STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335261	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	Route 100 Somers, NY 10589

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the abbreviated (NY00347929) survey from 7/23/2024 to 7/24/2024, the facility did not ensure the resident's right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer. This was evident for 1 (Resident #1) of 3 total sampled residents. Specifically, a mood stabilizer medication, Depakote, was ordered and administered to Resident #1 without the resident's Designated Representative being informed in advance of the risks and benefits of the medication and alternative treatment options. The findings are: The facility policy titled Family Notification dated 9/20/2021 documented family will be notified regarding resident changes and next steps. Progress notes regarding clinical changes should also include which familial contact was spoken to. Change in medication is an example of a family notification. Resident #1 was admitted to the facility on [DATE] with diagnoses of Lyme disease and unspecified dementia without behavioral disturbance. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired, displayed physical aggression towards others on 1 to 3 days in the 7 days prior to the assessment, and did not exhibit wandering behavior. Resident #1 had a Health Care Proxy and their family participated in the assessment. On 07/26/2024 at 12:45 PM, Resident #1's Designated Representative was interviewed and stated they called the facility and left messages for Medical Doctor #1 requesting a list of Resident #1's prescribed medication and any changes that were made since their admission to the facility on [DATE]. The Designated Representative stated the Psychiatrist attempted to order an antidepressant medication at one point and the Designated Representative refused because the Psychiatrist did not provide an adequate explanation of precipitating factors for initiating a new medication. The Designated Representative stated they were unaware of whether any new psychotropic medications had been ordered for Resident #1. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Psychiatry Consult dated 7/3/2024 documented Resident #1 was agitated and restless at times. The family requested Resident #1 resume Memantine 10 mg twice daily for dementia and refused other additional medications. The Nursing Note dated 7/11/2024 at 2:25 AM documented Resident #1 was agitated, aggressive, and punched Certified Nursing Assistant #1 in the face when redirected. The Nursing Note at 3:27 PM documented Resident #1 was involved in an unpleasant interaction with a staff member that morning and showed no signs of psychological harm as a result. The Psychiatry Consult dated 7/12/2024 documented Resident #1 was irritable and restless throughout the day and wandered into other residents' rooms. The Psychiatry Nurse Practitioner recommended adding Depakote 125 mg twice daily. The Physician Progress Note dated 7/12/2024 documented Resident #1 was evaluated by the Psychiatrist Nurse Practitioner, and it was recommended Resident #1 start Depakote 125 mg twice daily for mood and behavior control. The Physician Orders dated 7/13/2024 documented Resident #1 was ordered to receive Depakote 125 mg twice daily for mood disorder. The Medication Administration Record for July 2024 documented Resident #1 began receiving Depakote 125 mg twice daily on 7/13/2024. There was no documented evidence the Designated Representative was informed of the risks and benefits of Depakote 125 mg twice daily or alternative treatment options prior to initiating medication administration to Resident #1 on 7/13/2024. During an interview on 07/30/2024 at 04:12 PM, Medical Doctor #1 stated they discussed Resident #1's medication regimen with the Designated Representative following the resident's physical altercation that occurred with Certified Nursing Assistant #1 on 7/11/2024. Medical Doctor #1 stated they did not document the medication review in their notes and could not recall the exact date the conversation occurred with the Designated Representative. Medical Doctor #1 stated they did not sense the Designated Representative had any reluctance to starting new medications for Resident #1 and thought the Designated Representative was only resistant to decreasing or discontinuing the resident's medications. During a telephone interview conducted on 08/07/2024 at 4:14 PM, the Assistant Director of Nursing stated that aside from the Medical Doctor, the nurse on the unit should also reach out and notify the designated representative for any changes in medications and treatments. 10 NYCRR 415.3(f)(2)(ii)(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observations, record review, and interviews conducted during the abbreviated (NY00347929) survey the facility did not ensure the resident right to a clean, comfortable, and homelike environment. This was evident for 1 ([NAME] Unit) of 7 resident units. Specifically, a strong pervasive odor of urine was observed throughout the [NAME] Unit including in resident rooms. The findings are: The facility policy titled Carpet Cleaning and Operating the Speed-Ex Carpet Machine dated 7/22/2022 documented carpets located throughout the facility are shampooed weekly and spot-cleaned as needed. If the area is too soiled, full cleaning will be instituted. On 07/23/2024 at 11:29 AM and 07/24/2024 at 2:13 PM, the [NAME] Unit was observed to have a strong pervasive odor of urine throughout the unit and in resident rooms. The locked unit had double doors requiring a code to enter. The odor was noticeable and intense as the doors to the unit were opened. Approximately 20 residents were stationed at a lounge area in the front of the unit. The [NAME] Unit had 10 resident rooms that lined the hallway near the entry unit. The hallway turned left and made a U shape with 11 resident rooms across from hallway leading to the entrance. The unit contained both rooms with carpet and rooms with wooden floors. The odor of urine was noticeable along the hallways and strongest upon entering Rooms 102, 104, 108, 118, and 120. The wooden floor in room [ROOM NUMBER] was sticky. Each resident room had a musty damp smell. During an interview on 7/23/2024 at 2:13 PM, Licensed Practical Nurse #1 stated the [NAME] Unit did not have a housekeeper at night and the nursing staff did their best to clean the floors when residents had bowel movements or urinated on the floors. It was difficult to clean the carpeting and deep cleaning of the area took place when the housekeeper arrived in the morning. The [NAME] Unit was a dementia unit, and the carpeting was difficult to clean. During an interview on 7/24/2024 at 2:21 PM, Housekeeper #1 stated the nursing staff at night placed towels over the areas of the floor where residents urinated or defecated and waited for Housekeeper #1 to arrive at work on the unit in the morning to clean the floor. The carpets were cleaned weekly. The [NAME] Unit smelled sometimes because it was a dementia unit, and the residents were like babies. Housekeeper #1 sprayed air freshener when the unit smelled. Durign an interview on 7/24/2024 at 2:29 PM, the Lead Housekeeper stated they did notice the smell of urine. The odor was from residents urinating on the floor and the humid weather. Carpets were cleaned every 2 days and spot cleaning was done for the areas where residents defecated or urinated on the floor. During an interview on 7/29/2024 at 3:03 PM, the Director of Social Work stated the [NAME] Unit had incontinent residents that remove their incontinence briefs causing urine and fecal matter to end up on the floor and/or carpet. Housekeeping staff deep cleaned the carpeting when necessary. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2024 at 11:57 AM, the Housekeeping Director stated they conduct rounds on each unit daily to observe the environment and check on housekeeping staff performance. The housekeeping staff on the [NAME] Unit had to constantly clean the rooms because the unit contained residents with dementia. The Lead Housekeeper checked the [NAME] Unit to ensure all areas were sanitized appropriately. Carpet cleaning was done weekly, and fans were used to dry the carpets. There was 1 porter assigned to clean the [NAME] Unit in the evening once after dinner and no housekeeper assigned to the unit at night. The nursing staff cleaned the [NAME] Unit on the night shift if necessary. The beds were deep-cleaned and sanitized weekly. The mattresses might require another deep cleaning because urine soaked into the mattress. The housekeeping staff sanitized the mattresses in between the weekly cleanings if nursing staff alerted them that a particular mattress was soiled and needed sanitizing treatment. During an interview on 08/07/2024 at 3:40 PM, the Administrator stated that they do rounds in the morning and in the afternoon in all the units and when they see something they call the porter to get things cleaned or fixed. The Administrator stated that as they said during the exit conference, they did not smell anything on the [NAME] Unit. The carpets in the [NAME] Unit are shampooed once a week and it is against manufacturing instructions to shampoo them every day. They do have a machine in the [NAME] Unit that can do spot carpet cleaning if needed daily. They stated that the carpet in [NAME] unit is only 3 years old, but it looks older because of the amount of shampooing they have been doing. 10 NYCRR 415.5(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 0600 Level of Harm - Actual harm 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** 40686 Based on observations, interviews, and record reviews conducted during the abbreviated (NY00347929) survey, the facility did not ensure a resident was free from physical abuse by a staff member. This was evident for 1 (Resident #1) of 3 residents sampled for abuse. Specifically, on 7/11/2024 between 1:48 AM to 1:49 AM, Certified Nursing Assistant #1 was seen on the facility surveillance video approaching Resident #1 from behind at the entrance of another resident's room. Certified Nursing Assistant #1 was seen hitting Resident #1 on the upper part of their left shoulder, which startled Resident #1. Resident #1 was seen turning and trying to push Certified Nursing Assistant #1 away. Certified Nursing Assistant #1 was seen shoving Resident #1 and they both start hitting each other. Resident #1 was seen bending over and Certified Nursing Assistant #1 continued to hit Resident #1 with a closed fist several times on the arm and mid-section. Certified Nurse Assistant #1 then pushed Resident #1 and Resident #1 fell to the floor. Resident #1 was seen getting up and walking off camera. Resident #1 sustained an abrasion to the bridge of the nose. This resulted in actual harm to Resident #1 that was not immediate jeopardy. The findings are: The undated facility policy titled Abuse, Neglect, and Exploitation of Residents documented incidents are reviewed to identify areas for improvement, including environmental, operational, and staffing issues, as a form of abuse prevention. Resident #1 was admitted to the facility on [DATE] with diagnoses of Lyme disease and Unspecified Dementia without behavioral disturbance. The Minimum Data Set 3.0 assessment, dated 6/7/2024, documented Resident #1 was severely cognitively impaired, displayed physical aggression towards others on 1 to 3 days in the 7 days prior to the assessment, and did not exhibit wandering behavior. Review of a Victim for Abuse Comprehensive Care Plan initiated on 5/24/2024 documented Resident #1 had cognitive impairment, Dementia, wanders and had physical aggression which placed the resident at risk of being abused. Interventions included an assessment for abuse, investigation of allegations of abuse, provide support, referral to social services and the Medical Doctor, and offering the resident a snack or activities of interest while they wandered. The Comprehensive Care Plan related to behavior initiated 5/24/2024 documented Resident #1 exhibited physical aggression and wandering behavior. Interventions included allowing Resident #1 time to de-escalate when agitated and providing a safe and secure environment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 7/11/2024 between 1:48 AM and 1:49 AM, Certified Nursing Assistant #1 was seen on surveillance video approaching Resident #1 from behind while Resident #1 attempted to wander into another resident's room. Certified Nursing Assistant #1 used their right hand to shove Resident #1 on the left shoulder, which startled Resident #1. Resident #1 turned and used their left arm to swat at Certified Nursing Assistant #1 to push them away. Certified Nursing Assistant #1 shoved Resident #1 and they began hitting and pushing each other. Certified Nursing Assistant #1 used a closed fist to hit Resident #1 on their right arm and upper midsection of their body, causing the resident to bend over. Certified Nursing Assistant #1 then pushed Resident #1 causing the resident to fall on the floor. Resident #1 got up from the floor and walked off camera while Certified Nursing Assistant #1 stood at the door of room [ROOM NUMBER]. No other staff or residents were observed on surveillance footage in the area at the time of the incident. Certified Nursing Assistant #1's written Statement dated 7/11/2024 documented Resident #1 became aggressive when redirected from wandering into other resident's rooms and punched Certified Nursing Assistant #1 in the face. The facility Investigative Summary dated 7/11/2024 documented Licensed Practical Nurse #1 called a Code [NAME] alerting facility staff to the need for behavioral assistance on Resident #1's unit. Registered Nurse #1 arrived on the unit and was informed Resident #1 was aggressive and punched Certified Nursing Assistant #1 in the face. Certified Nursing Assistant #1 provided their statement and was sent to the hospital emergency room for evaluation. Registered Nurse #1 found Resident #1 had a small abrasion on the bridge of their nose. Resident #1 was unable to state what occurred due to cognitive impairments. Upon reviewing the surveillance video, the Administrator and Director of Nursing suspended Certified Nursing Assistant #1 pending completion of investigation. The facility's 5-day Investigation Report dated 7/16/2024 documented there was reasonable cause to believe that abuse of Resident #1 occurred on 7/11/2024. X-rays of Resident #1's nasal bone, hips and left ankle were negative for fracture. Resident #1 had no memory of the event and continued at baseline. There was no apparent psychosocial distress or harm. Certified Nursing Assistant #1 was terminated from the facility and reported to the police. Certified Nursing Assistant #1's Employee File contained a Progressive Discipline/Corrective Action Form dated 10/21/2022. The Form documented that on 10/3/2022, Certified Nursing Assistant #1 witnessed a resident-to-resident altercation on a Unit and while attempting to separate the residents involved caused one of the residents to fall to the floor. The Form noted that Certified Nursing Assistant #1 did not report the incident appropriately and should have separated the residents in a different manner. Certified Nursing Assistant #1 was directed to immediately report all abuse incidents to the abuse neglect officer and to call Code [NAME] if the situation escalated. On 7/11/2024 at 1:25 AM, Licensed Practical Nurse #1 documented Resident #1 was restless, agitated, wandering into other residents' rooms, and required constant redirection. Resident #1's agitation increased, and they became aggressive towards staff, cursing at Certified Nursing Assistant #1. Licensed Practical Nurse #1 documented they made the Nursing Supervisor (Registered Nurse #1) aware and indicated staff would continue to monitor Resident #1's behavior. Several attempts were made to contact Certified Nursing Assistant #1 for an interview without response. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with Resident #1's Designated Representative on 7/26/2024 at 12:45 PM, they stated Resident #1 was severely cognitively impaired and would forget occurrences immediately after they happened. During an interview with Licensed Practical Nurse #1 on 7/23/2024 at 2:13 PM, they stated they regularly work the 11PM to 7AM shift on the Resident #1's Unit, a locked dementia Unit. Licensed Practical Nurse #1 stated regular staffing for the night shift included 2 Certified Nursing Assistants and 1 Licensed Practical Nurse for 40 residents, including 6 residents that required 2-person assistance with Activities of Daily Living and 4 residents who wander throughout the night. Licensed Practical Nurse #1 stated they were the charge nurse on 7/11/2024 when Resident #1 was agitated, wandering into other residents' rooms, and aggressive towards staff. Licensed Practical Nurse #1 stated at 1:33AM they texted Registered Nurse #1 about Resident #1's escalating behaviors. Licensed Practical Nurse #1 did not receive a response from Registered Nurse #1, and they were at the Nursing Station in the center of the unit when Resident #1 wandered out of their view towards room [ROOM NUMBER]. Licensed Practical Nurse #1 stated at that time, Certified Nursing Assistant #1 was the only aide on the floor, and they were at a computer kiosk in the hall near room [ROOM NUMBER] completing their medical record documentation. Certified Nursing Assistant #2 was on their break and was off the unit at that time. Licensed Practical Nurse #1 stated they waited for about 15 minutes and paged Code [NAME] overhead to alert facility staff that assistance was needed to address a resident's escalating behavior. Licensed Practical Nurse #1 stated they then went towards room [ROOM NUMBER] and saw Resident #1 wandering away from room [ROOM NUMBER] and towards the nursing station. Licensed Practical Nurse #1 stated they observed Certified Nursing Assistant #1 near the entryway of room [ROOM NUMBER] bleeding from the nose and stated they were punched by Resident #1. Licensed Practical Nurse #1 followed Resident #1 in the hallway to a sitting area near the nursing station and stayed with Resident #1 until Registered Nurse #1 and another staff member came to the unit in response to Code Green. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 did not approach or interact with Resident #1 after the incident and after speaking with Registered Nurse #1 left the unit to go to the emergency room . Licensed Practical Nurse #1 stated they did not know Certified Nursing Assistant #1 had hit Resident #1 until the facility investigation was initiated and Certified Nursing Assistant #1 was suspended. Licensed Practical Nurse #1 stated Resident #1 had previous episodes of aggression towards staff, but they did not realize that Resident #1 was at risk for being victimized by staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with Registered Nurse #1 on 7/29/2024 at 9:15 AM, they stated they were the Nursing Supervisor for the night shift on 7/11/2024 when Certified Nursing Assistant #1 accused Resident #1 of punching them in the face. Registered Nurse #1 stated Licensed Practical Nurse #1 texted Registered Nurse #1 at 1:30 AM to inform them Resident #1 was agitated and was becoming more aggressive towards staff when redirected. Registered Nurse #1 stated they did not see the text message until later because they were busy assessing a resident on another unit. Registered Nurse #1 stated they heard the Code [NAME] page overhead and came to Resident #1's unit to find Licensed Practical Nurse #1 sitting with Resident #1 near the nursing station. Registered Nurse #1 stated Licensed Practical Nurse #1 informed them Resident #1 punched Certified Nursing Assistant #1 in the face. Registered Nurse #1 stated they assessed Resident #1 and observed redness and a small scratch on the resident's nose. Registered Nurse #1 stated Resident #1 was not aggressive towards staff, was confused, and stated they were attempting to sweep up when they got into a physical altercation with a drunken man, were punched in the nose and on the side of the head during the altercation and was waiting to give a statement to police upon their arrival. Registered Nurse #1 stated they found Certified Nursing Assistant #1 in room [ROOM NUMBER] bleeding from their nose. Registered Nurse #1 stated Certified Nursing Assistant #1 reported Resident #1 attacked them and denied hitting Resident #1. Registered Nurse #1 stated Certified Nursing Assistant #1 gave them a written statement and went to the emergency room for evaluation. Registered Nurse #1 stated they initiated an incident investigation and text messaged the Director of Nursing and Administrator to inform them Certified Nursing Assistant #1 required hospitalization . Registered Nurse #1 stated they began to question Certified Nursing Assistant #1's account of the incident because Resident #1 was consistent that they were involved in a physical fight with someone and had a scratch on their nose. Registered Nurse #1 stated upon the Director of Nursing's arrival at the facility in the morning, Registered Nurse #1 expressed their concern regarding the validity of Certified Nursing Assistant #1's version of events. During an interview with the Director of Social Work on 7/29/2024 at 3:03 PM, they stated they assessed Resident #1's cognitive and mental status following the incident on 7/11/2024 and Resident #1 had no recollection of the incident. During an interview with the Director of Nursing on 07/23/2024 at 4:30 PM, they stated they have staffing issues, they do need more staff, however, with the help of the nurses and the whole administrative team they are able to provide the care necessary. The Director of Nursing stated that they provide assistance when needed and the students from the New York Certified Nursing Assistant Schools also volunteer as needed. The Director of Nursing stated staff is trained to call a code if assistance is needed and that was why Licensed Practical Nurse #1 activated a Code [NAME] on 07/11/2024. The Director of Nursing stated they conducted a facility wide refresher on the emergency code (Code Green), and they completed a facility wide re-education on Managing Residents with Dementia and Behaviors with 100% compliance. The Director of Nursing stated that camera's surveillance video can only be accessed by the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Administrator Assistant, and the Food Services Director. The Director of Nursing stated the facility does not have security around the clock. During an interview with the Administrator on 07/23/2024 at 4:16 PM, they stated nothing of this nature (staff to resident altercation) had happened at the facility. The Administrator stated after the incident, all staff were in serviced on abuse prevention. The Administrator stated they are doing everything they can do with what they can control. The Administrator also stated that they hired a consultant to help them write a lesson plan for employees to handle and prevent burn out and avoid stressful life experiences. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	10 NYCRR 415.4(b)(1)(i)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39070 Based on record review and interviews conducted during an abbreviated survey (NY00347929), the facility did not ensure that the Comprehensive Care Plans (CCP) were reviewed and revised in a timely manner. This was evident for 1 of 4 residents (Resident #2) reviewed for behaviors. Specifically, Resident #2's At Risk for Fall Comprehensive Care Plan (CCP) was not updated after a fall incident on 04/02/2024. The findings are: The Facility Polity titled Care Plans, Comprehensive Person-Centered dated March 2022 documented that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Resident #2 had diagnoses that included Chronic Obstructive Pulmonary Disease, Abnormalities with Gait and Mobility, Bipolar Disorder, and Alzheimer's Disease. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 01/03/2024 documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). The Annual Minimum Data Set, dated dated dated [DATE] documented that the resident had severe cognitive impairment and had one fall with no injury. The Quarterly Minimum Data Set 07/02/2022 documented that the resident had severe cognitive impairment and had one fall with injury. Review of an Occurrence Investigation Form dated 03/16/2024 at 2:36 PM revealed that while sitting in the dining room the resident was witnessed falling on their right side and hit their head on the wall. The resident had neuro checks and was assessed with no redness, bruises, bleeding, or deformities. Resident #2 had an At Risk for Fall Care Plan related to behaviors, impaired cognition, Alzheimer's Dementia; psychotic disorder with hallucinations, anxiety, depression, muscle weakness and shuffling gait initiated on 09/16/2021. The care plan goal documented that the resident will be free of falls and fall related injuries. The interventions included to encourage the resident to stay in supervised setting while out of bed; to investigate cause of falls and evaluate patterns if more than 1 fall; to meet the resident needs in relation to current activities of daily living (ADL) function; resident must wear non-skid footwear; provide reality orientation as needed; Physical Therapy/Occupational Therapy referral as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the care plan was reviewed and revised post fall incident on 04/02/2024. During an interview conducted on 07/23/2024 at 1:50 PM, the Licensed Practical Nurse #1 stated that they are not responsible to initiate or update care plans.It is the responsibility of the unit managers in charge to do that. Licensed Practical Nurse #1 stated that they are responsible to follow the care plans and to keep the residents safe. During a telephone interview conducted on 08/07/2024 at 4:14 PM, the Assistant Director of Nursing stated that the Licensed Practical Nurse Unit Managers are responsible to initiate and update comprehensive care plans but the plans must be reviewed and signed by a Registered Nurse. All care plans must be reviewed post fall incidents. They are not sure why Resident #2's fall care plan was not updated. 415.11(d)(3)

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	335261	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	Route 100 Somers, NY 10589

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the abbreviated (NY00347929) survey from 7/23/2024 to 7/24/2024, the facility did not ensure a resident who was diagnosed with dementia, receives the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. This was evident for 1 (Resident #1) of 4 residents reviewed for behaviors. Specifically, Resident #1's Comprehensive Care Plan related to dementia care was not reviewed and revised to address the resident's increasing dementia-related behaviors. The findings are: The facility policy titled Dementia - Clinical Protocol dated 11/2018 documented the interdisciplinary team will maximize the resident-centered care plan for remaining function and quality of life. The interdisciplinary team will review changing needs as they arise. The facility policy titled Behavioral Assessment, Intervention and Monitoring dated 3/2019 documented the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The facility policy titled Care Plans, Comprehensive Person-Centered dated March 2022 documented that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Resident #1 was admitted to the facility on [DATE] with diagnoses of Lyme disease and unspecified dementia without behavioral disturbance. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired, displayed physical aggression towards others on 1 to 3 days in the 7 days prior to the assessment, and did not exhibit wandering behavior. Resident #1 had a Health Care Proxy and their family participated in the assessment. On 7/23/2024 at 11:20 AM, Resident #1 was observed on the [NAME] Unit, a locked dementia unit, seated at a table in the lounge area with another resident. Resident's room was a short distance down the hall with a [NAME] Poster affixed to the room door. The resident's name was written in small black letters beside the door. There were no family pictures, personalized decorations, or visible clock and calendar in Resident #1's room. Resident #1 was observed in the lounge area, rising from the table, and trying the knobs for different doors lining the hallway. Resident #1 did not recognize their room with the [NAME] Poster. Resident #1 stated they were looking for their keys and needed to drive home. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident had a Care Plan for Exhibiting Behavioral Symptoms related to history of physical abuse or aggression directed at staff, resist care, wanders, and refuses Identification (ID) bracelet that was initiated on 05/24/2024 and updated 07/11/2024. The care plan goals documented Resident #1 will safe and will be protected; the resident and others will not experience harm from behavioral episodes; and the resident will be free of injury. Interventions included to allow resident time to de-escalate when agitated; to encourage participation in activities of daily living; to notify and report behavioral changes to the physician; provide wander guard to decrease risk of elopement; refer for psychiatric consult; and provide a safe and secure environment. The Resident had an Impaired Cognition Care Plan related to Dementia diagnosis with behavioral disturbance initiated on 05/24/2024 and last updated on 07/11/2024. The care plan goals documented that the resident would demonstrate ability to make decisions in choices such as clothing, bathing, menu selection, and activities; the resident will demonstrate knowledge of location of room, staff names, current season, dining room seat, and self; and the resident will participate in selfcare within mental and physical limitations. The care plan interventions included to break tasks into simple steps; to encourage self-performance in activities of daily living; to provide leisure activities to improve socialization such as magazines with pictures, exercise groups, singing, etc.; to use simple words or instructions; to utilize staff and picture in the electronic medical record to identify. Review of Nursing Note dated 5/28/2024 documented Resident #1 rang their call bell for assistance in the bathroom. When staff entered the room, Resident #1 became annoyed and swung their cane at the staff member. Resident #1 would be monitored for behavioral triggers. Review of Nursing Notes dated 6/2/2024, 6/16/2024, 6/17/2024, 6/19/2024, 6/20/2024, 6/22/2024, and 6/26/2024 documented Resident #1 displayed exit-seeking and wandering behavior, was agitated and restless, was not easily redirected by staff, and was aggressive towards staff during the 11PM to 7AM shift. Review of Nursing Note dated 6/29/2024 documented Resident #1 displayed agitation and attempted to leave the facility at 3PM. Code [NAME] was called, and Resident #1 was administered 1 milligram of Ativan intramuscularly. Review of Nursing Note dated 7/1/2024 and 7/10/2024 documented Resident #1 wandered into other residents' rooms, was agitated, would not go to bed, and required staff monitoring for safety. The Psychiatry Consult dated 7/3/2024 documented Resident #1 was agitated and restless at times. Review of Nursing Note dated 7/11/2024 at 2:25 AM documented Resident #1 was agitated, aggressive, and punched Certified Nursing Assistant #1 in the face when redirected. The Nursing Note at 3:27 PM documented Resident #1 was involved in an unpleasant interaction with a staff member that morning and showed no signs of psychological harm as a result. The Certified Nursing Assistant Kardex Report, a list of resident care instructions as of 7/11/2024 documented to monitor and address Resident #1's anxiety and distress. The Psychiatry Consult dated 7/12/2024 documented Resident #1 was irritable and restless throughout the day and wandered into other residents' rooms. The Psychiatry Nurse Practitioner recommended adding Depakote 125mg twice daily. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence Resident 1's dementia care plan was reviewed and revised to include an individualized approach to address Resident #1's wandering, restlessness, agitation, and exit-seeking behaviors. On 7/11/2024 at 1:25 AM, Licensed Practical Nurse #1 documented Resident #1 was restless, agitated, wandering into other residents' rooms, and required constant redirection. Resident #1's agitation increased, and they became aggressive towards staff, cursing at Certified Nursing Assistant #1. Licensed Practical Nurse #1 documented they made the Nursing Supervisor, Registered Nurse #1, aware and would continue to monitor Resident #1's behavior. During an interview on 7/23/2024 at 2:13 PM, Licensed Practical Nurse #1 stated they regularly work the 11PM to 7AM shift on the Resident #1's Unit, a locked dementia Unit. Licensed Practical Nurse #1 stated regular staffing for the night shift included 2 Certified Nursing Assistants and 1 Licensed Practical Nurse for 40 residents, including 6 residents that required 2-person assistance with Activities of Daily Living and 4 residents who wander throughout the night. Licensed Practical Nurse #1 stated they were the charge nurse on 7/11/2024 when Resident #1 was agitated, wandering into other residents' rooms, and aggressive towards staff. Licensed Practical Nurse #1 stated Resident #1 had previous episodes of aggression towards staff. Licensed Practical Nurse #1 stated that they were in-serviced on abuse prevention and had a Dementia Care training. Licensed Practical Nurse #1 stated that they are not responsible to initiate or update care plans it is the unit managers who are in charge to do that. Licensed Practical Nurse #1 stated that they are responsible to follow the care plans and to keep the residents safe, so they do frequent rounds and check on the residents. Licensed Practical Nurse #1 stated that there are usually 3 or 4 restless residents wandering the unit and they keep on redirecting them and usually the residents are easily redirected. During an interview conducted on 07/24/24 at 02:59 PM, Licensed Practical Nurse #3 stated they usually work from 7AM to 3PM, and they received dementia care training. Licensed Practical Nurse #3 stated Resident #1 is not receptive to female nurses/care givers because they always talk down to them. They observed that Resident #1 responds better to redirection from male caregivers. Resident #1 wanders into other residents' room just trying to search for items. Redirection works best to show them where their room is and where the bathroom is. During a telephone interview conducted on 07/30/24 at 04:12 PM, the Medical Doctor #1 stated that they are responsible for the [NAME] Unit. Medical Doctor #1 stated that for the most part, Resident #1 was a pleasant guy. They would become agitated when they would ask for their car keys, ask where their car is, and want to leave. They would get very upset in the moment and then they would forget and calm down. Most people become forgetful with dementia, but some have a trigger that makes them agitated. Redirection, distraction, educate staff that this is the resident's trigger. Engage them in activities. When behavioral measures don't work then medication from psychiatry. Medical Doctor #1 stated they were aware that resident wandered at night. At night, if they can't fall asleep, they should bring them to the nurse's station, tv, snack, and keep them under observation. Medical Doctor #1 stated that staff did not alert them to any escalation of behaviors or unmanageable behavior. Staff was supposed to communicate to them by calling them on their phone. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 07/23/2024 at 4:30 PM, the Director of Nursing stated they have staffing issues, they do need more staff, however, with the help of the nurses and the whole administrative team they are able to provide the care necessary. The Director of Nursing stated they conducted a facility wide refresher on the emergency code (Code Green), and they completed a facility wide re-education on Managing Residents with Dementia and Behaviors with 100% compliance. During a telephone interview conducted on 08/07/2024 at 4:14 PM, the Assistant Director of Nursing stated that the Licensed Practical Nurse Unit Managers are responsible to initiate and update comprehensive care plans but the care plans must be reviewed and signed by a Registered Nurse. All care plans must be reviewed post fall incidents. 10 NYCRR 415.12

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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 and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the abbreviated (NY00347929) survey from 7/23/2024 to 7/24/2024, the facility did not ensure a facility-wide assessment was conducted to determine what resources are necessary to care for its residents competently. This was evident for 1 ([NAME] Unit) of 7 resident units. Specifically, the Facility Assessment did not identify the [NAME] Unit as a specialized dementia unit and did not identify the staffing assignment necessary to care for residents during day-to-day operation. The findings are: The facility policy titled Facility assessment dated ,d+[DATE] documented the Facility Assessment is intended to help determine budget, staffing, training, equipment, and supplies needed. The Facility assessment dated [DATE] documented common resident diagnoses included impaired cognition, Alzheimer's disease, and non-Alzheimer's dementia. The facility uses basic par levels for each residential unit as a standard measure: Licensed Nurses = 10, Nurses' Aides = 30, Registered Nurse Supervisor = 4, Other staff needed for behavioral healthcare = 2. Individual staff assignment: the facility reviews care assignments daily by resident, based on acuity to ensure quality of care is maintained every shift, every day. There was no documented evidence the Facility Assessment identified and addressed the specialized care needs of the [NAME] Unit, a unit specifically for residents with dementia. There was no documented evidence the Facility Assessment defined the staffing assignments necessary to provide the care and services required for the day-to-day operation of the [NAME] Unit with the resident population as a determining factor. During an interview on 7/23/2024 at 2:13 PM, Licensed Practical Nurse #1 stated they regularly worked the 11PM to 7AM shift on the [NAME] Unit, a locked dementia unit. Regular staffing for the night shift included 2 Certified Nursing Assistants and 1 Licensed Practical Nurse for 40 residents, including 6 residents that required 2-person assistance with activities of daily living and 4 residents who wander throughout the night. There were no housekeeping staff assigned to the unit on the night shift and there were residents on the unit that had bowel movements or urinated on the floor in their room. The nursing staff did their best to clean the fecal matter or urine on the floor and covered the stains with towels until the housekeeping staff arrive in the morning. Licensed Practical Nurse #1 stated they will provide resident care when 1 Certified Nursing Assistant is on break and 1 Certified Nursing Assistant is on the unit. The facility used to schedule for 3 Certified Nursing Assistants for the [NAME] Unit, but this was no longer the staffing level for the unit. Licensed Practical Nurse #1 stated they informed the 11PM to 7AM Registered Nurse Supervisor and the 7AM to 3PM Unit Manager that more staff on the night shift would be ideal but no changes were made in the schedule. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/2024 at 2:46 PM, the Staffing Coordinator stated staffing par levels for Certified Nursing Assistants were set by the Administrator based on the acuity of the resident population on each unit. The [NAME] Unit was a memory care unit that housed residents with dementia. The Staffing Coordinator stated they have worked for the facility for 18 months and there has not been a change to the par level of 4 Certified Nursing Assistants on the day shift, 4 Certified Nursing Assistant on the evening shift, and 2 Certified Nursing Assistants on the night shift. Durign an interview on 08/07/2024 at 3:40 PM, the Administrator stated that they are responsible in managing/updating the Facility Assessment, and they did a lot of updating during COVID. With regards to the skills needed for the [NAME] Unit, they work closely with the Director of Nursing since they are more familiar with the acuity of the residents and the skills required to take care of them. They do involve other disciplines such as the Recreation Team to socialize with the residents on the [NAME] Unit. 10 NYCRR 415.5(h)(2)