supervisor #1 stated they were the assigned unit supervisor on the date of the incident. Registered Nurse Supervisor #1 stated Registered Nurse #1 called the nursing office on [DATE] (time unknown) and reported that Resident #1 was not in bed, the wheelchair was there but the room was empty. Registered Nurse Supervisor #1 stated together with the other supervisors they immediately responded to the unit to search but when they arrived in the unit, Registered Nurse #1 and other staff had already found Resident #1. Registered Nurse Supervisor #1 stated they observed Resident #1 laying on the floor face down and when they turned them on their back, Resident #1 had no pulse, was not breathing, called a stat and started cardiopulmonary resuscitation at 9:50 PM, and notified Medical Doctor #1 (unsure of time). Registered Nurse Supervisor #1 stated they did not notice blood on the floor and the skin on Resident #1's face was intact. Registered Nurse Supervisor #1 stated the Emergency Medical Services arrived on the unit at 10:07 PM and took over. Registered Nurse Supervisor #1 stated Emergency Medical Services intubated Resident #1. Registered Nurse Supervisor #1 stated after Emergency Medical Services left they observed the skin on the right side of Resident #1's face peeled off and looked like an open blister. Registered Nurse Supervisor #1 stated Medical Emergency Services pronounced Resident #1 expired at 10:24 PM. Registered Nurse Supervisor #1 stated they spoke to Registered Nurse #1, and they did not report Resident #1 was initially missing or how long the resident was missing. Registered Nurse Supervisor #1 stated they were not aware Resident #1 did not receive their scheduled evening medications on [DATE].During an interview on [DATE] at 7:10 PM, Registered Nurse Supervisor #2 stated they also responded to the call of Registered Nurse #1 on [DATE] (unsure of time). Registered Nurse Supervisor #2 stated they immediately responded to do the search on the unit but when they arrived at the unit, Resident #1 was found already laying on the floor unresponsive at the right side of their bed. Registered Nurse Supervisor #2 stated they did not observe oxygen connected to Resident #1's nose.During an interview on [DATE] at 4:17 PM, the Infection Control Director stated they were the on-call staff person responsible for covering the weekend on [DATE] during the evening when incident occurred. Infection Control Director stated they received a call report from Registered Nurse (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Supervisor #2 stating that Resident #1 could not be found, and the family was called. Infection Control Director stated this information should have been reported in the morning report on [DATE] (Monday) and it should have been included in the accident/incident report.During an interview on [DATE] at 3:14 PM, Director of Nursing stated that on [DATE] between 2:00 AM to 3:00 AM, they received a message from Registered Nurse Supervisor #1 through hospitalization chat (group chat) that on [DATE] at 9:49 PM, Resident #1 was found on the floor unresponsive, a stat was called, cardiopulmonary resuscitation was initiated until Emergency Medical Services took over the scene and pronounced Resident #1 expired at 10:24 PM. The Director of Nursing stated that not until [DATE] were they notified that Resident #1 had been reported missing by nursing staff. The Director of Nursing stated that the Infection Control Director was on duty, and it was initially reported to them. The Director of Nursing stated that the Infection Control Preventionist failed to report this information to them during the morning meeting on [DATE]. The Director of Nursing reviewed the certified nursing assistant accountability record for the [DATE] from 3:00 PM-11:00 PM shift and acknowledged that there was no documentation for hourly safety checks, or meal consumption. The last documentation was 2:45 PM for hourly safety checks. The Director of Nursing also reviewed the medication administration record and stated that it revealed that there were no medications administered to Resident #1 from 4:00 PM to 9:49 PM the time they were found. During an interview on [DATE] at 4:00 PM, The Administrator stated the first time they were made aware of the incident was through the hospitalization chat received on [DATE] at 12:20 AM by Registered Nurse Supervisor #1 that Resident #1 was found unresponsive on [DATE] at 9:49 PM. The Administrator stated they were not made aware Resident #1 had not been seen by nursing and direct care staff for hours or that the resident had not received ordered medications, or treatments or a meal because staff thought the resident was missing or out with family During an interview on [DATE] at 1:37 PM, the Medical Director stated they never heard Resident #1 was missing for several hours on [DATE] on the evening shift. The Medical Director stated they were not made aware that Resident #1 was missing prior to [DATE]. The Medical Director stated they were not made aware of the incident on [DATE], but they became aware after a day or two (2) after, through the hospitalization chat received. The Medical Director stated they did not review the chart. They were not made aware Resident #1 did not receive medications scheduled for 4:00 PM through 9:00 PM until [DATE]. The Medical Director stated they cannot opine whether Resident #1 missing one (1) cycle of medications caused them to collapse and expire. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)On [DATE] at 4:39 PM, Immediate Jeopardy was identified and declared. The Director of Nursing and Quality Assurance Performance Improvement Coordinator were notified.The Director of Nursing returned the signed IJ Template on [DATE] at 5:30 PM. On [DATE] at 6:39 PM, the facility presented a removal plan that listed the immediate action the facility would take to prevent serious harm from occurring or recurring. The removal plan was accepted on [DATE] at 6:53 PM.The facility revised removal plan was accepted on [DATE] at 8:31 PM. Based on observation, interviews, and record review, the facility completed implementation of the removal plan on [DATE] at 5:00 PM. Immediate Jeopardy was lifted based on the following corrective actions taken by the facility: Registered Nurse #1 was terminated on [DATE]. Certified Nursing Assistant #1 was terminated dated [DATE]. A facility wide headcount and room-to-room safety check was completed on [DATE]. All 572 residents were immediately accounted for and assessed for safety and supervision needs. All 572 residents were immediately accounted for and assessed for safety and supervision needs. Dinner on [DATE] was observed and noted to have been served. Meals served audit dated [DATE] to [DATE]. The Administrator and the Medical Director were notified of identified care gaps on [DATE] at 5:00 PM. A meeting was conveyed immediately on [DATE] with Registered Nurse Supervisors with Nursing Leadership, reinforcing rounding and communication protocols. Immediate audit of medication administration practices and all were noted to be administered on [DATE]. Review of Policy and Procedures on [DATE] and no changes were made Abuse/neglect prevention (F600), Missing (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident Procedures and Medication Administration. Facility-wide education on Abuse, Neglect, and Mistreatment, Rounding on Residents, Code Orange-Missing Resident, and Missed Medication Administration were initiated. The lesson plan and Facility-wide education on Abuse, Neglect, and Mistreatment, Rounding on Residents, Code Orange-Missing Resident, and Missed Medication Administration were initiated dated [DATE] to [DATE]. Staff attendance sheet received and reviewed. Total staff: 642, Total In-service : 642, Overall Percentage : 100 % Certified nursing assistants will be educated to ensure that missed meals are documented and reported to the Unit Nursing Supervisor on [DATE] to [DATE]. It was determined by the State Agency that the facility fully implemented their plan to abate the immediate jeopardy as of [DATE] at 5:00 PM.

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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 reviews, and interviews, conducted during survey, the facility failed to ensure that all alleged violations involving abuse, exploitation, or mistreatment, including injuries of unknown source are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident for one (1) of five (5) residents (Resident #1) sampled. Specifically, on [DATE], Registered Nurse #1 arrived in the unit at 4:15 PM and was informed by staff (unsure of staff) that Resident #1 had a visitor. Registered Nurse #1 did not check for Resident #1 until 9:40 PM and was unable to locate Resident #1 to give their medication. At 9:49 PM, Resident #1 was found unresponsive on the floor face down with no pulse and no breathing. Resident #1 was pronounced expired by Emergency Medical Services. The facility did not report the alleged allegation of abuse to New York State Department of Health.The findings include: A review of the facility's policy titled Prevention/Identification and Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident's Property with a review date [DATE] documented, all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to New York State Department of Health.Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (poor air flow to the lung), diabetes mellitus (high sugar in the blood), and heart failure (heart muscle do not pump enough blood), and Resident #1 was receiving continuous oxygen.A review of the Minimum Data Set (a resident assessment tool) dated on [DATE] documented that Resident #1's cognition was intact and required supervision/touching assistance with activities of daily living care. They received continuous oxygen therapy. A review of the Comprehensive Care Plan for at risk of abuse, neglect with a reviewed date [DATE], documented interventions allow resident to express feelings of being fearful, anxious, as necessary and provide physical and emotional support for resident safety. A review of the nursing progress notes dated [DATE] at 11:53 PM, by Registered Nurse #1 documented at 9:49 PM Resident #1 was found on the floor unresponsive with no pulse, no breathing, emergency was called at 9:50 PM and cardiopulmonary resuscitation initiated. At 9:51 PM, emergency 911 was called. At 10:07 PM, 911 arrived and took over. At 10:24 PM, Resident #1 was pronounced expired by Emergency Medical Services. Registered Nurse #1 notified Adult Child #1.A review of the nursing progress notes, and accident/incident investigation form dated [DATE], revealed there was no documented evidence that Resident #1 was missing from 4:15 PM until 9:48 PM. There was no documentation that nursing supervisor and medical doctor were notified. A review of the Accident/Incident Investigation form dated [DATE] at 9:49 PM, documented after the investigation the incident appears to have been related to a medical event. Resident #1 was found lying on the floor beside their bed unresponsive. No measurable vital signs were obtained. Emergency help was called and cardiopulmonary resuscitation initiated, and Emergency Medical Services (911) arrived. Resident #1 was pronounced by Emergency Medical Services at 10:24 PM. On initial assessment Resident #1 had no visible injuries and skin was intact. During postmortem care a large skin tear was observed to Resident #1's right cheek. On investigation the call bell was found to be within reach but had not been activated. Bed was in lowest and locked position. Floor of the room (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was clean and dry, free of clutter. After investigation the interdisciplinary team determined that there is no cause to believe an alleged abuse, mistreatment, or neglect regarding this resident has occurred. Therefore, the allegation of abuse was not investigated or reported to the Department of Health.During an interview on [DATE] at 3:14 PM, Director of Nursing stated the facility utilizes a hospitalization group chat and they saw a message approximately on [DATE] between 2:00 AM to 3:00 AM from Registered Nurse Supervisor #1 that Resident #1 was found on the floor unresponsive on [DATE] at 9:49 PM, emergency was called, cardiopulmonary resuscitation was initiated until the 911 emergency took over the scene and pronounced Resident #1 expired at 10:24 PM. Director of Nursing stated they were not notified of Resident #1 reported missing prior to the incident and they heard it only yesterday ([DATE]). Director of Nursing stated the Infection Control Director, aware of the Resident #1 was reported to them initially missing and was not reported to them in the morning meeting on [DATE]. Director of Nursing stated looking at the Certified Nursing Assistant accountability on [DATE] from 3:00 PM-11:00 PM shift; there was no documentation for dinner, the hourly safety checks the last documentation was 2:45 PM meaning Resident #1 was not accounted for and reviewing the medications administration record that there were no medications received by Resident #1. Director of Nursing stated with all of this information and if it was investigated thoroughly the investigation would draw a different conclusion. Therefore, the allegation of abuse or neglect was not investigated or reported to the Department of Health.During an interview on [DATE] at 4:00 PM, Administrator stated the first time they made aware of the incident was through the hospitalization chat received on [DATE] at 12:20 AM. Administrator stated they were not aware that Resident #1 was initially missing prior to the incident, not aware that Resident #1 was not monitored hourly, had no record if they had eaten their dinner meal and not received their medication at 4:00 PM to 9:00 PM, not aware when Registered Nurse #1 has not seen Resident #1 from 4:15 PM, had called the Adult Child #1 to look for Resident #1 and called the Registered Nurse Supervisor #1 to report they were missing. Administrator stated they made aware of Resident #1 that they were initially missing yesterday [DATE]. The Administrator stated it was not reported to Department of Health because they were not aware of the other information that was left out in the investigation. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that alleged violations involving abuse were thoroughly investigated. This was evident for one (1) of five (5) residents (Resident #1) sampled. Specifically, on [DATE] Registered Nurse #1 arrived in the unit at 4:15 PM and was informed by staff (unsure of staff) that Resident #1 had a visitor. Registered Nurse #1 did not check for Resident #1 until 9:40 PM to give their medications and did not locate Resident #1. At 9:49 PM, Resident #1 was found unresponsive on the floor face down with no pulse and no breathing. Resident #1 was pronounced deceased by Emergency Medical Services. The facility did not conduct a thorough investigation to ascertain how Resident #1 was found to be unresponsive.The findings are:A review of the facility's policy on Prevention/Identification and Reporting of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident's Property with a reviewed date [DATE], documented Residents of the facility will be protected from abuse, neglect, mistreatment, and misappropriation of property in accordance with State and Federal regulations. The policy also documented all alleged or suspected incidents of abuse, neglect, mistreatment or misappropriation of resident's property will be thoroughly investigated and findings documented and reported.Resident #1 was admitted to the facility with diagnosis including chronic obstructive pulmonary disease, respiratory failure, and diabetes mellitus. A review of the Minimum Data Set (a resident assessment tool) dated [DATE] documented that Resident #1's cognition was intact and required supervision/touching assistance with activities of daily living care. They received continuous oxygen therapy. A review of the nursing progress notes dated [DATE] at 11:53 PM by Registered Nurse #1 documented at 9:49 PM Resident #1 was found on the floor unresponsive with no pulse, no breathing, called emergency call was made at 9:50 PM and cardiopulmonary resuscitation initiated right away. At 9:51 PM 911 was called, At 10:07 PM, 911 arrived and took over. At 10:24 PM, Resident #1 was pronounced expired by Emergency Medical Services. Registered Nurse #1 notified Adult Child #1.A review of the nursing progress notes, and accident/incident investigation form dated [DATE], revealed there was no documented evidence that Resident #1 was missing from 4:15 PM until 9:48 PM. There was no documentation that nursing supervisor and medical doctor were notified. A review of the Accident/Incident Investigation form dated [DATE] at 9:49 PM, incident documented after the investigation the incident appears to have been related to a medical event. Resident #1 was found lying on the floor beside their bed unresponsive. No measurable vital signs were obtained. Emergency was called and cardiopulmonary resuscitation initiated, and Emergency Medical Services (911) arrived. Resident #1 was pronounced by Emergency Medical Services at 10:24 PM. On initial assessment Resident #1 had no visible injuries and skin was intact. During postmortem care a large skin tear was observed to Resident #1's right cheek. On investigation the call bell was found to be within reach but had not been activated. The bed was in lowest and locked position. The floor of the room was clean and dry, free of clutter. After investigation the interdisciplinary team determined that there is no cause to believe an alleged abuse, mistreatment, or neglect regarding this resident has occurred. The facility did not conduct a thorough investigation to ascertain how Resident #1 was found to be unresponsive.During an interview on [DATE] at 4:37 PM, Assistant Director of Nursing stated they were Risk Management and responsible for the completion and accuracy of the incident. Assistant Director of Nursing stated they received the incident report and statement given by Infection Control Director the following day on [DATE]. Assistant Director of Nursing stated it was their first time hearing that Resident #1 was initially reported that could not be found, the Adult Child #1 was called by Registered Nurse #1 and arrived after the incident, the position how Resident #1 was found on the floor should have been included in the incident report and all of these they are expected to know . Assistant Director of Nursing stated if that information was provided to them; they would further re-investigate the incident to find out what led to the incident. During an interview on [DATE] (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clove Lakes Health Care and Rehab Center, Inc	25 Fanning Street Staten Island, NY 10314

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:14 PM, Director of Nursing stated the facility utilizes a hospitalization group chat and they saw a message approximately on [DATE] between 2:00 AM to 3:00 AM from Registered Nurse Supervisor #1 that Resident #1 was found on the floor unresponsive on [DATE] at 9:49 PM, a stat was called, cardiopulmonary resuscitation was initiated and until the 911 took over the scene and pronounced Resident #1 expired at 10:24 PM. Director of Nursing stated the Registered Nurse Supervisor #1 also notified them of the injury to Resident #'s face that when they came in the morning of [DATE] they asked the Infection came during the attempt of intubation by the Emergency Medical Services. Director of Nursing stated this was not noted in the nursing notes, but they should have documented it. Director of Nursing stated they were not notified of Resident #1 reported missing prior to the incident and they heard it only yesterday ([DATE]). Director of Nursing stated the Infection Control Director, aware of the Resident #1 was reported to them initially missing and was not reported to them in the morning meeting on [DATE]. Director of Nursing stated with all this information and if it was investigated thoroughly the investigation would draw a different conclusion. During an interview on [DATE] at 4:00 PM, Administrator stated the first time they made aware of the incident was through the hospitalization chat received on [DATE] at 12:20 AM. Administrator stated they were not aware that Resident #1 was initially missing prior to the incident, not aware that Resident #1 was not monitored hourly, had no record if they had eaten their dinner meal and not received their medication at 4:00 PM to 9:00 PM, not aware when Registered Nurse #1 has not seen Resident #1 from 4:15 PM, had called the Adult Child #1 to look for Resident #1 and called the Registered Nurse Supervisor #1 to report they were missing. Administrator stated they made aware of Resident #1 that they were initially missing yesterday only, [DATE]. Administrator stated it was not reported to Department of Health because they were not aware of the other information that was left out in the investigation and had it known, the facility would re-investigate the incident.10 New York Codes, Rules, and Regulations 415.4(b)(3)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not ensure that the Minimum Data Set assessment accurately reflected a resident's status. This was evident for five residents (Resident #6, # 7, #8, #10, and #11) out of seven total sampled residents. Specifically, the Minimum Data Set assessments for Residents #6, #7, #8, #10, and #11 did not reflect that the residents were active smokers. The findings are:The facility's policy titled Accuracy of Assessment" with a last reviewed date of 10/2025 documented it is the policy of the facility to ensure accurate assessment of all residents in accordance with Federal and State Operations Manual. The policy stated the assessment will include direct observations, and communication with the residents, as well as communication with resident and direct care staff on all shifts. 1) Resident #6 was admitted to the facility with diagnoses including chronic obstructive disease, benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland), and diabetes.During observations on 04/21/2026 at 1:00 PM and on 04/22/2026 at 1:30 PM, Resident #6 was in the smoking room seated in the wheelchair and was smoking with other residents. A Smoking Regulation Agreement dated 08/08/2024 documented Resident #6 identified as a smoker and was signed by Resident #6. A Smoking assessment dated [DATE] documented Resident #6 was a smoker.A care plan tilted Known Smoker initiated as 09/26/2024 documented Resident #6 was a smoker, and Resident will smoke safely within the designated smoking area. The Annual Minimum Data Set (an assessment tool) dated 12/29/2025 documented that Resident #6 was cognitively intact and the assessment did not document Current Tobacco Use in Section J1300.2) Resident #7 was admitted to the facility with diagnoses including chronic obstructive disease, pulmonary fibrosis, and testicular cancer.During the observations on 04/20/2026 at 10:40 AM, 1:00 PM, 4:00 PM and on 04/21/2026 at 10:00 AM, 1:00PM, and on 04/22/2026 1:00 PM, Resident #7 was in the smoking room, seated in the wheelchair and smoking with other residents. A Smoking Regulation Agreement dated 12/04/2024 documented Resident #7 identified as a smoker and was signed by Resident #7. A Smoking assessment dated [DATE] documented Resident #7 was a smoker.A nursing progress note dated 03/11/2026 at 10:01PM documented that Resident #7 was found smoking in the room while oxygen in use.A care plan tilted Known smoker initiated as 01/12/2026 documented Resident #7 was a smoker, and Resident will smoke safely within the designated smoking area. The Annual Minimum Data Set, dated [DATE] documented that Resident #7 was cognitively intact and the assessment did not document Current Tobacco Use in Section J 1300.3) Resident #8 was admitted to the facility with diagnoses including hypertension, schizophrenia, and paraplegia (the inability to voluntarily move the lower parts of the body).During the observations on 04/22/2026 at 1:30 PM and 4:00 PM, Resident #8 was in the smoking room, seated in the wheelchair and was smoking with other residents. A Smoking Regulation Agreement dated 05/23/2024 documented Resident #8 identified as a smoker and was signed by Resident #8.A Smoking assessment dated [DATE] documented Resident #8 was a smoker.A care plan tilted Known Smoker initiated on 09/10/2024 documented Resident #8 was a smoker, and Resident will smoke safely within the designated smoking area. The admission Minimum Data Set, dated [DATE] documented that Resident #8 was cognitively intact and the assessment did not document Current Tobacco Use in Section J1300.4) Resident #10 was admitted to the facility with diagnoses that included heart failure, chronic pancreatitis, and depression.During the observations on 04/20/2026 at 1:00 PM, 4:00 PM and on 04/21/2026 at 10:00 AM, and 1:00 PM, Resident #10 was in the smoking room, seated in the wheelchair and smoking with other residents. A Smoking Regulation Agreement dated 03/13/2026 documented Resident#10 identified as a smoker and was signed by Resident #10. A Smoking assessment dated [DATE] documented Resident #10 was a smoker.A care plan tilted Known Smoker initiated on 03/13/2026 documented Resident #10 was a smoker, and Resident will smoke safely within the designated smoking area. The Annual Minimum Data Set, dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] documented that Resident #10 was cognitively intact and the assessment did not document Current Tobacco Use in Section J1300.5) Resident #11 was admitted to the facility with diagnoses including hypertensive heart disease, epilepsy, and depression.During the observations on 04/20/2026 at 1:00 PM, 4:00 PM and on 04/21/2026 at 10:00 AM, 1:00 PM, Resident #11 was in the smoking room, seated in the wheelchair and smoking with other residents. A Smoking Regulation Agreement dated 05/25/2025 documented Resident #11 identified as a smoker and Resident#11's signature present. A Smoking assessment dated [DATE] documented Resident #11 was a smoker.A care plan tilted Known Smoker initiated as 08/16/2025 documented Resident #11 is a smoker, and Resident will smoke safely within the designated smoking area. The Significant Minimum Data Set assessment dated [DATE] documented that Resident #11 was cognitively intact and the assessment did not document Current Tobacco Use in Section J1300.On 04/22/2026 at 5:28 PM, Minimum Data Set Manager was interviewed and stated that the Current [NAME] Use section on Minimum Data (J1300) Assessment was completed by Minimum Data Set Department. Minimum Data Set Manager stated that they collected information from residents' assessments, staff interviews, and reviewed of the medical records to complete the Minimum Data Set assessments. Minimum Data Set Manager also stated that they obtained smoking residents' list from Recreation department for about every two weeks in regular basis and each Minimum Data Set nurse have responsible for accuracy for section of J1300 (Current [NAME] Use). Minimum Data Set Manager stated for accuracy, they check Minimum Data Set Assessment randomly for random sections for every month. Minimum Data Set Manager stated that they were not aware of the discrepancies in Resident #6, # 7, #8, #10, and #11's Minimum Data Set assessments.10 New York Codes, Rules, and Regulations 415.11(b)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during survey, the facility failed to ensure that services provided or arranged by the facility met professional standards of quality. This was evident in one (1) of five (5) residents (Resident #1) sampled. Specifically, on [DATE], Registered Nurse #1 failed to administer Resident 1's significant medications and treatments that were ordered between the hours of 4:00PM and 9:00 PM including continuous oxygen as per Physician's orders. Registered Nurse #1 did not notify the physician and Registered Nurse Supervisor #1 when the medications were not administered. Additionally, from 4:15 PM to 9:49 PM on [DATE], Registered Nurse #1 and other direct care staff were unaware of Resident #1's whereabouts until Resident #1 was found unresponsive on the floor, face down with no pulse and no breathing. Cardiopulmonary resuscitation was initiated until Emergency Medical Services (911) arrived at 10:07 PM and assumed care. Resident #1 expired at 10:24 PM. This resulted in actual harm to Resident #1 that is not Immediate Jeopardy. Cross Reference: F760 - Residents Are Free of Significant Medication ErrorsThe findings are: The facility policy and procedure titled Medication Administration with a review date [DATE] documented it is a standard of practice that medications be administered as ordered by the physician. Medications be administered to the resident within a one-hour time frame before/after the indicated administration time, unless otherwise specified by drug information. Electronic-Medication Administration Record must be signed by the nurse who administered the medication. When medication cannot be administered, or is refused, it is to be documented electronically on the Electronic- Medication Administration Record including the reason and physician notification.The facility policy and procedure titled Medication Errors with a review date [DATE] documented it is the facility policy that a medication error will be reported as soon as it is recognized. In the event of significant error: One (1) occurrence of a significant error may result in termination. It is noted that the safe, appropriate administration of all prescribed medications and treatments is one of the major responsibilities of the licensed professional nurse. Failure to consistently follow the medications policies and procedures and/or repeated medication errors may be cause for termination of employment.Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (poor air flow to the lung), diabetes mellitus (high sugar in the blood), and heart failure (heart muscle does not pump enough blood), and Resident #1 was receiving continuous oxygen. The Minimum Data Set (a resident assessment tool) dated [DATE] documented that Resident #1's cognition was intact. Resident #1 was assessed to be on an antipsychotic medication, antidepressant medication, and hypoglycemic medication.A review of the Order Summary Report (Physician's order) from [DATE] through [DATE] revealed Resident #1 had orders for Fluticasone-Salmeterol inhalation aerosol two (2) times daily and Incruse Ellipta inhalation aerosol one (1) time a day for chronic obstructive pulmonary disease, Metformin 500 milligram tablet two (2) times daily for diabetes mellitus, and Sertraline 100 milligram two (2) times daily for Major Depressive Disorder, Varenicline Tartrate 1 milligram every 12 hours for smoking cessation, Atorvastatin 20 milligram one (1) tablet at bedtime for high fat level in the blood, Quetiapine Fumarate (antipsychotic medication) 300 milligram one (1) tablet at bedtime for major depressive disorder and Trazodone 100 milligram tablet at bedtime for depression. Oxygen at 3-liters per minute via nasal cannula continuously every shift for chronic obstructive pulmonary disease. A review of the Medication Administration Record dated [DATE] for the 3:00 PM-11:00 PM shift revealed Resident #1 was scheduled to receive the above medications at 4:00 PM, 8:00 PM, and 9:00 PM. There was no documented evidence Resident #1 received any medications and treatment during the evening shift. A review of the Accident/Incident Investigation form dated [DATE] at 9:49 PM incident revealed after the investigation, the incident appears to have been related to a medical event. Resident #1 was found lying on the floor beside their bed unresponsive. No measurable vital signs were obtained. Stat (emergency call to act immediately) was called and cardiopulmonary (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	resuscitation initiated, and Emergency Medical Services arrived. Resident #1 was pronounced by Emergency Medical Services at 10:24 PM. On initial assessment Resident #1 had no visible injuries and skin was intact. During postmortem care a large skin tear was observed to Resident #1's right cheek. On investigation the call bell was found to be within reach but had not been activated. Bed was in lowest and locked position. Floor of the room was clean and dry, free of clutter. After investigation, the interdisciplinary team determined that there is no cause to believe alleged abuse, mistreatment, or neglect regarding this resident has occurred. There was no documentation in the incident report that from 4:15 PM to 9:48 PM Resident #1 was missing, staff were unaware of Resident #1's whereabouts until the resident was found unresponsive, Resident #1 did not receive any medications on the evening shift, and when the resident was found, they were not connected to any oxygen tank or concentrator. A review of the nursing progress note by Registered Nurse #1 dated [DATE] at 11:53 PM, documented at 9:49 PM Resident #1 was found on the floor unresponsive with no pulse, no breathing, called stat at 9:50 PM and cardiopulmonary resuscitation initiated right away. A nonrebreather mask attached to run at 15 liters per minute. At 9:51 PM 911 was called, intravenous line inserted at right peripheral arm and normal saline 0.9 bolus started. At 10:07 PM, 911 arrived and took over. At 10:24 PM, Resident #1 was pronounced expired by Emergency Medical Services. Registered Nurse #1 notified Adult Child #1.There was no documentation in the report that Resident #1 was missing for several hours prior to being found face down on the floor not breathing nor that Resident #1 did not receive 4:00 PM, 8:00 PM and 9:00 PM medications and was not connected to their oxygen when they were found. There was no documentation Resident #1's whereabouts were unknown from 4:15 PM to 9:49 PM. During an interview on [DATE] at 2:37 PM, Registered Nurse #1 stated they arrived on the unit on [DATE] at 4:15 PM and did not see Resident #1 on the unit during their rounds. Registered Nurse #1 stated they received information (from unknown staff) that Resident #1 had a visitor. Registered Nurse #1 stated they did not look for Resident #1 (thinking they were with visitor) and continued working. Registered Nurse #1 stated they were not sure Resident #1 had returned to the unit but started looking for Resident #1 at 9:40 PM and briefly looked in Resident #1's room but did not see them. Registered Nurse #1 stated Resident #1's 4:00 PM medications were not given because they thought Resident #1 was with a visitor. Registered Nurse #1 stated they have an hour before and an hour after to give scheduled medications. Registered Nurse #1 stated they were aware that the 4:00 PM, 8:00 PM and 9:00 PM medications were not given but does not recall notifying Registered Nure Supervisor #1 or Medical Doctor #1. Registered Nurse #1 stated they knew they were supposed to notify their supervisor and medical doctor when Resident #1 did not receive their medications.During an interview on [DATE] at 5:43 PM, Registered Nurse Supervisor #1 stated they were the assigned unit supervisor on the date of the incident. Registered Nurse Supervisor #1 stated Registered Nurse #1 called the nursing office on [DATE] (unsure of time) and reported that Resident #1 was not in bed, the wheelchair was there but the room was empty. Registered Nurse Supervisor #1 stated together with the other supervisors they immediately responded to the unit to search but when they arrived in the unit, Registered Nurse #1 and other staff had already found Resident #1. Registered Nurse Supervisor #1 stated they observed Resident #1 laying on the floor face down and when they turned them on their back, Resident #1 had no pulse, was not breathing, called a stat and started cardiopulmonary resuscitation at 9:50 PM, and notified Medical Doctor #1 (unsure of time). Registered Nurse Supervisor #1 stated they did not notice blood on the floor and the skin on Resident #1's face was intact. Registered Nurse Supervisor #1 stated the Emergency Medical Services arrived on the unit at 10:07 PM and took over. Registered Nurse Supervisor #1 stated the Emergency Medical Services intubated Resident #1. Registered Nurse Supervisor #1 stated after the Emergency Medical Services left they observed the skin on the right side of Resident #1's face peeled off and looked like an open blister. Registered Nurse Supervisor #1 stated Emergency Medical Services pronounced Resident #1 expired at 10:24 PM. Registered Nurse Supervisor #1 stated they spoke to Registered Nurse #1, and they did not report Resident #1 was initially missing or how long the resident was (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	missing. Registered Nurse Supervisor #1 stated they were not aware Resident #1 did not receive their evening medications on [DATE]. During an interview on [DATE] at 7:10 PM, Registered Nurse Supervisor #2 stated they also responded to the call of Registered Nurse #1 on [DATE] (unsure of time). Registered Nurse Supervisor #2 stated they immediately responded to search on the unit, but when they arrived at the unit, Resident #1 was found already laying on the floor unresponsive at the right side of their bed. Registered Nurse Supervisor #2 stated they did not observe oxygen connected to Resident #1's nose.During an interview on [DATE] at 1:37 PM, the Medical Director stated they never heard Resident #1 was not found for several hours on [DATE] during the evening shift incident. The Medical Director stated they were not made aware that Resident #1 was missing prior to [DATE]. The Medical Director stated they were not made aware of the incident on [DATE], but they became aware after a day or two (2) after through the hospitalization chat (group chat) received. Medical Director stated they did not review the chart. They were not made aware that Resident #1 did not receive medications scheduled for 4:00 PM through 9:00 PM until [DATE]. The Medical Director stated they cannot opine whether Resident #1 missing one (1) cycle of medications caused them to collapse and expire. During an interview on [DATE] at 3:14 PM, the Director of Nursing stated that on [DATE] between 2:00 AM to 3:00 AM they received a message from Registered Nurse Supervisor #1 through hospitalization chat that on [DATE] at 9:49 PM, Resident #1 was found on the floor unresponsive, and that a stat was called, cardiopulmonary resuscitation was initiated until emergency medical services took over the scene and pronounced Resident #1 expired at 10:24 PM. The Director of Nursing stated that not until [DATE] were they notified that Resident #1 had been reported missing by nursing staff. The Director of Nursing stated that the Infection Control Preventionist was on duty, and it was initially reported to them. The Director of Nursing stated that the Infection Control Preventionist failed to report this information to them during the morning meeting on [DATE]. The Director of Nursing reviewed the Certified Nursing Assistant accountability record for the [DATE] 3:00 PM-11:00 PM shift and acknowledged that there was no documentation for hourly safety checks, or meal consumption for Resident #1 The last documentation was 2:45 PM for hourly safety checks. The Director of Nursing also reviewed the medications administration record and stated that it revealed that there were no medications administered to Resident #1 from 4:00 PM to 9:49 PM.During an interview on [DATE] at 4:00 PM, the Administrator stated the first time they were made aware of the incident was through the hospitalization chat received on [DATE] at 12:20 AM by Registered Nurse Supervisor #1 that Resident #1 was found unresponsive on [DATE] at 9:49 PM. The Administrator stated they were not made aware Resident #1 had not been seen by nursing and direct care staff for hours or that the resident had not received ordered medications, or treatments or a meal because staff thought the resident was missing or out with family. This was not reported to them. During an interview on [DATE] at 9:42 AM, Medical Doctor #1 stated they were Resident #1's assigned doctor. Medical Doctor #1 stated they received a call from Registered Nurse #1 and Registered Nurse Supervisor #1 at different times (unsure of time) on [DATE] notifying them Resident #1 was found unresponsive and that emergency measures were provided. Medical Doctor #1 stated Registered Nurse #1 did not notify them Resident #1 did not receive their medications as ordered on the evening shift of the incident. 10 New York Codes, Rules, and Regulations 415.11(c)(3)(i)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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, record reviews, and interviews conducted during survey, the facility failed to ensure that five (5) of seven (7) residents (Resident #7, Resident #9, Resident #10, Resident #11 and Resident #12) received adequate supervision and interventions to prevent accidents. Specifically, 1) On 04/16/2026 at 1:30 PM Resident #7 was observed entering the smoking room while using oxygen. Smoking Monitor #1 did not prevent Resident #7 from entering the smoking room nor did they attempt to remove Resident #7's oxygen. Resident #7 also had three (3) known incidents of smoking in their room while using oxygen.2) On 04/17/2026, the facility conducted room searches for all 35 identified smokers and 19 were found with smoking materials. Four (4) out of 19 residents (Resident #9, Resident #10, Resident #11 and Resident #12) were found with lighters, and two (2) of them (Resident #9 and Resident #10) were found with continuous use oxygen order in their room. There was no documented evidence that a smoking reassessment was provided for safe smoking for the four (4) residents after they were found with lighters. These circumstances subjected all 565 residents to the likelihood of serious adverse outcome that was Immediate Jeopardy.3) The facility failed to provide adequate supervision and interventions to address one (1) of five (5) residents (Resident #2) at risk of falls. Resident #2 experienced recurring falls on seven (7) occasions between 08/29/2025 and 02/24/2026. Preventive supervision of Resident #2 was not documented in the care plan. Resident #2 sustained injuries in three (3) of the fall incidents (09/02/2025, 12/17/2025, and 02/07/2026). These circumstances resulted in actual harm that was not Immediate Jeopardy.The findings are: A review of the facility's policy and procedure titled Smoking Regulations, Fire Prevention and Smoke Free Act Air with a reviewed date 10/2025 documented the facility has a designated Smoking Room in building A first floor for residents who smoke. Only staff assigned to assist and/or familiar with the residents' smoking plan are allowed to give out smoking materials or light up cigarettes for residents. All staff, upon witnessing a resident smoking in their room/non-designated area, inform the resident that they are not permitted to smoke in that area and immediately report the incident and stay with the resident until the charge nurse arrives. Notify the nursing supervisor and speak to the resident and inform him/her of the rules and regulations, remove all smoking materials from resident's possession and secure them at nurse's station. The person and room are to be searched. The Social Service (staff) will set up a team meeting to discuss and develop residents' discharge plan and then initiate process. Resident #7Resident #7 was admitted to the facility with diagnoses that included chronic obstructive disease, pulmonary fibrosis (scarring of lung tissue).The Annual Minimum Data Set (a resident assessment tool) dated 03/02/2026 documented that Resident #7 was cognitively intact. The Section J assessment did not identify Current Tobacco Use.A review of the Smoking Regulation Agreement dated 12/04/2024 documented Resident #7 as an identified smoker and Resident #7's signature was noted on the agreement.A review of the Smoking assessment dated [DATE] documented Resident #7 was a smoker.A review of the Physician's order dated 02/04/2026 documented Oxygen five (5) liters per minute through nasal cannula every shift for shortness of breath. A review of Comprehensive Care Plan titled Known Smoker dated 01/12/2026 documented Resident #7 was a smoker with interventions of Resident #7 will smoke safely within the designated smoking area with supervision, review smoking policy, and encourage smoking cessation. A review of the hourly safety check dated 03/2026 revealed there was no documented evidence Resident #7 was provided with more frequent safety checks after the three (3) incidents of unsafe smoking.A review of the nursing notes dated 01/12/2026 at 7:55 PM by Registered Nurse #6 documented Resident #7 closed the door and started smoking. Two (2) boxes of cigarettes and one (1) lighter were confiscated. Resident #7 was aware of the smoking protocol in the facility and put themselves and facility in danger. A review of the nursing note by Registered Nurse #7 dated 01/16/2026 at 9:40 PM, documented Certified Nursing Assistant #7 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clove Lakes Health Care and Rehab Center, Inc	25 Fanning Street Staten Island, NY 10314

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	observed Resident #7 smoking in their room and immediately notified the nursing staff. A review of the nursing note by Registered Nurse #8 dated 03/11/2026 at 10:01 PM, documented that it was reported to them that Resident #7 was found smoking in their room while oxygen was in use.On 04/16/2026 at 1:30 PM Resident #7 was observed entering the smoking room while using oxygen. Smoking Monitor #1 did not prevent Resident #7 from entering the smoking room nor did they attempt to remove the oxygen. During an interview on 04/20/2026 at 5:13 PM, the Director of Recreation stated they conduct smoking assessments upon admission on ly. The Director of Recreation stated that on 04/16/2026 Smoking Monitor #1 should have removed the oxygen before Resident #7 entered the smoking room. The Director of Recreation stated residents should have no smoking materials with them as all smoking materials should be kept in the Recreation office in the designated locked cabinet. The Director of Recreation stated Resident #7 received counselling for non-compliant behavior, but they could not describe or provide documentation of the counselling. During an interview on 04/20/2026 at 6:45 PM, the Director of Nursing stated Resident #7 was on hourly checks for safety. Director of Nursing stated they have not increased the frequency of monitoring or safety checks after each incident, and they do not reassess Resident #7 for safe smoking after each smoking incident.During an interview on 04/20/2026 at 7:10 PM, the Administrator stated they continuously provide education (to Resident #7) by reviewing the facility policy and procedure and smoking agreement after each incident. Administrator stated smoking assessments are completed upon admission and as needed. During an interview on 04/21/2026 at 4:19 PM, the Medical Director stated they were not the direct care giver to Resident #7, so they are not the most appropriate person to answer questions. The Medical Director stated they did not know of Resident #7's noncompliant behavior with smoking. The Medical Director stated if Resident #7 has noncompliant behavior, the facility should keep educating them. The Medical Director stated smoking in a room with continuous oxygen is dangerous. The Medical Director stated they cannot determine at this time if Resident #7 was a safe smoker or not. A review of the facility's Accident Prevention Program with a review date of 02/18/2026 documented an accident is defined as an event which results in serious bodily harm, such as fractures, lacerations which require closure, second or third degree burns or any other requiring admission to a hospital. The Licensed Nurse/Nurse Supervisor reviews resident's medical record and completes fall risk status, develops care plan interventions, reviews/revises resident's plan of care as needed, and updates Certified Nursing Assistant Assignment as applicable. Resident #2Resident #2 was admitted to the facility with diagnoses including bilateral nasal bone fracture due to fall, Alzheimer's dementia, muscle weakness, and vitamin D deficiency.A review of the Minimum Data Set, dated [DATE] documented that Resident #2's cognition was severely impaired. Resident #2 required supervision/touching assistance with bed mobility and transfer and was able to ambulate 10 to 50 feet. A review of Fall Risk Evaluation dated 07/24/2025 documented Resident #2 as a high risk for falls. Resident #2 was reevaluated after each fall incident, but there was no change to the resident's fall risk category. A review of the Comprehensive Care Plan for At Risk for Fall with a facility review date of 07/29/2025 documented interventions of anticipate and meet resident's needs, ensure a clean and dry environment, and ensure well-fitting shoes. A review of the Comprehensive Care Plans titled Actual Fall dated 08/29/2025, 09/02/2025, 12/17/2025, 12/28/2025, 02/07/2026, 02/17/2026 and 02/24/2026 revealed there was no documented evidence of supervision reflected in Resident #2's care plan to implement/ensure adequate supervision. A review of the Task List Report (instructions for certified nursing assistants) dated 04/16/2025 revealed Resident #2 was on hourly safety check monitoring. A review of the Kardex Report (instructions for certified nursing assistants) for 08/29/2025 under toileting, documented to check Resident #2 every two (2) hours and as needed, anticipate needs and meet needs. It also indicated be sure call light is within reach and monitor/document/report as needed any changes and decline in function.Incidents: A review of the Incident Report dated 08/29/2025 at 10:30 AM documented Resident #2 was found on the floor on the side of their bed. Resident #2 was assessed by Registered Nurse Supervisor #4 and there was no (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	injury. Medical Doctor and family notified. Recommended measure was to increase supervision. The investigation concluded there was no reasonable suspicion of abuse or neglect. A review of the Documentation Survey Report (certified nursing assistants accountability record documentation sheet) dated 08/29/2025 between 10:00 AM-11:00 AM revealed no documented evidence that Resident #2 was monitored for safety.A review of the actual Care Plan dated 08/29/2025 revealed interventions to monitor/document for pain, bruises, and change in mental status. There was no documented evidence of an increase in supervision for Resident #2 reflected in the care plan or Task List Report.A review of the Incident Report dated 09/02/2025 at 8:30 AM revealed Resident #2 was found sitting on the bathroom floor by Registered Nurse #5 and Resident #2 stated they lost their balance. Resident #2 was assessed and observed with a one (1) inch laceration to their left middle finger. Medical Doctor was notified, and treatment was ordered. Recommended preventive measures were to increase supervision and provide frequent checks. The investigation concluded there was no reasonable suspicion of abuse or neglect.A review of the actual care plan dated 09/02/2025 revealed to administer treatment as directed and neuro checks times three (3) days. There were no preventive measures to increase supervision or frequent checks reflected in the care plan and Task List Report (instructions to certified nursing assistants).A review of the Incident Report dated 12/17/2025 at 3:25 AM revealed Licensed Practical Nurse #5 heard a noise in the hallway and observed Resident #2 sitting on the floor and stated they walked and wanted to go to the bathroom and then later said, they do not need to go. Resident #2 was assessed and noted with open skin tear to right elbow. There was no pain. Medical Doctor was notified, and treatment was ordered. A care plan was updated with the intervention to determine and address causative factors of the fall. The investigation concluded there was no reasonable suspicion of abuse or neglect.A review of the actual care plan dated 12/17/2025 revealed interventions to determine and address causative factors of the fall and ensure that resident is wearing appropriate footwear while in the wheelchair. There was no documented evidence of increased supervision.A review of the Incident Report dated 12/28/2025 at 10:20 AM documented Resident #2 was found sitting on the floor near their room door. Resident #2 was assessed and no injury and did not complain of pain. Recommendation of preventive measures to increase supervision. The investigation concluded no reasonable suspicion of abuse or neglect. A review of the actual fall care plan dated 12/28/2025 revealed there was no documented evidence of increased supervision reflected in the care plan. A review of Documentation Survey Reports dated 12/28/2025 between 5:00 AM - 6:00 AM and 10:00 AM-11:00 AM revealed there was no documented evidence that Resident #2 was monitored for safety.A review of the Incident Report dated 02/07/2026 at 4:35 AM revealed Resident #2 was found lying on the floor on the right side of their bed, bleeding noted on their right eyebrow. Resident #2 was assessed and observed with laceration on their right eyebrow, measuring 3.0-centimeter by 0.5-centimeter by 0.5 centimeter and cold compress applied. Medical Doctor notified. Resident #2 was transferred to hospital and returned on the same day after receiving six (6) stitches to their right eyebrow. The investigation concluded no reasonable suspicion of abuse or neglect.A review of the actual care plan dated 02/07/2026 revealed there was no documented evidence of increased supervision for Resident #2. A nursing note dated 02/07/2026 at 1:25 PM by Licensed Practical Nurse # 6 documented Resident #2 returned from emergency room visit at 12:20 PM. Observed six (6) stitches in their right eyebrow. No complaint of pain. Neuro checks maintained. Record review of the hospital records dated 02/07/2026 at 7:36 AM revealed Resident #2 with 1.5-centimeter laceration noted to the right eyebrow. Laceration irrigated and repaired without complication and discharged back to facility. The Incident Report dated 02/17/2026 at 11:00 AM documented Resident #2, unwitnessed, slid out of the wheelchair and was found sitting on the floor. Resident #2 was last seen two (2) minutes before the incident. Resident #2 was assessed by Registered Nurse Supervisor #6 and there was no injury. Recommendation to continue close observation by nurse's station. The investigation concluded no reasonable suspicion of abuse or neglect.A review of the actual care plan dated 02/17/2026 revealed there was no documented (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	evidence of increased supervision reflected in the care plan. A review of the Incident Report dated 02/24/2026 at 5:42 AM documented Resident #2 was found sitting on the floor and trying to pull themself up by holding onto the side rail. Resident #2 was assessed and there was no injury. Recommendation for preventive measures of frequent observation every 30 minutes. The investigation concluded no reasonable suspicion of abuse or neglect.A review of actual care plan dated 02/24/2026 revealed there was no documented evidence of increased supervision reflected in the care plan. During an interview on 04/24/2026 at 12:12 PM, Registered Nurse Supervisor #5 stated they were one of the supervisors who assessed Resident #2 during their 12/28/2025 fall incident. Registered Nurse Supervisor #5 stated they reviewed and updated the care plan but did not reflect frequency of adequate supervision in the care plan.During an interview on 04/27/2026 at 10:26 AM, Registered Nurse Supervisor #6 stated Resident #2 had an unwitnessed fall in the hallway and there should have been staff monitoring Resident #2 to prevent them from falling. Registered Nurse Supervisor #6 stated they should have added new interventions in Resident #2's care plan. During an interview on 04/27/2026 at 9:16 AM, the Director of Nursing stated every incident must have a care plan review and an update of the care plan by the nursing supervisor. Director of Nursing stated there should be supervision documented in the care plan. Director of Nursing stated they reviewed the care plan, and there were not enough interventions in place. Director of Nursing stated there was no formal root cause analysis done for the incidents. During an interview on 04/27/2026 at 11:25 AM, Social Worker #1 stated they had a care plan meeting with regard to fall incidents of Resident #2 and spoke to Adult Child #1 about the plan of care to ensure Resident #2 has appropriate footwear and to continue to monitor Resident #2, but they do not recall discussing the root cause analysis of their fall. Social Worker #1 stated going forward they need to check to see if they should discuss or offer a room change with the team. During an interview on 04/27/2026 at 11:35 AM, Medical Doctor #2 stated Resident #2 was very uncooperative and restless at times. Medical Doctor #2 stated prior to facility admission, Resident #2 had multiple injuries with fractures due to falls at home. Medical Doctor #2 stated they tried to talk to Resident #2,but they would not listen, but sometimes they listened. Medical Doctor #2 stated they were aware that Resident #2 had multiple fall incidents in the facility that were unwitnessed, but staff continued to monitor them to prevent them from falling. Medical Doctor #2 stated Resident #2's accidents are mostly unavoidable because it was hard to find out what happened due to unwitnessed incidents. Medical Doctor #2 stated they do not attend care plan meetings but discussed the plan of care to the unit supervisor and other nursing staff in the unit. On 04/22/2026 at 2:34 PM, Immediate Jeopardy was identified and declared. The Director of Nursing and Administrator were notified.The Director of Nursing and Administrator returned the signed IJ Template on 04/22/2026 at 2:41 PM. On 04/22/2026 at 5:15 PM, the facility presented a removal plan that listed the immediate action the facility would take to prevent serious harm from occurring or recurring. The facility's removal plan was revised and later accepted on 04/22/2026 at 7:57 PM. Based on observation, interview, and record review, the facility completed implementation of the removal plan on 04/22/2026 at 7:57 PM. The Immediate Jeopardy was lifted based on the following corrective actions taken by the facility: Resident #7 was placed on 1:1 supervision starting 04/20/2026 until possible discharge. Physician and Medical Director were notified of the issued IJ Template F689 immediately on 04/22/2026. Quality Assurance Performance Improvement meeting was held with multidisciplinary team on 04/22/2026. Unit Physician conducted a physical assessment on Resident #7 on 04/22/2026 and no injuries were found. Education focused on safe smoking was provided by the Unit Physician and Resident #7 was offered smoking cessation options. Oxygen removed by the smoking monitor prior to allowing residents access to the smoking area starting 04/22/2026, utilizing a smoking safety audit tool. A comprehensive smoking reassessment was completed for Resident #7 on 04/22/2026. Resident #7's care plan updated to reflect increased supervision and safety precautions on 04/20/2026. Resident #7 received re-education regarding smoking risks with oxygen with 2 witnesses present on 04/22/2026. Resident #7 verbalized (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	understanding but refused to sign. All (35) identified smokers underwent immediate reassessment and received education regarding safe smoking practices on 04/22/2026. Policy and Procedure on Smoking was reviewed and revised on 04/17/2026 to include increased frequency of Smoking Assessments on admission/readmission, quarterly and/or as needed. Non-compliant smokers, monitoring will be increased to every 30 minutes, immediately upon identification. Care Plan will be updated as necessary. Any resident identified smoking in undesignated area/times will be placed on 1:1 supervision until alternate placement is identified. It was determined by the State Agency that the facility fully implemented their plan to remove the immediate jeopardy as of 04/22/2026 at 7:57 PM. 10 New York Codes, Rules, and Regulations 415.12 (h)(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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during survey, the facility failed to ensure that residents are free of significant medication errors. This was evident in one (1) out of five (5) residents sampled (Resident #1). Specifically, on [DATE], Registered Nurse #1 did not administer significant medications at 4:00 PM, 8:00 PM, and 9:00 PM to Resident #1 in accordance with Physician's orders. Additionally, Resident #1 did not receive ordered oxygen 3-Liters via nasal cannula continuously every shift for chronic obstructive pulmonary disease. From 4:15 PM to 9:49 PM on [DATE], Registered Nurse #1 and other direct care staff were unaware of Resident #1's whereabouts until Resident #1 was found unresponsive on the floor face down with no pulse and no breathing. Cardiopulmonary resuscitation was initiated until Emergency Medical Services arrived at 10:07 PM and assumed care. Resident #1 expired at 10:24 PM. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. Cross Reference: F658 - Services Meet Professional StandardsThe findings are:The facility policy and procedure titled Medication Administration with a review date [DATE] documented it is a standard of practice that medications be administered as ordered by the physician. Medications are administered to the resident within a one-hour time frame before/after the indicated administration time, unless otherwise specified by drug information. Electronic-Medication Administration Record must be signed by the nurse who administered the medication. When medication cannot be administered, or is refused, it is to be documented electronically on the electronic- Medication Administration Record including the reason and physician notification. The facility policy and procedure titled Medication Errors with a review date [DATE] documented it is the facility policy that a medication error will be reported as soon as it is recognized. In the event of significant error: one (1) occurrence of a significant error may result in termination. It is noted that the safe, appropriate administration of all prescribed medications and treatments is one of the major responsibilities of the licensed professional nurse. Failure to consistently follow the medications policies and procedures and/or repeated medication errors may be cause to termination employment. Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (poor air flow to the lung), diabetes mellitus (high sugar in the blood), and heart failure (heart muscle do not pump enough blood), and Resident #1 was receiving continuous oxygen. A review of the Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #1's cognition was intact. Resident #1 was assessed to be on an antipsychotic medication, antidepressant medication, and hypoglycemic medication.A review of the Order Summary Report (Physician's orders) from [DATE] through [DATE] revealed Resident #1 had orders for Fluticasone-Salmeterol inhalation aerosol two (2) times daily and Incruse Ellipta inhalation aerosol one (1) time a day for chronic obstructive pulmonary disease, Metformin 500 milligram tablet two (2) times daily for diabetes mellitus, and Sertraline 100 milligram two(2) times daily for Major Depressive Disorder, Varenicline Tartrate one (1) milligram every 12 hours for smoking cessation, Atorvastatin 20 milligram one (1) tablet at bedtime for high fat level in the blood, Quetiapine Fumarate (antipsychotic medication) 300 milligram one (1) tablet at bedtime for major depressive disorder and Trazodone 100 milligram tablet at bedtime for depression. Oxygen at 3-liters per minute via nasal cannula continuously every shift for chronic obstructive pulmonary disease. A review of the Medication Administration Record dated [DATE] for the 3:00 PM-11:00 PM shift revealed Resident #1 was scheduled to receive the above medications at 4:00 PM, 8:00 PM, and 9:00 PM. There was no documented evidence Resident #1 received their medications and treatment on [DATE] as ordered and scheduled. During an interview on [DATE] at 2:37 PM, Registered Nurse #1 stated they arrived on the unit on [DATE] at 4:15 PM and did not see Resident #1 on the unit during their rounds. Registered Nurse #1 stated they received information (from unknown staff) that Resident #1 had a visitor. Registered Nurse #1 stated they did not look for Resident #1 and continued working on the unit. Registered Nurse #1 stated they were not sure Resident #1 had returned to the (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	unit but started looking for Resident #1 at 9:40 PM to administer their medications. Registered Nurse #1 stated they briefly looked in Resident # 1's room but did not see them. Registered Nurse #1 stated Resident #1's 4:00 PM medications were not given because they thought Resident #1 was with a visitor. Registered Nurse #1 stated they have an hour before and an hour after to give scheduled medications. Registered Nurse #1 stated they were aware that the 4:00 PM, 8:00 PM and 9:00 PM medications were not given but does not recall notifying Registered Nure Supervisor #1 or Medical Doctor #1. Registered Nurse #1 stated they knew they were supposed to notify their supervisor and medical doctor when Resident #1 did not receive their medications.During an interview on [DATE] at 5:43 PM, Registered Nurse Supervisor #1 stated they were the assigned unit supervisor on the date of the incident. Registered Nurse Supervisor #1 stated they were not aware Resident #1 did not receive their scheduled medications on [DATE]. Registered Nurse Supervisor #1 stated Registered Nurse #1 should have notified them that the medications were not given, and they would have notified the medical doctor. Registered Nurse Supervisor #1 stated that when medications are not administered it must be documented in the electronic Medication Administration Record along with the reason. Registered Nurse Supervisor #1 stated Registered Nurse #1 called the nursing office on [DATE] (unsure of time) and reported that Resident #1 was not in bed, the wheelchair was there but the room was empty. Registered Nurse Supervisor #1 stated together with the other supervisors, they immediately responded to the unit to do search but when they arrived in the unit, Registered Nurse #1 and other staff had already found Resident #1 laying on the floor face down and when they turned them on their back, Resident #1 had no pulse, was not breathing, called STAT (an action must be taken immediately) and started cardiopulmonary resuscitation, Emergency Medical Services (911) were called. Registered Nurse Supervisor #1 stated Emergency Medical Services pronounced Resident #1 expired at 10:24 PM. Registered Nurse Supervisor #1 stated they spoke to Registered Nurse #1, and they reported Resident #1 was initially missing, but did not mention to them what time Resident #1 was missing. During an interview on [DATE] at 7:10 PM, Registered Nurse Supervisor #2 stated they also responded to the call of Registered Nurse #1 on [DATE] (unsure of time). Registered Nurse Supervisor #2 stated they did not observe oxygen connected to Resident #1's nose.During an interview on [DATE] at 1:37 PM, the Medical Director stated they never heard Resident #1 was missing for several hours for several hours on [DATE] during the evening shift incident. The Medical Director stated they were not made aware that Resident #1 was missing prior to [DATE]. The Medical Director stated they were not made aware of the incident on [DATE], but they became aware after a day or two (2) through the hospitalization chat (group chat) received. The Medical Director stated they did not review Resident #1's chart and they were not made aware Resident #1 did not receive medications scheduled for 4:00 PM through 9:00 PM until [DATE]. The Medical Director stated they cannot opine whether Resident #1 missing one (1) cycle of medications caused them to collapse and expire. During an interview on [DATE] at 3:14 PM, the Director of Nursing stated that on [DATE] between 2:00 AM to 3:00 AM they received a message from Registered Nurse Supervisor #1 through hospitalization chat that on [DATE] at 9:49 PM Resident #1 was found on the floor unresponsive, and that a stat was called, cardiopulmonary resuscitation was initiated until emergency medical services took over the scene and pronounced Resident #1 expired at 10:24 PM. The Director of Nursing stated that not until [DATE] were they notified that Resident #1 had been reported missing by nursing staff. The Director of Nursing stated that the Infection Control Preventionist was on duty, and it was initially reported to them. The Director of Nursing stated that the Infection Control Preventionist failed to report this information to them during the morning meeting on [DATE]. The Director of Nursing reviewed the certified nursing assistant accountability record for the [DATE] from 3:00 PM-11:00 PM shift and acknowledged that there was no documentation for hourly safety checks, or meal consumption. The last documentation was 2:45 PM for hourly safety checks. The Director of Nursing also reviewed the medications administration record and stated that it revealed that there were no medications administered to Resident #1 from 4:00 PM to 9:49 PM. During an (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	interview on [DATE] at 9:42 AM, Medical Doctor #1 stated they were Resident #1's assigned doctor. Medical Doctor #1 stated they received a call from Registered Nurse #1 and Registered Nurse Supervisor #1 at different times (unsure of time) on [DATE] notifying them Resident #1 was found unresponsive and that emergency measures were provided. Medical Doctor #1 stated Registered Nurse #1 did not notify them Resident #1 did not receive their medications as ordered. 10 New York Codes, Rules, and Regulations 415.12(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335239	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clove Lakes Health Care and Rehab Center, Inc	25 Fanning Street Staten Island, NY 10314

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, 1) The Administrator and the Director of Nursing failed to ensure that the residents were free from neglect. Immediate Jeopardy was determined on [DATE] when direct care and nursing staff failed to ensure that Resident #1 received medications, dinner meal, oxygen therapy and safety monitoring. This resulted in actual harm for Resident #1 who was found unresponsive and expired. 2) The Administrator and the Medical Director failed to ensure enforcement of smoking safety policies for residents with known unsafe smoking behavior and oxygen use. Immediate Jeopardy was determined on [DATE]. Cross Reference: F600 -Resident Neglect. F689- Free of Accident Hazards/Supervision/Devices The findings include:The facility's policy and procedure titled Administration Management with a reviewed date [DATE] documented to establish a structured administrative management system that ensures the skilled nursing facility operates efficiently, maintains compliance with federal, state, and local regulations, promotes resident-centered care, and supports quality improvement initiatives. The facility Administrator shall oversee the daily operations of the facility and ensure that all departments function in accordance with applicable laws, regulations, facility policies, and standards of car. Administrative management shall promote resident safety, dignity, quality of life, staff accountability, and organizational effectiveness. 1. Immediate Jeopardy was determined [DATE]. The facility failed to ensure systems were in place and functioning to account for and monitor Resident #1, a resident with continuous oxygen use and high fall risk, after staff became aware the resident could not be located on the unit. The facility failed to ensure implementation of required hourly safety checks, medication administration, oxygen therapy, meal provision, staff communication, physician notification, and timely escalation of concerns after Resident #1 was reportedly not seen beginning at approximately 4:15 PM on [DATE]. In addition, the Director of Nursing, Administrator, and Medical Director, were unaware until weeks later that Resident #1 had reportedly been missing for several hours prior to being found unresponsive on the floor at 9:49 PM. During an interview on [DATE] at 3:14 PM, the Director of Nursing stated the facility uses a hospitalization group chat and recalled seeing a message from Registered Nurse Supervisor #1 sent between 2:00 AM and 3:00 AM on [DATE] reporting that Resident #1 was found unresponsive on the floor on [DATE] at 9:49 PM. A STAT (an action must be taken immediately) call was made, cardiopulmonary resuscitation was initiated, 911 responders later took over and pronounced the resident deceased at 10:24 PM. The Director of Nursing stated they were not informed that Resident #1 had been reported missing prior to the incident and only became aware of this on [DATE]. They also stated the Infection Control Director knew the resident had initially been reported missing, but this information was not discussed during the morning meeting on [DATE].During an interview on [DATE] at 4:00 PM, the Administrator stated they first became aware of the incident through a hospitalization group chat message received on [DATE] at 12:20 AM. The Administrator reported they were unaware that Resident #1 had initially been reported missing prior to the incident and did not know the resident had not been monitored hourly, had no documented dinner intake, and had not received medications between 4:00 PM and 9:00 PM.2) The facility failed to ensure enforcement of smoking safety policies for residents with known unsafe smoking behaviors and oxygen use, failed to reassess residents after repeated smoking incidents, failed to remove prohibited smoking materials, and failed to implement effective monitoring and/or supervision interventions. During an interview on [DATE] at 5:13 PM, Director of Recreation stated they conduct smoking assessments upon admission on ly. Director of Recreation stated they do not reassess residents when they find smoking materials but continue providing them with education about the smoking policy. Director of Recreation stated (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they bring it to the interdisciplinary team to decide what further intervention to put in place (did not identify what kind of intervention would be in place). Director of Recreation stated Smoking Monitor #1 should monitor the smoking room during smoking hours and should have removed the oxygen prior Resident #7 entered the smoking room on [DATE]. Director of Recreation stated residents should have no smoking materials with them. Director of Recreation stated Resident #7 received counselling for non-compliant behavior (could not describe what type of counselling). Director of Recreation also stated room searching was conducted for all 35 smokers and any found smoking materials were surrendered to Recreation Department. During an interview on 04/2026 at 6:45 PM, Director of Nursing stated Resident #7 was on hourly checks for safety. Director of Nursing stated they have not increased the frequency of monitoring or safety checks after each incident, and they do not reassess Resident #7 for safe smoking after each smoking incident. Director of Nursing stated they did not know that the other residents had smoking materials with them and they did not know any issue with smoking until the surveyors walked in in the facility. During an interview on [DATE] at 12:00 PM, Director of Social Worker stated the Recreation Department took over the Smoking Assessment on 10/2025 and they were not involved in Smoking Assessment anymore. Director of Social Worker stated together with the social service department and nursing they conducted room search to all identified smokers with their consent and those found with smoking materials were confiscated and given to Recreation for safekeeping then Director of Social Worker stated they provided reeducation and smoking agreement to all smokers after room search.During an interview on [DATE] at 4:19 PM, Medical Director stated they were not the direct care giver to Resident #7, so they are not the most appropriate person to answer questions. Medical Director stated they did not know of Resident #7's noncompliant behavior with smoking. Medical Director stated if Resident #7 has noncompliant behavior the facility should keep educating them. Medical Director stated smoking in a room with continuous oxygen is dangerous. Medical Director stated they cannot determine at this time if Resident #7 was a safe smoker or not. During an interview on [DATE] at 7:10 PM, the Administrator stated they continuously provide education (to Resident #7) by reviewing the facility policy and procedure and smoking agreement after each incident. Administrator stated smoking assessment is being done upon admission and as needed.10 New York Codes, Rules, and Regulations 415.26

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, and record review conducted during the abbreviated survey the facility's assessment failed to address/include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. This was evident for one (1) out of four (4) smoking monitors. Specifically, the facility designated the Activities staff to provide assessments of residents who smoke to identify residents who exhibit unsafe smoking practices. The Activities staff were also designated to conduct monitoring during residents smoking activity. A review of the Facility assessment dated 09/2025 revealed the position for Activity Aide did not identify the knowledge, training and /or skills required in safe smoking monitoring and oxygen safety. The findings include: The facility policy titled Facility assessment dated 09/2025 documented identifying resident's acuity levels will help evaluate level of care and services needed to provide sufficient care for facility's residents. The facility's vision is to provide continuous care through consistency. The facility's staffing plan is based on the resident population and their needs for care and support. The facility reviews their residents' acuities and census in order to determine if they need to staff enough employees for each position to meet the needs of the residents at any given time. A review of the Facility assessment dated 09/2025 revealed the position for Activity Aide did not identify the knowledge, training and /or skills required in safe smoking monitoring and oxygen safety. During an interview on 04/27/2026 at 2:29 PM, the Administrator stated when the have a newly hired smoking monitor staff (Recreation Transporter) they made sure they get specific training and are evaluated through demonstration that shows how to properly monitor the residents in the smoking room and residents with oxygen. Administrator stated that when they have residents with noncompliant behavior in smoking, they continuously reeducate staff on the smoking policy and remind them of the smoking agreement. Administrator stated their Facility Assessment indicated that they determined that smoking was another special care needs of residents in the facility. The Administrator said the smoking monitoring was documented in the facility assessment under the other special needs, and on services related to buildings. However, it did not elaborate on the actual training for monitoring for safe smoking. 10 New York Codes, Rules, and Regulations 415.5(h)(2)