STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335275	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Nursing at Wappingers	37 Mesier Avenue Wappingers Falls, NY 12590

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review and interview during a recertification survey 4/8/24-4/17/24, the facility did not ensure residents had the right to a dignified existence for 8 of 8 residents reviewed for dining (Residents #54, #40, #39, #19, #25, #49, #56 and #28). Specifically, 1)clothing protectors were applied to Resident # 54, #40, #39, #19, #25, and #49 without first obtaining the residents permission; and 2) staff were observed standing over Resident #56 and #28 while feeding the residents their lunch. Findings include: The facility policy titled Resident Rights dated 2/27/18 documented all residents will be treated with kindness, respect, and dignity. The facility policy titled Preparing Resident for Meal dated 8/30/18 documented to inquire if the resident would like to wear a clothing protector in order to prevent spills of food items from staining clothes. 1. Resident #54 had diagnoses of atrial fibrillation, cerebrovascular accident, and dysphagia (difficulty swallowing). The Minimum Data Set (assessment tool) dated 2/25/24 documented the resident had moderate cognitive impairment -Resident #40 had diagnoses of Type II Diabetes Mellitus, dementia, and hypertension. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment and fed themselves. -Resident #39 had diagnoses of hypertension, dementia, and Type II Diabetes Mellitus. The Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment and fed themselves. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on 4/11/24 at 12:18 PM of Staff #14 (Certified Nurse Aide) placing a clothing protector over the head of Residents #54, #40, and #39 without asking permission. Staff #14 stated they put the clothing protectors on every resident daily. Staff #14 stated they did not ask the residents prior to placing the clothing protector because all residents get them. During an interview on 4/17/24 at 09:10 AM, Resident #54 stated they were bothered by it and would like to be told and asked before the clothing protector was applied. 2. Resident #56 had diagnoses of quadriplegia, neurogenic bladder, and alcohol abuse. The admission Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and was dependent on staff for eating. During an observation on 4/9/24 at 12:38 PM, Resident #56 was in their room being fed by Staff #13 (Certified Nurse Aide) and on 4/11/24 at 01:05 PM Resident #56 was in the hallway being fed by Staff #13. During both observations Staff #13 stood over Resident #56. During an interview on 4/9/24 at 12:40 PM and 4/11/24 at 1:05 PM, Staff #13 stated they were aware they should sit while feeding residents but they preferred to stand. During an interview on 4/12/24 at 9:15 AM, Resident #56 stated they would like to see the person who was feeding them, but were unable to raise their head due to a prior neck surgery and use of a neck collar. -Resident #28 has diagnoses of major depressive disorder and obstructive uropathy. The Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment and needed assistance from staff with activities of daily living. During an observation on 4/11/24 at 01:02 PM Staff #8 (Certified Nurse Aide) was standing over Resident #28 while feeding them their lunch. During an interview on 04/11/24 01:10PM, Staff #8 stated they were standing while feeding residents because there were so many residents that required assistance. Staff #8 stated they should sit while assisting but choose to stand. During an interview on 04/17/24 at 09:24 AM, Staff #7 (Licensed Practical Nurse Unit Manager) stated the certified nurse aides had been trained to ask for permission prior to applying the clothing protectors. Staff #7 stated staff should be seated while assisting residents with their meals, but stated sometimes there were no chairs. 10 NYCRR 415.3

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47626 Based on observation, interview, and record review conducted during the recertification survey from 4/08/24 to 4/17/24, it was determined for 1 of 1 resident (Resident # 11) reviewed for personal property, the facility did not ensure grievances were resolved in a timely manner. Specifically, the facility lacked documentation that a thorough investigation was completed or that there was timely resolution after Resident #11's report of missing clothing. The findings are: The facility Policy and Procedure titled Investigation of Grievance/concerns reviewed 11/20/23 documented that the facility would complete a prompt, thorough investigation of all grievances. Resident #11 was admitted with diagnoses of chronic obstructive pulmonary disease, bipolar disorder, and atrial fibrillation. The Quarterly Minimum Data Set (MDS an assessment tool) dated 3/5/2024 documented the resident was cognitively intact and had continuous behaviors. The social work progress note dated 3/27/2024 documented they would look into the resident's missing clothes. There was no documented evidence that a grievance was completed during March 2024. During an interview on 04/8/2024 at 10:00 AM Resident #11 stated their clothing was missing and they told the social worker, but had not heard anything back. During an interview on 4/11/24 at 11:31 AM Staff #6 (Social Worker) stated missing clothes were documented on a missing personal and misappropriation of property form, not a grievance form. Staff #6 stated they had only 1 report of missing property for the current year and were unaware of any other missing property. When asked about Resident #11's clothing Staff #6 stated they were unaware of Resident 11's missing clothing. When the progress note from 3/27/2024 was reviewed, Staff #6 could not say why a grievance or missing property form was not completed or why when asked initially they said no missing property had been reported. During an interview on 4/11/24 at 11:45 AM the Administrator stated if the facility was not able to locate the missing property quickly, they would fill out a form to ensure an investigation was done. The Administrator stated if after an investigation they were unable to locate the property, they would replace the items or reimburse the resident . The Administrator stated an investigation should have been documented and either a missing property or a grievance form completed. 10 NYCRR 415.3(c)(1)(i)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 47626 Based on staff interviews and record review during the recertification survey conducted from 4/8/2024-4/17/2024 the facility did not ensure that required documentation was sent to the receiving provider at the time of a hospital transfer for 1 of 2 residents (Resident #54) reviewed for hospitalization . Specifically, there was no documented evidence that a transfer summary was completed/sent when Resident #54 was transferred to the hospital. The findings are: Policy and Procedure dated 11/1/2017 titled Admission/Discharge/Transfer documented: when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Resident #54 was admitted with diagnoses which include history of cerebral vascular accident, dysphagia, and seizures. The 5 Day Minimum Data Set (an assessment tool) dated 2/25/2024 documented the resident had moderately impaired cognition. The nursing progress note dated 2/17/2024 documented the family requested that the resident be transferred to the hospital. There was no documented evidence that a transfer summary was completed. There was no evidence that documentation including the contact information of the practitioner/resident representative, advance directive information, special instructions/precautions/medications, comprehensive care plan goals, and other necessary information was sent with the resident. During an interview on 4/16/24 at 11:55 AM after reviewing the electronic medical record the Assistant Director of Nursing stated that they were unable to locate the transfer to the hospital documentation. 10 NY CRR 413.3(h)(1)(ii)(a-c)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47626 Based on record review and interview during a recertification survey conducted from 4/8/2024-4/17/2024 the facility did not ensure that they provided written notice of the facility's Bed Hold policy upon transfer to all residents or residents' representative(s) for 1 of 2 residents (Resident #54) reviewed for hospitalization . Specifically, Resident #54 and/or their representatives were not provided written notice of the bed hold upon discharge to the hospital. The findings are: The Policy and Procedure dated 11/12/2019 and titled Bed Hold documented: The facility will notify the designated representative and / or the resident of the facility's bed reservation policies, in writing, at the time of admission and at the time of transfer. Resident #54 had Diagnosis's of cerebral vascular accident, dysphagia, and seizures. The 5 Day Minimum Data Set (an assessment tool) dated 2/25/2024 documented the resident had moderately impaired cognition. The nursing progress note dated 2/17/2024 documented the family requested that the resident be sent to the hospital. The nursing progress note dated 2/23/2024 documented that the resident returned from the hospital. There was no documented evidence that Resident #54 and/or their representative was given written notice of the bed hold policy. During an interview on 4/16/24 at 1:39 PM Staff #6 (Social Worker) stated they did not send notice of bed hold to any resident unless they were private pay. During an interview on 4/16/24 at 1:43 PM the Administrator stated the facility should give residents and/or resident representatives the notice of bed hold when a resident was discharged to the hospital. 10 NYCRR 415.3(h)(4)(i)(a)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 41666 Based on observation, record review and interview conducted during a recertification 4/8/24-4/17/24, the facility did not ensure that necessary assistance and care were provided to carry out activities of daily living for 1 of 3 residents reviewed for activities of daily living (Resident #52). Specifically, Resident #52 was not toileted timely after calling for assistance. The findings are: Resident #52 was admitted on with diagnoses including Type II Diabetes Mellitus, and Major Depressive Disorder. The Annual Minimum Data Set (a resident assessment and screening tool) dated 1/14/24 documented the resident was cognitively intact and required moderate staff assistance for walking and toilet use and was always continent of bowel and occasionally incontinent of urine. The care plan for Activities of Daily Living initiated on 1/7/24 had interventions that included toilet every 2-4 hours and as needed. The care plan for incontinent care dated 1/7/24 documented the resident would be free from skin breaks, free from psycho social complications including withdrawal, embarrassment, humiliation, isolation and resignation. Interventions included educate resident on toileting plan, encourage resident to use call bell and toilet every 2-4 hours as needed. The nurse note dated 4/2/24 at 12:02 AM documented the resident was using the call bell complaining of diarrhea. The resident did not allow the certified nursing assistant working on the unit to care for them, so the resident was told they had to wait a few minutes until the certified nursing assistant from the other unit was free to change them. The resident stated, I don't care I am going to keep ringing until someone changes me. The nurse documented they went to the room four times and asked the resident to stop because someone would be there shortly. The resident refused and kept arguing with the nurse. Approximately 5 minutes later the certified nursing assistant from the other unit came to take care of the resident. During an interview on 4/12/24 02:52 PM with Resident #52, they stated there was a problem with not enough staff and described the instance in the nurses note. The resident stated they have bowel troubles and sometimes just couldn't wait. Staff come into their room to turn the call bell off then leave without taking care of the problem. The resident stated they felt humiliated they had a bowel movement in bed. During an interview 4/16/24 at 10:56 AM Staff #7, (Licensed Practical Nurse Unit Manager) stated they were shocked the nurse did not help the resident. Staff #7 stated that a lot of residents used the call bell but this resident had a real concern. Staff #7 stated if there was only one certified nursing assistant on the unit and the resident did not want that certified nursing assistant, then the nurse should have provided the care. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/24 at 12:36 PM the Director of Nursing stated in this case the nurse would be responsible to care for the resident and they did not know why that did not happen. 10 NYCRR 415.12(a)(3)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47626 Based on observation, record review and interview during the recertification survey conducted 4/8/2024-4/17/2024, the facility did not ensure all residents were provided an ongoing program to support residents in their choice of activities and designed to meet their individual needs based on the comprehensive assessment and care plan and the preferences of each resident for 1 of 1 resident (Resident #50) reviewed for activities. Specifically, Resident #50 did not have an admission activity assessment completed to assess for and provide meaningful activities. Findings include: A review of the policy and procedure titled Activities dated 2/4/2019 documented the activities programs are staffed with personnel who have appropriate training and experience to meet the needs and interests of each resident. Resident #50 was admitted with diagnoses including diabetes, end stage renal disease, and anxiety disorder. The activities care plan dated 12/7/2023 documented the resident was on contact isolation for clostridium difficile (C. diff, bacterial infection of bowel) and required in room activities. The Quarterly Minimum Data Set (an assessment tool) dated 3/12/2024 documented the resident's cognition was severely impaired. During an observations on 04/09/24 at 01:33 PM and 04/11/24 at 01:34 PM, the resident was sitting in their room alone. There was no documented evidence in the electronic medical record that an activities admission assessment had been completed. There was no documented evidence in the he electronic medical record that a March quarterly activities assessment had been completed. The activities attendance sheets documented the resident was seen 1 time in March 2024 for a 1:1 visit and had not attended any other activities. During an interview on 04/11/24 01:38 PM the Activity Director stated they should have assessed the resident for activities on admission but could not find the assessment. The care plan was developed when the resident was on precautions, and should have updated when the resident came off precautions. The care plan and assessment should have been updated in March with the quarterly Minimum Data Set. The Activity Director stated they should have identified this, and if the original assessment had been done it would have triggered the review. 10NYCRR 415.5(f)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observations, record review and interviews during a recertification survey 4/8/24-4/17/24, the facility did not ensure residents received treatment and care in accordance with professional standards of quality for 4 of 6 residents (Residents #14, #27, #54 and #56) reviewed for quality of care. Specifically, 1) Resident #14 vascular wound dressing was not changed daily as ordered and was observed on 4/12/24 with a date of 4/9/24 on the dressing. 2) Resident #54 did not have post hospitalization appointments scheduled for follow up care. 3) Resident #56's order for compression stockings was not carried out and a follow up urology appointment was not scheduled. 4) Resident #27 did not receive daily wound care as ordered on 8 of 19 days from 3/29/24 to 4/16/24. Findings include: 1) Resident #14 was admitted with diagnoses including adult failure to thrive, venous insufficiency, and hypothyroidism. Resident #14's Minimum Data Set (an assessment tool) dated 3/23/24 documented the resident had moderate cognitive impairment and was dependent on staff for assistance with hygiene and toileting, and required cueing for eating. The Physician's orders dated 3/08/24 document to cleanse the vascular wound to left lower extremity with normal saline or wound cleanser, apply Silver Alginate, cover with a gauze pad, and wrap with Kling. Change the dressing daily and as needed. The nursing care plan for vascular wound initiated 7/22/22 documented to provide treatments as ordered. During a Resident Council meeting on 4/9/24 at 10:24 AM, the resident stated they had a wound dressing on their leg that went days without being changed. On a second interview with the resident 4/10/24 at 10:13 AM they stated they had a wound on their left foot that was not always changed and sometimes it could be a few days without changing. The Treatment Administration Record from 3/8/24-3/31/24 documented no evidence the treatment was completed on 3/8,3/9,3/10,3/11, 3/13,3/14,3/19,3/20. The April 2024 Treatment Administration Record documented no evidence the treatment was completed on 4/1,4/2,4/3, 4/6,4/7,4/11/24. During a wound dressing change observation on 4/12/24 at 9:42 AM with the Staff #15 (wound care nurse) the old dressing on the left lower leg was wet with brown color on outside of the Kling which was loosely in place. The silk tape over the Kling had date of 4/9/24 written on it. When interviewed during the dressing change, Staff #15 stated they saw the resident on Monday, Wednesday and Friday and was not sure why it had not been changed since 4/9/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/12/24 at 12:17 PM, Staff #11 (Licensed Practical Nurse) stated the leg dressing change should have been done everyday and they did not know why it was not done. Staff #7 (Licensed Practical Nurse Unit Manager) stated they were not aware the dressing changes were not being done. Staff #7 stated that the expectation would be that if the dressing change was not done on the day shift it would be done on the evening shift. 2) Resident #54 was admitted from the hospital with diagnoses that include respiratory failure, atrial fibrillation, dysphagia, septicemia. The Minimum Data Set (an assessment tool) dated 2/25/24 documented the resident had moderate cognitive impairment, with impairment on upper extremity, and a percutaneous endoscopic gastrostomy tube (feeding tube) in place. During an interview with Resident #54 on 4/17/24 at 9:06 AM they stated they did not know why they still had the feeding tube as it was not being used. They stated they had not been to see the gastroenterologist or the cardiologist and was told it had to wait until they were discharged . Review of the resident discharge instructions from the hospital on 1/30/24 documented the resident had a gastrostomy tube in place after a cerebrovascular accident. The discharge instructions documented a follow up appointment was made by the hospital for the resident for July 1, 2024 at 11:30 with the cardiologist. Additional instructions included to schedule appointments with the gastroenterologist and the neurologist to be seen in 1-2 weeks. Review of the resident's recorded revealed no documented evidence the appointments with the gastroenterologist and the neurologist were made. On 2/17/24 the resident was hospitalized and returned to the facility on [DATE] with discharge instructions to schedule an appointment with the maxillofacial surgeon within 2 weeks. Further review of the resident's recorded revealed no documented evidence the appointment with the maxillofacial surgeon was made. During an interview on 4/17/24 at 9:35 AM, Staff#7 (Licensed Practical Nurse Unit Manager) stated they reviewed the discharge instructions and stated the follow up appointments were not needed and were listed on the discharge instructions for billing purposes. During an interview on 4/17/24 at 1:02 PM, the Assistant Director of Nursing stated the Staff #7 was new to the role and needed more training. 3) Resident #56 was admitted [DATE] with diagnoses including quadriplegia after fall with fractured cervical (neck) vertebrae, neurogenic bladder, subluxation of right shoulder. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and had impairment of bilateral upper and lower extremities. The resident was totally dependent on staff for all activities of daily living, wore an Aspen collar and required a mechanical lift to transfer out of bed. The resident had a Foley catheter. Urology consult: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The hospital discharge instructions dated 2/23/24 documented the resident had a Foley catheter and to follow up with urology for urodynamic testing. Review of the resident's record revealed no documented evidence that urology was contacted. The resident care plan for Foley(Urinary Incontinence) initiated 2/27/24 had interventions that included urology consult as indicated. During an interview on 4/11/24 at 12:55 PM, Staff #7 stated they were not aware of a visit to the urologist and stated the resident had not left the building since their admission in February. The Staff #7 stated the discharge instructions were reviewed on admission and the urology order was missed. Compression stockings: The Physician orders dated 2/23/24 documents TED anti-embolic stocking to extremities before getting out of bed daily. The Treatment Administration Record was reviewed from 2/23/24-4/17/24 and documented the stockings were not in place 38 of 55 days. The Certified Nurses Assistant Care Guide listed the anti-embolic stockings. Observations were made on 4 /11/24 at 1:00 PM , 4/12/24 at 8:59 AM, and 4/16/24 at 10:15 AM, the resident was in their wheelchair and the anti-embolic stockings were not worn. During an interview with Resident #56 on 4/16/24 at 10:15 AM, they stated they had the anti-embolic stockings before coming to the facility but did not get them at this facility and did not know why. During an interview on 4/11/24 at 01:00 PM, Staff#8 (Certified Nurse Aide) stated the resident did not have the stockings and did not know why they were on their Care Guide. During an interview on 4/12/24 at 11:31 AM, Staff #11 (Licensed Practical Nurse) stated they did the medications first in the morning then moved on to the treatments. Staff #11 stated they signed off on treatments including stockings. Staff #11 stated they had not seen a pair of stockings for the resident but would put in an order. Order placed 4/14/24. As of 4/17/24 the resident had not received the stockings. During an interview on 4/16/24 at 10:39 AM, Staff # 7 (Licensed Practical Nurse Unit Manager) they stated they did not know what happened to the stockings. Staff #7 then went into the Resident #56 and asked the resident if they liked the stockings and Resident #57 stated the stockings made their legs feel good. During an interview on 4/15/24 04:26 PM, the Nurse Practitioner they stated they were not aware the resident was not provided the stockings. 10NYCRR 415.12 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49255

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review and interview conducted during the recertification survey from 4/8/24-4/17/24, the facility did not ensure that pain management was consistently provided for 2 of 2 residents reviewed for pain (Resident #56 and #43). Specifically, 1) Resident #56 did not receive Lidocaine patches as ordered and was not provided monitoring of their pain level to determine the need for an alternate treatment; and 2) Resident #43's pain level was not monitored. The findings are: A review of the policy and procedure titled Pain dated 5/25/2018, documented the staff will reassess the individuals pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain. 1) Resident #56 was admitted with diagnoses including quadriplegia after fall with a neck fracture, neurogenic bladder, and subluxation (partial dislocation) of the shoulder. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and had impairment of bilateral upper and lower extremities. The hospital Discharge Summary dated 2/23/24 documented the resident had pain most likely from subluxation of left shoulder versus neuropathic pain and to continue Lidocaine patches to this area. The physician order dated 2/23/24 documented Lidocaine External Patch apply 1 patch daily at 9:00 AM; remove at 09:00 PM. Tylenol oral tablet 325 milligrams, 2 tabs every 4 hours as needed. The nursing care plan for Pain Management initiated 2/23/24 documented the resident would maintain adequate level of comfort. Interventions included administering medications as ordered, monitoring for/observing verbal pain indicators and documenting using 0-10 pain scale every shift and as needed. The pain assessment dated [DATE] documented the resident had guarding and moaned during cares, received Tylenol with relief and had daily pain in the left shoulder with intermittent duration. The Medication Administration Records dated 2/23/2024- 04/17/2024 documented the Lidocaine patches were not administered and not available on 2/27,2/28, 2/29, 3/4, 3/5, 3/6, 3/8,3/9,/3/11,3/12, 3/13, 4/4,4/5, 4/6, 4/7, 4/8, 4/9, 4/11, 4/12, and 4/13/24. Tylenol 325 mg tablet 2 tablets every 4 hours as needed was administered once daily on the following days: 3/5, 3/15, 3/18, 3/22, 3/26, 3/27, 3/28, 3/29, and 3/31/24. Further review of the medication administration record and treatment administration record revealed no documented evidence of a pain scale or pain monitoring. During an interview on 4/9/24 at 12:36 PM, Resident #56 they stated they received pain medications but not all the time because the facility told them they ran out of medications. Resident #56 stated their pain was mostly in the left shoulder and sometimes in their back. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/24 at 11:48 PM, Staff#10 (Licensed Practical Nurse) stated they gave medications to the resident regularly and patches were not always available in the resident's supply box. Staff #10 stated they did not offer an alternate to the resident or notify the nurse practitioner or medical doctor about the problem. They further stated they did not do pain scales. During an interview on 4/12/24 at 12:11 PM, Staff #7 (Licensed Practical Nurse Unit Manager) stated they were aware of a supply problem when the resident first came but was not aware it was on going. Staff #7 stated they told Staff#1 (Staffing Coordinator) that the patches needed to be reordered since it was a stock item. Staff #7 reviewed the Medication Administration Record and stated they were not aware the resident had missed so many of the patches. They stated the physician should have been notified. During an interview on 4/15/24 at 12:34 PM, Staff #1 stated they got requests from nurses about low stock meds and reordered them from pharmacy. The patches were requested and they were not aware there was a problem. During an interview on 4/15/24 at 4:26 PM, the Nurse Practitioner they stated they reviewed the resident's medications on a visit and when they saw the red X on the Medication Administration record they assumed it was because the resident refused the drug. They stated they were unaware the resident was not getting the patches due to unavailability and would have offered an alternative pain option if they knew. 47626 2) Resident #43 with diagnosis of type 2 diabetes, schizophrenia, and dysphagia following unspecified cerebral vascular disease. The Quarterly Minimum Data Set (an assessment tool) dated 1/3/2024 documented the resident had intact cognition, and no behaviors. The pain management care plan dated 1/2024 documented an intervention for monitoring and document the reaction to pain medication. The March 2024 physicians orders documented Tylenol 650 every 6 hours for pain. Review of the April 2024 Medication Administration Record documented the resident received Tylenol every 6 hours, however there was no documentation regarding an assessment of pain. During an interview and observation on 04/10/24 at 11:39 AM, Resident #43 was sitting in a wheel chair and stated they had pain that affected their sleep and had been reported to the staff. Resident #43 stated staff only gave them Tylenol. During an interview on 4/12/24 at 1:56 PM the Assistant Director of Nursing stated the staff were not documenting the residents pain scale in the medical record as it was not included in the order. The Assistant Director of Nursing stated staff should document a pain scale for residents who receive pain medications so they would know if the intervention was effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/24 at 4:00PM Staff #12 (Registered Nurse) stated Resident #43 did not have an order to document pain level. 10 NYCRR 415.12

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on record review and interviews conducted during the Recertification and Abbreviated surveys (NY0322448, NY00308142 and NY00320376) from 4/08/24 to 4/17/24, the facility did not ensure that there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, upon review of the staffing schedule for multiple days and on all three shifts of staffing for each unit, the facility did not provide adequate staffing to meet the needs of the residents. The findings are: Review of the facility policy titled Staffing, Sufficient and Competent Nursing dated 11/2/18 documented that out facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Review of the Facility-Wide assessment dated [DATE], and reviewed by the Quality Assurance Agency/Quality Assurance and Performance Improvement committee on 3/20/24, did not provide a staff to resident ratio for comparison and did not provide the number of staff required to work on each of the two units. Facility-Wide Assessment for Nursing Staff documented: - Certified nurse aides: minimum number needed per day was 7. - Licensed practical nurse/Registered nurse: minimum number needed per day was 4. - Total number of facility nursing staff: minimum number needed per day was 11 and the maximum number needed per day was 34. - Total number of Agency nursing staff: minimum number needed per day was 0 and the maximum number needed per day was 0. During an interview on 04/09/24 at 1:30 PM, Resident #31 stated that during the whole month of February 2024 and some of March 2024, they did not get a shower because the facility was so short staffed. Resident #31 stated that on the weekends there was sometimes only one certified nurse aide working in the whole building, residents did not get out of bed, and resident were screaming requesting assistance with cares. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/11/24 at 1:35 PM, the Director of Nursing stated that the nursing staffing scheduling was not being done correctly prior to 3/15/24 when the previous scheduler was employed at the facility. The Director of Nursing stated that the previous scheduler was doing the nursing staffing scheduling on a day to day basis and not on a month by month basis as it should have been done. The Director of Nursing stated the nursing staffing schedule was supposed to be printed a month in advance and the scheduler was responsible for filling in the empty slots with per diems and agency staff, and making sure the facility was staff efficiently. During an interview on 04/11/24 at 01:40 PM, Staff #1 (staffing coordinator) stated they started the staffing coordinator position on 3/18/24 and that they did not receive any documentation or old schedules and the nursing staffing scheduling book was blank. During an interview on 04/11/24 at 02:45 PM, Staff #1 (staffing coordinator) stated they could not provide a staffing plan and was unaware if one was available. During an interview on 04/11/24 at 03:18 PM, Staff #19 (Human Resource Director) stated the facility did not have a staffing plan in place as there was a staffing conflict with the previous staffing coordinator. They stated with the new staffing coordinator the facility plans to repair the staffing issues. During an interview on 04/12/24 at 11:00 AM, Staff #2 (certified nurse aide) stated at times there was only one certified nurse aide in the whole building to cover both units during the night shift. During an interview on 04/12/24 at 11:47 AM, Staff #5 (receptionist) stated: - at times the facility had only 2 certified nurse aides working. This happened on the weekends and occasionally on the weekdays when someone had time off. - sometimes there was not a registered nurse in the building. - residents had called the receptionist desk when their call lights were on and staff were not answering, and staff complained about the call lights. - residents called the receptionist desk to ask for assistant with care such as toileting. During an interview on 04/16/24 at 02:29 PM, Staff #10 (certified nurse aide) stated that they were employed by an agency and that they have been working alone since 2 PM due to another certified nurse aide going home at 2 PM. Staff #10 stated that they were always working alone and there was a huge problem with staffing in the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/24 at 09:57 AM, the Director of Nursing stated that on both units the minimum nursing staffing needed on day shift was two certified nurse aides and one licensed practical nurse. The minimum staffing needed on evening shift was two certified nurse aides and one licensed practical nurse per unit, and the minimum nursing needed on night shift was one certified nurse aide and one licensed practical nurse. The Director of Nursing stated that they and the Assistant Director of Nursing were in the building Monday-Friday on the day shift and the facility tried to have one registered nurse supervisor in the building on the evening shift but was not always able. The Director of Nursing stated that they did employ agency nursing staff and was not sure why the Facility-Wide Assessment did not indicate the agency staff was a part of the staffing. 415.13(a)(1)(i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on record review and interview conducted during the recertification survey conducted from 4/08/24 to 4/17/24, the facility did not ensure certified nurse aide performance reviews were completed at least once every 12 months for 5 of 5 (Staff #'s 8, 9, 16, 17, and 18) certified nurse aides reviewed. The findings are: There was no documented evidence that Staff #8, 9, 16, 17, and 18 had performance reviews completed at least once every 12 months. During an interview on 04/11/24 at 03:35 PM, the Assistant Director of Nursing stated that they became employed by the facility on 2/28/23 and became the staff educator in September 2023. The Assistant Director of Nursing stated certified nurse aide performance reviews had not been done prior to and since they became employed at the facility; and staff competencies should be done every 12 months and as needed. During an interview on 04/11/24 at 03:40 PM, the Director of Nursing stated that certified nurse aide performance reviews had not been done and should have been done. The Director of Nursing stated that staff performance was not being monitored and there had been complaints from residents and visitors about the staff. During an interview on 04/16/24 at 02:43 PM, Staff #8 (Certified Nurse Aide) stated that they had been working at the facility for over [AGE] years and had never received a performance review. 10NYCRR 415.26 (c)(2)(iii)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48847 Based on record review and interviews conducted during the recertification survey conducted from 4/08/24 to 4/17/24, the facility did not ensure that they consistently posted the daily nurse staffing information (daily resident census, total number/ actual hours worked by licensed nurses and certified nurse aides, and specific units) to be readily accessible to residents and visitors. Specifically, the daily nursing staff information was posted in the lobby area of the building on the other side of a coded door that the residents were unable to unlock unless accompanied by staff. Furthermore, the daily nursing staff information was not updated to reflect any staffing changes throughout the day and the specific units were not reflected on the posting. The findings are: On 04/09/24 at 9:20 AM, upon entering the lobby of the building the daily nurse staffing information was posted and not easily accessible to residents due to needing a code to unlock the door that led to the lobby area. Additionally, the specific units were not reflected on the posting. On 04/11/24 at 5:08 PM, the daily posted nurse staffing information, posted in the lobby, documented there were 2 registered nurses directly responsible for resident care working on the day shift. The staffing sheet documented that there were no registered nurses directly responsible for residents working on 4/11/24 day shift. On 04/12/24 at 9:38 AM, the daily posted nurse staffing information documented there were 3 registered nurses directly responsible for resident care working on the day shift. The staffing sheet documented there were no registered nurses working on 4/12/24 day shift. Additionally, the daily posted nurse staffing information documented there was 1 evening shift registered nurse directly responsible for resident care. The staffing sheet documented that there were 2 registered nurses directly responsible for residents working 4/12/24 evening shift. On 04/15/24 at 9:02 AM, the daily posted nurse staffing information documented there were 3 registered nurses directly responsible for resident care working on the day shift. The staffing sheet documented there were no registered nurses directly responsible for resident care working on 4/15/24 day shift. On 04/15/24 at 10:40 AM, the daily posted nurse staffing information for both 4/13/24 and 4/14/24 was received incomplete by Staff #1 (Staffing Coordinator). On both days for evening and night shift the current resident census, the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift were blank. On 04/16/24 at 9:29 AM, the daily posted nurse staffing information documented there were 3 registered nurses directly responsible for resident care working on the day shift. The staffing sheet documented that there were no registered nurses directly responsible for resident care working on 4/16/24 day shift. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 9:22 AM, the daily posted nurse staffing information documented there were 3 registered nurses directly responsible for resident care working on the day shift, The staffing sheet documented that there were no registered nurses directly responsible for resident care working on 4/16/24 day shift. During an interview on 04/12/24 at 11:47 AM, Staff #5 (Receptionist) stated they were told that they were responsible for posting daily nurse staffing/resident census information and had not seen a supervisor or nurse update the sheet. Staff #5 stated the daily staffing sheets were not accurate and the resident census at the receptionist desk was days old at times at times. During an interview on 04/15/24 at 4:10 PM, Staff #1 (Staffing Coordinator) stated they used to be the receptionist and they were not trained on the daily posted nurse staffing/resident census information. They stated they were told to fill in the day shift and the Nursing Supervisor would fill out all the other shifts. Staff #1 stated Nursing Supervisor did not fill out the sheet. During an interview on 04/15/24 at 4:22 PM, the Director of Nursing stated the Nursing Supervisors were responsible for completing the daily posted nurse staffing/resident census information. They stated the receptionist should not completing the posted staffing as they were not aware of updates on staffing. Additionally, the Director of Nursing stated that the daily posted nurse staffing/resident census information should not be posted in the lobby because the residents did not have easy access to the lobby due to needing a code to get out. 10NYCRR 415.13

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49364 Based on observation, record review and interview conducted during the recertification survey from 4/8/2024-4/17/2024, the facility did not ensure that sanitary conditions were being maintained in the main kitchen area. Specifically, 1) undated and unlabeled food were in the freezer; 2) the dishwasher was not reaching the appropriate temperature; 3) staff were storing personal food in the refrigerator used for the residents' meals; 4) the exhaust wall fan was covered with dust and grease debris; 5) staff were not wearing beard cover while serving the residents their meals; and 6) tuna fish in a stainless steel container and lettuce were on the same shelf in the refrigerator. The findings include: The facility policy entitled Food Receiving And Storage Issued 6/26/2018 stated food services, or other designed staff, will always maintain clean food storage areas. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). Uncooked and raw animal products and fish will be stored separately in drip proof containers and below fruits, vegetables and other ready to eat foods. On 4/8/24 at 9:57 AM, during the initial tour of the kitchen, the following was observed: - a sealed plastic bag with sausage patties undated and unlabeled in the freezer been stored on the top shelf. - a low temperature dishwasher not reaching the appropriate final rinse water temperature at 120 degrees, but has a final water rinse temperature at 110 degrees. (A low temperature dishwashing machine final rinse water temperature ranges from 120-150 degrees.) - staff stored their personal food in refrigerator 1 and refrigerator 2, the same refrigerators used for facility food storage and for the residents' meals. - the exhaust fan on the wall was soiled with dust and grease debris blowing on a rack where clean dishes were stored. - the dietary aide was not wearing a beard cover/restraint while serving the residents their meals in the dining room. - tuna fish was prepared and left in a stainless steel bowl was covered with a plastic wrap next to and on the same shelf with a container of lettuce. During an interview on 4/8/24 at 09:59 AM the Food Service Director stated the unlabeled and undated sausages patties were used within the week and were left over. The Food Service Director stated if the dish washing machine did not work, they would contact the vendor and would use disposable plates and utensils until the dish washer was repaired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/8/24 at 1:05 PM the Dietary Aide was not wearing a beard cover while serving the resident's their lunch trays. At that time the Food Service Director stated the staff did not know they should be wearing a beard cover. During an observation on 4/12/24 at 11:18 AM during a follow-up of the kitchen area the Food Service Director was not wearing a beard cover. At that time the Food Service Director stated they ordered the beard covers and were waiting for them to be delivered. During an observation on 4/12/24 at 11:20 AM during a follow-up of the kitchen area, staff's personal food was noted in 2 refrigerators which were used to store residents' food. The Food Service Director stated that staff's food should be stored in the staff refrigerator. 10 NYCRR 415.14 (h)

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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. 48847 Based on record review and interview conducted during the recertification survey from 4/08/24 to 4/17/24, the facility did not ensure that the Facility Assessment was reviewed, accurate and updated as necessary. Specifically, the education, training, and competencies required for the certified nurse aides on the Facility Assessment were out of their scope of practice. The findings are: The Facility Profile dated 2/21/24 and last reviewed with the Quality Assurance Agency/Quality Assurance and Performance Improvement committee on 3/20/24 documented the certified nurse aides had training and competencies in glucometers, medication administration, gastronomy tube placement, ventilation/tracheostomy, aseptic dressings, electrocardiograms, and Pleural catheters. During an interview on 04/12/24 at 12:15 PM, the Administrator stated the Facility Assessment was accurate and it was reviewed recently with the Quality Assurance Agency/Quality Assurance and Performance Improvement committee. During an interview on 04/12/24 at 12:20 PM, the Director of Nursing stated that the Facility Assessment was not accurate and that certified nurse aides were not able to perform those duties as indicated on the facility assessment. During an interview on 04/12/24 at 01:05 PM, the Administrator stated that they reviewed the Facility Assessment realizing that the certified nurse aide and registered nurse/licensed practical nurse duties were inaccurate and stated that they did not know how that was not observed by the Quality Assurance Agency/Quality Assurance and Performance Improvement committee on 3/20/24. 10NYCRR 483.70(e)(1)-(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review and interview conducted during a recertification survey from 4/8/24-4/17/24, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infections for 5 of 5 residents (#22, #8, #14, #56, and #18) reviewed for infection control. Specifically, 1) staff did not change gloves after touching a resident and/or assistive device and before handing out Resident #8's food tray and staff were observed using the same hand while feeding Resident #22 and Resident #8; 2) staff did not wear a gown during a dressing change for Resident #14 on Enhanced Barrier Precautions; 3) staff did not wear a gown during a treatment for Resident #56 on Enhanced Barrier Precautions and 4) there was no documentation that oxygen tubing was changed weekly and as needed for Resident #18. The findings are: The facility policy for Infection Prevention and Control Program dated 3/21/24 documented the program was a facility wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program. The undated facility policy for Enhanced Barrier Precautions documented precautions were used as an infection prevention and control intervention to reduce the spread of multi drug resistant organisms to residents. 1. Resident #22 had diagnoses of dementia, seizure, and Alzheimer's disease. Resident #22's Minimum Data Set (a resident assessment and screening tool) dated 3/4/24 documented the resident had severe cognitive impairment and was dependent on staff for eating. Resident #8 had diagnoses of dementia, alzheimer's disease, and dysphagia (difficulty swallowing). Resident #8's Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment and needed assistance from staff for eating. During a meal observation on 4/9/24 at 12:45 PM Staff #8 (Certified Nurse Assistant) was wearing gloves and touched Resident #28's wheelchair, touched the brake adjusted the chair, touched the brake, parked the chair, then walked over to the food truck, opened the door and removed a tray. Staff #8 placed Resident #8's tray, touched Resident #8 on the shoulder/hand and removed their gloves. Staff #8 applied a new pair of gloves without performing hand hygiene and proceeded to feed Resident #22 and Resident #8 using the same right hand. Staff #8 was then observed holding Resident #22's spoon, putting it down and picking up Resident #8's spoon to feed the resident. During an interview on 4/17/24 at 9:26 AM Staff# 7 (Licensed Practical Nurse Unit Manager) stated they monitored and watched staff in the dining room to make sure infection control practices were maintained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335275	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Nursing at Wappingers	37 Mesier Avenue Wappingers Falls, NY 12590

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/24 at 1:22 PM Staff #8 stated they were right-handed and had a slip up and further stated you caught me. When asked about wearing the gloves Staff #8 stated it was something new and they were confused about when to wear the gloves. 2. Resident #14 had diagnoses of hypothyroidism, anxiety disorder and venous insufficiency. The Minimum Data Set, dated dated dated [DATE] documented the resident had impaired cognition and had a foley catheter. The physician orders dated 4/1/24 documented Enhanced Barrier Precautions for lower leg extremity wound every shift. During a wound dressing observation on 4/12/24 at 9:42 AM, Staff #15 (wound care nurse) without the use of a gown, applied gloves and after removing the old dressing leaned over to inspect the wound causing their identification badge to come in contact with the wound drape and the residents leg before resting on Staff #15's shirt. During an interview on 4/12/24 at 9:45 AM Staff #15 stated they should have been wearing a gown the whole time when doing the wound treatment but forgot. Staff #15 stated they did not noticed their identification badge coming in contact with the resident and wound drape but if they had a gown on that would not have happened. 3. Resident #56 was admitted [DATE] with diagnoses including quadriplegia after fall with avulsion fracture of C7, neurogenic bladder, and subluxation of right shoulder. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and had impairment of bilateral upper and lower extremities and had a foley catheter. There was no documented evidence in the physician orders to indicate the resident was on Enhanced Barrier Precautions. During a treatment observation on 4/16/24 at 10:27 AM Staff #7 gathered supplies and explained the procedure to the resident. Staff#7 washed hands, donned gloves and performed the treatment. The Staff #7 was not wearing a gown at the time they performed the treatment. The resident#56 had signage on the door for Enhanced Barrier Precautions. During an interview with Staff #7 4/16/24 at 10:27 AM they stated they were supposed to wear the gown even if it is just skin prep and stated they usually do but at the time was nervous and was still getting used to the new precautions. During an interview on 4/17/24 at 9:26 AM Staff# 7 (Licensed Practical Nurse Unit Manager) stated the Enhanced Barrier Precautions came out in March and the staff were in serviced. 10 NYCRR 415.19(b)(4) 47626

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 47626 Based on record review, and interview conducted during a recertification survey from 4/8/2024-4/17/2024, the facility did not implement an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. Specifically, the facility was unable to provide a February or March 2024 infection/antibiotic tracking report. The findings are: There was no documented evidence for an infection and antibiotic tracking report for February and March 2024. During an interview on 4/15/24 at 12:00 PM the Infection Control Practitioner stated the facility was a little behind in reviewing, the tracking and antibiotic stewardship. They stated the last one reviewed was in January 2024. During an interview on 4/15/24 at 12:16 PM the Administrator stated that the infection control nurse was responsible for the antibiotic stewardship. The Administrator stated they were unaware that the facility was behind in infection control tracking and antibiotic stewardship. 10 NYCRR 415.19 (a)(1,3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49364 Based on observation and interview conducted during the recertification survey from 4/8/24-4/17/24, the facility did not ensure that residents were provided a safe, sanitary, and comfortable home-like environment. Specifically, 1. there was a strong urine odor in Resident #33 and 36's shared room and 2. the window curtain in Resident #25's room was hanging off the rod. The findings including: The facility policy entitled: Cleaning and Disinfecting Rooms Revised 11/12/2019. The facility policy stated environment surfaces will be disinfected on a regular basis, three times per week and when surfaces are visibly soiled. Clean curtains, window blinds, and walls when they are visibly soiled or dusty. Conduct monthly spot checks to ensure that all curtains and window treatments are cleaned and orderly. During an interview on 4/8/24 at 10:35 AM, Resident #33 stated everything was broken in the facility. At that time there was a strong urine odor inside the room. During an observation on 4/9/24 at 12:47 PM, and 4/10/24 at 9:35 AM Resident #25's window curtain was ripped, hanging down and not attached to the curtain rod. During an observation on 04/11/24 at 12:37 PM, Resident #33 and Resident #36's shared room continued to have a strong urine odor. During an interview on 4/12/24 at 9:51 AM, Resident #33 stated they were not sure if the facility was doing anything about the strong urine odor. During an interview on 4/12/24 at 9:51 AM Resident #36 stated that they told the staff a long time ago about the strong urine odor in the room. During an interview on 4/12/24 at 10:12 AM, Staff # 7(Licensed Practical Nurse Manager) stated Resident #33's mattress had a strong urine odor. Staff #7 stated Resident #33 has gotten better with changing their clothes and not wearing the same pair of shorts several times. During an interview on 4/15/2024 at 10:15 AM, Staff #8 (Certified Nurse Aide) stated Resident #33 washed and hung their clothing in their room, but the mattress had a urine odor because Resident #33 was incontinent and was non-complaint with cares. During an interview on 4/15/24 at 10:28 AM, the Director of Housekeeping/Laundry stated that Resident #33 was not sending all their dirty clothing to the laundry. The Director of Housekeeping stated the resident's mattress was wiped down daily, but the resident may need a new mattress. During an interview on 4/15/24 at 10:38 AM Staff #12 (Maintenance Worker) stated the curtains in Resident #25's room were the only ones the facility had; the facility had been trying to get rid of curtains and change to blinds. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.29