STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335273	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Verrazano Nursing and Post-Acute Center	100 Castleton Avenue Staten Island, NY 10301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49169 Based on record review and interviews conducted during an Abbreviated Survey (NY00322823), the facility did not ensure that the results of all investigations of alleged violations involving abuse were reported to the State Survey Agency within 5 working days of the incident. This was evident for 2 (Residents #4 and #5) of 4 residents reviewed for abuse. Specifically, on 08/26/2023, the facility received a report that Resident #5 inappropriately touched Resident #4. The facility submitted a Follow-up Investigation Report on 09/05/2023. The findings are: A Dear Nursing Home Administrator Letter (DAL: NH 22-20) dated 10/18/2022 regarding Facility Incident Reporting System stated that the notice was to inform the Administrator of changes in reporting of nursing home facility incidents as detailed in QSO-22-19-NH and effective on 10/24/2022. The guidance stated that in addition to an initial facility incident report that must be submitted following reporting timelines, nursing homes must submit to the New York State Department of Health the results of the facility investigation. Within 5 business days of the incident, the facility must provide, in its report, sufficient information to describe the results of the investigation, and must indicate any corrective action(s) taken if the allegation was verified. The facility should include any updates to information provided in the initial report and the following additional information, including, but are not limited to, the following: 1. Additional/Updated information related to the reported incident, 2. Steps taken to investigate the allegation, 3. A conclusion, 4. Corrective action(s) taken, and 5. The name of the facility investigator. The facility policy on Accident and Investigation Reporting with a last reviewed date of 10/20/2023 documented that the Director of Nursing / Administrator are responsible to investigate the allegations and report findings to the New York State Department of Health within 5 working days of the reported incident. The Resident Grievance form dated 08/28/2023 documented Resident #4 reported to nursing staff they were sexually abused by their roommate on 08/27/2023. The Social Worker interviewed each resident independently. The grievance form documented that there was no reasonable suspicion on the findings of investigation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Castleton Avenue Staten Island, NY 10301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Home Facility Incident Report documented that the incident occurred on 08/26/2023 at 3:00 am and that the initial incident report was submitted to the New York State Department of Health on 08/26/2023 at 5:11 pm. The report documented that the staff was first made aware on 08/26/2023 at 2:55 pm. A Nursing Home Investigation Report documented that the 5-day Follow Up report was submitted to the New York State Department of Health on 09/05/2023 at 10:07 am. The report documented that the investigation findings were inconclusive. During an interview on 04/15/2024 at 3:51 pm, the Director of Nursing stated they recently started working in the facility and was not the director when the alleged incident occurred. They stated that the nursing director was responsible for conducting a thorough investigation of abuse allegations and that an initial report must be submitted to the New York State Department of Health within a 2-hour window. The Director of Nursing stated that the result of the investigation must be submitted to the New York State Department of Health in 5 days. During an interview on 04/12/2024 at 1:15 pm, the Administrator stated it was a Director of Nursing's responsibility to report alleged incidents of abuse to the New York State Department of Health. 10 NYCRR 415.4(b) (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49169 Based on interviews and record review conducted during an Abbreviated Survey (NY00322823), the facility failed to ensure that all alleged violations involving abuse were thoroughly investigated. This was evident in 2 (Residents #4 and #5) of 4 residents sampled. Specifically, on 08/26/2023, the facility received a report that Resident #5 inappropriately touched Resident #4. The facility initiated an investigation but did not thoroughly investigate the allegation. The facility did not gather statements from staff members who may have potentially witnessed the allegation. The findings are: The facility policy and procedure titled Abuse Prevention with a last reviewed date of 10/2022 documented that if any staff was made aware of any alleged violation of abuse, neglect, or mistreatment, the facility will thoroughly investigate the alleged violation, attempt to prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress and take appropriate corrective action. The facility policy on Accident and Incident Investigation and Reporting with a last reviewed date of 10/20/2023 documented that the registered nurse supervisor is responsible for initiating the Accident/Incident form by ensuring that all required investigation statements are completed in a timely manner. Investigation statements are to be obtained from the unit nurse, the assigned certified nursing assistant, any witnesses to the occurrence and the person who reported the occurrence. Resident #4 was admitted to the facility with diagnoses of Panic Disorder and Generalized Anxiety Disorder. The Minimum Data Set with assessment reference date of 09/01/2023 documented that Resident #4 was cognitively intact. Resident #5 was admitted to the facility with diagnoses of Acquired Absence of Right Leg Above Knee and Major Depressive Disorder. The Minimum Data Set with assessment reference date of 05/20/2023 documented that Resident #5 was cognitively intact. Review of the Resident Grievance form dated 08/28/2023 documented Resident #4 reported to nursing staff that they were sexually abused by their roommate on 08/27/2023. The Social Worker interviewed each resident independently. The grievance form documented that there was no reasonable suspicion on the findings of investigation. An Incident Report form dated 08/28/2023 completed by the Director of Social Services documented they interviewed Resident #5. Resident #5 denied the allegation and stated that they were a double amputee and that their arms were not long enough to reach Resident #4's bed. An Incident Report dated 08/28/2023 completed by the Director of Social Services documented they interviewed Resident #4. Resident #4 stated they felt like their child placed them in the nursing home against their will and that they do not like black people. Resident #4 also stated they were asleep and was dreaming. The Director of Social Services documented that based on Resident #4's statement, the alleged incident never happened. (continued on next page)

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	335273	A. Building B. Wing	04/16/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that frontline unit staff members were interviewed or provided statements regarding the alleged abuse allegation. A Nursing Home Facility Incident Report documented that the incident occurred on 08/26/2023 at 3:00 am and that the initial incident report was submitted by the facility to the New York State Department of Health on 08/26/2023 at 5:11 pm. The report documented that the staff was first made aware on 08/26/2023 at 2:55 pm. During an interview on 04/12/2024 at 10:52 am, the Director of Social Services stated they were notified of Resident #4's allegation that they were inappropriately touched by Resident #5. They stated they interviewed Residents #4 and #5 and reported the information to the former Director of Nursing. The Director of Social Services stated they did not interview the staff in the unit where Residents #4 and #5 reside, and that it was the Director of Nursing's responsibility to interview the staff. The Director of Social Services stated that based on their interview with Residents #4 and #5, they concluded that the allegation was unfounded. During an interview on 04/15/2024 at 10:35 am, the Director of Nursing stated they recently started working in the facility and was not the director when the alleged incident occurred. They stated it was a nursing director's responsibility to initiate and conduct a thorough investigation of abuse allegations. During an interview on 04/12/2024 at 1:15 pm, the Administrator stated it was the responsibility of the nursing supervisor on duty to initiate the investigation of an alleged abuse and gather statements from the staff who were present at the time of the alleged incident. The Administrator stated that it was the Director of Nursing's responsibility to conduct an investigation of abuse allegations. 10 NYCRR 415.4(b)(3)

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NAME OF PROVIDER OR SUPPLIER: Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Castleton Avenue Staten Island, NY 10301	

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on record review and interviews conducted during the Abbreviated Survey (NY 00311407), the facility did not ensure Preadmission Screening for individuals with mental disorders and individuals with intellectual disability was done prior to admission. This was evident for 1 of 3 residents (Resident #1) sampled for Pre-Admission Screening and Record Review (a federal requirement to ensure that residents were not inappropriately placed in a skilled nursing facility). Specifically, Resident #1's Screen Form Department of Health-695 was dated 01/04/23. Level I was positive for serious mental illness but was not completed, and Resident #1 was not evaluated for Level II screening prior to admission to the facility. Resident #1 or the legal representative did not sign the Screen Form. The findings are: The facility policy entitled, Screen/Pre-Admission Screening and Record Review Evaluation, not dated, documented it is the policy of the facility to be complaint with Department of Health 695 in completing or obtaining a screen that will determine if a Pre-Admission Screening and Resident Review (PASRR) evaluation is require. Prior to admission to the facility every individual will have a Screen (Level I) available to be reviewed by Social Service department to ensure that the proper level of care can be provided. Upon review of the Screen, if a Pre-Admission Screening and Resident Review Level II is recommended, it will be obtained prior to admission to the facility. A Patient Review Instrument dated 01/02/23, documented Resident #1 required Guardianship. Resident #1 was admitted to the facility with diagnoses including Failure to Thrive, Major Depressive Disorder, and Schizophrenia (a serious brain disorder that causes people to interpret reality abnormally). A review of Resident #1's Screen Form Department of Health-695 Level 1 dated 01/04/23, done by hospital's Social Worker was incomplete. Resident #1 was triggered yes for serious mental illness (question 21) with directions to proceed to items 24-26. The instructions indicate that questions 24-26 must be answered; the questions were not answered. The Screen Form indicated that a Level II Pre-Admission Screening and Resident Review screen was needed. Resident #1's Pre-Admission Screening and Record Review documented that Resident #1 was in agreement with discharge plan but the document was not signed by Resident #1 or legal representative. There was no documented evidence a Level II Pre-Admission Screening and Record Review was completed prior to Resident #1 being admitted to the facility. An Admission Minimum Data Set 3.0 (a resident assessment tool) dated 01/10/23, documented that Resident #1 had intact cognition. Section A documented Resident #1 was not considered to have a serious mental illness by the state level II Pre-Admission Screening and Resident Review process. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Castleton Avenue Staten Island, NY 10301	

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/24 at 3 :15 pm, the Director of Social Service stated that Resident #1's Patient Review Instrument and Screen should be completed before Resident #1 was admitted from the hospital. The Director of Social Service stated they were not reviewing preadmission documents prior to residents' admission. The Director of Social Service stated that they reviewed Resident #1's Patient Review Instrument and Screen Form the next day after admission and think that date 01/04/24 on the Screen Form was a error. The Director of Social Service stated that Resident #1's Screen Level I was not showing recommendations for Level II evaluation, and it was not done. The Director of Social Service stated that they saw Level 1 was checked positive for serious mental illness and the don't know why the rest of the Screen Form was not checked. The Director of Social Service stated that they don't know what to do if Screen Form was not completed in the hospital. During an interview on 03/05/24 at 3:30 pm, the Director of Admissions stated they are responsible for obtaining and reviewing Patient Review Instrument and Pre-Admission Screening and Record to make sure Social Worker in the hospital completed the screen, signed, put their license number and the resident or resident's representative signed it prior to admission. Director of Admissions stated if the Screen Form was not completed the Director of Admissions must reach out Social Service in the hospital to request completed Screen Level I and if applicable Level II prior to admission to the facility. Director of Admissions further stated Resident #1's Patient Review Instrument and Screen Form was reviewed by former Director of Admissions. Director of Admissions stated that Resident #1 was admitted on [DATE], but the hospital Social Worker dated and signed Screen Form Level on 01/04/23 meaning the Screen Level I was done after Resident #1 was admitted . Director of Admissions stated that Social Worker who was completing Screen Level I missed to answer questions 24, 25, and 26 which resulted in Screen was not completed to prompt the rest of the evaluation. The Director of Admissions stated that Screen should be done in the facility to make sure Resident #1 was properly placed in the facility. During an interview on 3/6/24 at 4:32 pm, the Administrator stated the Director of Admission was responsible for Patient Review Instrument and Screen review prior to residents' admission. The Administrator stated Screen Level I and Level II should be received and reviewed prior to the resident's admission to the facility to make sure the resident is placed in the facility appropriately. The Administrator stated if Level II evaluation was needed, it should be sent from the hospital with a Patient Review Instrument prior to admission. The Administrator stated they oversee the Director of Admission but personally do not review the Screen or Patient Review Instruments prior to Admission. The Administrator stated the Director of Nursing reviewed the Patient Review Instrument prior to admission to determine from a clinical point if it is appropriate placement for the resident. 10 NYCRR 415.11(e)

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	335273	A. Building B. Wing	04/16/2024

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49169 Based on record reviews and interviews conducted during an Abbreviated Survey (NY00322823), the facility did not ensure that a comprehensive person-centered care plan was developed and implemented for each resident. This was evident for 2 (Residents #4 and #5) of 4 residents reviewed for abuse. Specifically, a comprehensive care plan related to abuse was not developed for Resident #4 and Resident #5 following an allegation of sexual abuse. The findings are: A facility policy titled Resident Care Planning with a last revised date of 02/15/2023 documented that the facility's care planning / interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. Resident #4 was admitted to the facility with diagnoses of Panic Disorder and Generalized Anxiety Disorder. The Minimum Data Set with assessment reference date of 09/01/2023 documented that Resident #4 was cognitively intact. Resident #5 was admitted to the facility with diagnoses of Acquired Absence of Right Leg Above Knee and Major Depressive Disorder. The Minimum Data Set with assessment reference date of 05/20/2023 documented that Resident #5 was cognitively intact. A Resident Grievance form dated 08/28/2023 documented Resident #4 reported to nursing staff that they were sexually abused by Resdient #5 on 08/27/2023. The Social Worker interviewed each resident independently. The grievance form documented there was no reasonable suspicion on the findings of investigation. A review of Resident #4 and Resident #5's medical records showed no documented evidence that a care plan was developed to address Resident #4's allegation of sexual abuse against Resident #5. During an interview on 04/15/2023 at 10:35am, the Director of Nursing stated they recently started working in the facility and was not the director when the alleged incident occurred. They stated it was the responsibility of the Registered Nurses who were on duty to initiate and update a resident's care plans as soon as an abuse allegation was made. 10 NYCRR 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY 00311407), the facility did not ensure that an effective discharge plan was developed that focused on the resident's discharge goals, preparation of the resident to be an active participant in their care and effectively transition the resident to post-discharge care. This was evident for 1 out of 3 residents sampled (Resident #1). Specifically, Resident #1 was admitted to the facility on [DATE] and was discharged to the community on 11/01/2023. A discharge care plan was not developed for Resident #1. The findings are: The facility's Policy and Procedure, titled Care Planning-Baseline Care Plan and Comprehensive Care Plan with review date 02/12/23, documented the facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). Resident #1 was admitted to the facility with diagnoses including Failure to Thrive, Major Depressive Disorder, Bipolar Disorder, and Schizophrenia (a serious brain disorder that causes people to interpret reality abnormally). An Admission Minimum Data Set 3.0 (a resident assessment tool) dated 01/10/23, documented that Resident #1 had intact cognition and required limited assistance with most of Activity of Daily Living. Section Q of the Minimum Data Set documented no active discharge planning, already occurring for the resident to return to the community. A Base Line Care Plan dated 01/03/23 documented the resident was admitted for a short term. A review of Resident #1's medical record from 01/03/23 to 11/01/2023, revealed that a discharge care plan was not initiated to address the resident's need for safe and orderly discharge from the facility to the community. A Social Service note dated 02/23/23 at 8:57 am, written by the Director of Social Service, documented Resident #1 had no virtual active discharge plan at this time due to pending guardianship proceeding. A Facility's Administrator Petition dated 03/01/23, documented that the facility's Administrator filed a petition to be the Guardianship for Resident #1. A Social Service note dated 03/02/23 at 12:52 pm, written by Director of Social Service documented there is no virtual active discharge planning at this time because resident has no home available to ensure a safe return back to the community. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Castleton Avenue Staten Island, NY 10301	

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Service note dated 03/28/23 at 3:39 pm, written by the Director of Social Service, documented Court attorney came in to visit Resident #1 for court assessment due to guardianship. The Court Evaluator Report dated 04/10/23, reviewed and revealed that Court Evaluator recommended Contact Person #2 granted as a temporary Guardian over person and permanent over property of Resident #1. A Social Service note dated 04/13/2023 at 4:00 pm documented tentative discharge planning: Resident #1 had a guardianship hearing on 04/13/2023 at 10:00 am to determine guardianship appointee. The Supreme Court of the State of the New York County, dated 05/25/23, documented Contact Person #2 was appointed as Temporary Guardian of Person and Property for Resident #1. A Psychchiatric note dated 07/11/23, documented Resident #1 has the capacity to make a medical /financial decision. Resident #1 wants to leave the facility. A Social Service note dated 07/19/23 at 2:06 pm, documented that the Interdisciplinary Team meeting to review Resident #1's general / or current medical status. Resident #1 expressed satisfaction with care. Resident #1 is stable, and placement is appropriate. Nursing Note dated 11/1/2023 at 2:20 pm, documented Resident #1 was discharged to Supported Housing. Discharge teaching was provided to the Guardian and Resident #1, and they verbalized understanding. Resident #1 left the facility at 2:30 pm with Guardian in no distress. During an interview on 3/5/24 at 3:43 pm, the Assistant Social Worker stated that they and the Director of Social Service were responsible for developing, implementing, and updating a discharge care plan. The Assistant Social Worker stated that they didn't know why it was not done. During an interview on 03/05/24 at 3:15 pm, the Director of Social Service stated that Resident #1's discharge care plan was not initiated because there was no discharge due to Resident #1 requiring a Guardianship. The Director of Social Service stated that they and the Assistant of the Social Worker were supposed to create a discharge care plan with interventions for safe discharge. The Director of Social Service stated that they documented in the progress notes and emails Resident #1's discharge process. 10 NYCRR 415.11(d)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Verrazano Nursing and Post-Acute Center	100 Castleton Avenue Staten Island, NY 10301

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49169

Based on interviews and record review during an Abbreviated Survey (Complaint # NY00314677), the facility failed to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. This was evident in 1 (Resident #2) of 3 residents reviewed for pressure ulcers (ulcers which occur on the skin surface due to prolonged pressure). Specifically, Resident #2, who was at mild risk for developing a pressure ulcer, was identified with a pressure ulcer on the sacrum (a bone located on the lower back) on 03/28/2023. The resident's pressure ulcer was not promptly assessed, and treatment was not started until 04/07/2023. Subsequently, on 04/10/2023, Resident #2 was assessed by the physician and diagnosed with a decubitus (Damage to a person's skin caused by constant pressure on an area for a long-time) ulcer infection. Additionally, a care plan to prevent pressure ulcer was not developed for Resident #2. This resulted in actual harm to Resident #2 that is not Immediate Jeopardy.

The findings are:

The undated facility's policy titled Pressure Ulcer Tracking documented it is the policy of the facility to ensure that all residents with potential for or actual pressure ulcer achieves intactness in skin. All residents identified via the Nursing Admission Assessment as well as the Braden Scale Assessment and the Minimum Data Set to be at risk for pressure ulcers will have an active nursing care plan addressing this variable.

Resident #2 was admitted to the facility with diagnoses of Peripheral Vascular Disease (is a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm), schizoaffective disorder (a mental health condition characterized by abnormal thought processes and unstable mood), and Delusional Disorders (a type of psychotic disorder characterized by firmly held false beliefs).

The Minimum Data Set (an assessment tool that measures health status in nursing home residents) assessment dated [DATE] documented that Resident #2 was moderately cognitively impaired. Section M (an item in the Minimum Data Set that documents the risk, presence, appearance, and change of pressure ulcers in nursing home residents) of the assessment documented Resident #2 did not have pressure ulcers and was at risk for developing pressure ulcers. The Minimum Data Set assessment documented that Resident #2 required extensive assistance with 1-person physical assist for transfer, toilet use, dressing, and personal hygiene; limited assistance with 1-person physical assist for bed mobility and eating.

The Nursing Admission assessment dated [DATE] documented that Resident #2 had intact skin.

The Braden Scale (an assessment tool to assess and document a resident's risk for developing pressure ulcer) for Resident #2 dated 01/14/2023 documented Resident #2 had mild risk of developing pressure ulcers. The risk factors documented were slightly limited sensory perception, skin was occasionally moist, slightly limited mobility, and potential problem (requires minimum assistance) on friction and shear.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Castleton Avenue Staten Island, NY 10301	

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Despite the Braden Scale identifying that Resident #2 was at mild risk of developing a pressure ulcer, a review of Resident #2's Comprehensive Care Plans did not reveal documented evidence that a care plan was developed that identified resident as at risk for pressure ulcer development. There was no documented evidence that interventions were in place to prevent the development of pressure ulcers. The Weekly Skin Assessment forms dated 03/14/2023 and 03/21/2023 documented Resident #2 had intact skin. A Weekly Skin Assessment form for Resident #2 dated 03/28/2023 documented skin exam, with the sacral part circled, description was unstageable. The progress notes from 03/28/2023 through 04/06/2023 had no documented evidence that the unstageable pressure ulcer was evaluated. The Certified Nursing Assistant Documentation Record dated 03/21/2023, 03/28/2023, 04/04/2023, and 04/11/2023 documented that skin check was performed but did not document the skin observations or impairment. A review of the physician's orders from 03/28/2023 through 04/06/2023 did not reveal orders for unstageable pressure ulcer on the sacrum. A review of the Treatment Administration Record from 03/28/2023 through 04/06/2023 did not reveal documented evidence that Resident #2 received treatment to the unstageable sacral pressure ulcer. A review of Resident #2's comprehensive care plans revealed that the facility did not develop a care plan that identified the development of a pressure ulcer or skin alteration until 04/14/2023. At this time the wound was identified as a Stage 4 pressure ulcer to the sacrum. The care plan had no documented goals or interventions in place to guide the care of the wound. Physician #2's progress note dated 04/07/2023 at 2:02 pm documented Resident #2 was seen for sacrum wound break down and copious foul-smelling necrotic (medical term for the death of body tissue that can occur when there is lack of blood flow to the tissues) tissue present on exam. Resident will need twice a week debridement until it improves. The note documented sacrum unstageable decubitus with breakdown 7 by 9-centimeter, 63-centimeter, depth 3.5-centimeter, copious foul-smelling tissue, no granulation tissue, minimal exudate; will debride at bedside today. Recommended topical sodium hypochlorite dressing (a strong topical antiseptic used to treat pressure sores) twice a day, consider Collagenase (treatment for skin ulcers that removes dead skin and tissue), offload pressure, pain control, optimize nutrition. Physician #1's order dated 04/07/2023 documented dilute sodium hypochlorite solution 0.25% -(a solution used to treat bedsores), apply by topical route 3 times per day, cleanse with normal saline wet gauze with dilute sodium hypochlorite solution 0.25% apply to affected area and cover with dry abdominal dressing. The order did not specify the site of treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Castleton Avenue Staten Island, NY 10301	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Treatment Administration Record dated 04/07/2023 through 04/30/2023 documented that Resident #3 received treatment of topical sodium hypochlorite dressing, apply by topical route 2 times per day cleanse with normal saline, wet gauze with topical sodium hypochlorite dressing solution, apply to affected area and cover with dry abdominal dressing. The Treatment Administration Record did not specify the site of treatment. Physician #1's progress note dated 04/10/2023 at 7:11 pm documented Resident #2 was seen for follow up on decubitus ulcer infection. Resident was started on intravenous antibiotics for 7 days. Physician #1's progress note dated 04/17/2023 at 4:09 pm documented Resident #2 was seen for follow up on decubitus ulcer infection. Resident #2 completed antibiotic therapy for decubitus infection with no adverse reaction. The note documented that Resident #2 was stable and that the wound improved. Physician #2's progress note dated 04/28/2023 at 12:14 pm documented Resident #2 was seen for follow up of the pressure ulcer on the sacrum. Wound assessment documented sacrum stage 4 pressure ulcer, 7 by 6 centimeter with undermining, depth of 5-centimeter, moderate necrotic tissue, moderate granulation tissue, minimal exudate. The pressure ulcer was debrided down to the depth level and including bone. Resident #2 tolerated the procedure with no complications. Physician #2's progress note dated 05/05/2023 at 12:34 pm documented Resident #2 was seen for follow up of the pressure ulcer on the sacrum, Wound assessment documented sacrum stage 4 pressure ulcer, 8 by 6-centimeter, depth of 5 centimeter, with undermining, with moderate necrotic and granulation tissue, minimal exudate. The pressure ulcer was debrided down to the depth level and including bone. Resident #2 tolerated the procedure with no complications. Physician #1's progress note dated 05/19/2023 at 10:39 am documented that Resident #2's pressure ulcer in the sacrum area presented with foul odor and purulent drainage; recommended to transfer Resident #2 to the hospital for wound debridement and antibiotic therapy. A nurse's progress notes dated 05/20/2023 at 6:45 am documented Resident #2 was admitted in the hospital. During an interview on 03/06/2024 at 12:17 pm, Registered Nurse #1, who was the nursing supervisor in Resident #2 unit, stated they knew about Resident #2's unstageable pressure ulcer in April 2023, could not recall the exact date, after it had been reported by a staff. Registered Nurse #1 stated they were not aware and had not received report about Resident #2's pressure ulcer prior to April 2023. Registered Nurse #1 stated Registered Nurses are responsible for initiating the care plan for at risk to develop pressure ulcer upon admission and must be updated when there is a change in resident's condition. Registered Nurse #1 stated care plans must have long and short-term goals and interventions. During an interview on 04/11/2023 at 9:11 am, Registered Nurse #2 stated they identified the pressure ulcer on the sacrum on 03/28/2023 during weekly skin assessment. Registered Nurse #2 stated they documented the observation on the Weekly Skin Assessment form and verbally notified the Director of Nursing and the Attending Physician of the suspected pressure ulcer. Registered Nurse #2 stated the facility did not have a wound care nurse at that time. Registered Nurse #2 stated they were responsible for initiating a care plan for pressure ulcer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Verrazano Nursing and Post-Acute Center	100 Castleton Avenue Staten Island, NY 10301

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/06/2024 at 12:17 pm, Physician #1 stated they were not notified that Resident #2 developed pressure ulcer until 04/07/2023. They stated the Wound Care Consultant evaluated Resident #2 and debrided the wound. They stated Resident #2 was started on antibiotic therapy so that wound did not get worse. Physician #1 stated they believe the reason they were not notified immediately was because the facility had a high turnover of nurses and were using travel nurses. They stated the facility did not have a wound care nurse. Physician #1 stated they cannot say that Resident #2's pressure ulcer was avoidable, but it could have been prevented. They stated they could have referred Resident #2 to a wound care specialist had they been immediately notified. During an interview on 03/12/2024 at 11:20 am, Physician #2, who was the Wound Care Consultant, stated it was the primary attending physician who was responsible for managing a resident's wound. They stated their responsibility was to make recommendations on how to manage the wound. Physician #2 stated Resident #2 was very sick and was bed ridden, and that could lead to developing pressure ulcers. They stated that Resident #2's pressure ulcer was preventable, but the facility must have preventive measures in place. During an interview on 04/11/2024 at 12:00 pm, Director of Nursing #1 stated they recently started working at the facility and was not the director when Resident #2 developed the pressure ulcer. The Director of Nursing stated weekly resident skin assessments were performed by the licensed nurses, and if a nurse identifies a pressure ulcer, they must immediately notify the attending physician to evaluate the wound and get treatment orders; a referral must also be made to the wound care consultant. The Director of Nursing stated the Registered Nurse Supervisors were responsible for developing care plans upon admission and it must be updated when there was a change in resident's condition. During an interview on 03/18/2024 at 1:25 pm, the Administrator stated they started working at the facility towards the end of May 2023 and was not the Administrator when Resident #2 developed the pressure ulcer. They stated they do not recall the issues surrounding Resident #1's pressure ulcer development. The Administrator stated it was the nurse manager and the Director of Nursing's responsibility to ensure care plans were developed and updated with each change in a resident's condition. 10 NYCRR 415.12(c)(1)