STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335279	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Care Center	100 Baldwin Road Hempstead, NY 11550

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024 the facility did not ensure that the interdisciplinary team had determined that self-administration of medications was clinically appropriate for each resident. This was identified for one (Resident #75) of ten residents reviewed for Accidents. Specifically, Resident #75 was applying the Biofreeze Professional Pain-Relieving Gel to their knees and the facility staff was aware. A review of the resident's medical records revealed there was no assessment to determine if the resident could safely self-administer the medication. Additionally, Resident #75 did not have a Physician's Order to apply the Biofreeze Professional Pain-Relieving Gel. The finding is: The facility's policy and procedure titled Self-Administration of Medications, last revised on 1/2024 documented that as part of a resident's overall evaluation, the staff and the practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. The staff and the practitioner will ask residents who are identified as being able to self-administer medications whether they wish to do so. Self-administered medications must be stored in a safe place, which is not accessible by other residents. Staff shall identify and give the Charge Nurse any medicines found at the bedside that are not authorized for self-administration. Resident #75 was admitted to the facility with diagnoses including a Periprosthetic (close to an implant or artificial joint) Fracture Around the Internal Prosthetic Right Knee Joint, Atrial Fibrillation, and Malignant Neoplasm. A Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #75 had intact cognition. Resident #75 received Pain Management and scheduled pain medications as needed. A Comprehensive Care Plan (CCP) dated 2/13/2023 and revised on 9/19/2024 documented that Resident #75 had an altered comfort related to immobility and gout. Resident #75 received pain medications. Interventions included administering medications as ordered. Assess for breakthrough pain and the need for supplemental doses. Assess the nature, intensity, location, duration, and frequency of pain. Notify the Physician if interventions are unsuccessful or if the current complaint is a significant change from the resident's experience of pain. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) dated 6/8/2024 documented that Resident #75 was at risk for contractures and functional impairment. Interventions included assessing joints for limitations, swelling, redness, or pain. Resident #75 will participate in ambulation exercises as prescribed. During an observation on 9/17/2024 at 10:45 AM, Resident #75 was observed with a tube of Biofreeze Professional Pain-Relieving Gel on their overbed table. Resident #75 stated they had the Biofreeze tube for a while and used the medication on both knees. The medical record lacked documented evidence of a Physician's Order and assessment for self-administration of the Biofreeze medication. Certified Nursing Assistant #8 was interviewed on 9/17/2024 at 10:45 AM and stated they had seen the Biofreeze Professional Pain-Relieving Gel on top of the resident's overbed table and in the drawer a few times. Certified Nursing Assistant #8 stated they could not recall if they informed the Nurse about the Biofreeze medication. Licensed Practical Nurse #6 was interviewed on 9/17/2024 at 10:59 AM and stated they had never seen Resident #75 with Biofreeze Professional Pain-Relieving Gel. Licensed Practical Nurse #6 stated that Resident #75 should not have any medications stored in their room because Resident #75 did not have any order for self-administration of medications. Resident #75 was interviewed on 9/23/2024 at 9:38 AM and stated they had purchased the Biofreeze Professional Pain-Relieving Gel online. Resident #75 stated the Physical Therapist used to apply the Biofreeze Professional Pain-Relieving Gel on their knee during therapy, but the Physical Therapist is not always available when they (Resident #75) need the medication. Resident #75 stated they had the Biofreeze Professional Pain-Relieving Gel for a while and kept it on their overbed table. Resident #75 stated the staff was aware that they had the Biofreeze Professional Pain-Relieving Gel tube. Physical Therapist #1 was interviewed on 9/23/2024 at 9:49 AM and stated they used Biofreeze Professional Pain-Relieving Gel for Resident #75 to relieve pain during therapy. Physical Therapist #1 stated they did not need a Physician's order to apply the Biofreeze medication because it is part of Physical Therapy. The Biofreeze is applied after the exercises and they only keep the medication in the therapy gym. The Director of Nursing Services was interviewed on 9/24/2024 at 8:34 AM and stated that Certified Nursing Assistant #8 should have reported the Biofreeze Professional Pain-Relieving Gel was at Resident #75's overbed table. The Director of Nursing Services stated nurses should perform a self-administration of medication competency assessment and get a Physician's Order if a resident is deemed capable of self-administering the medications. 10 NYCRR 415.3(f)(1)(vi)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 28173 Based on interviews and record review during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024 the facility did not ensure that comprehensive assessments of residents were conducted within 14 calendar days after admission and not less than once every 12 months. This was identified for three (Residents #126, Resident#168, and Resident #181) of 11 residents reviewed for the Resident Assessment Task. Specifically, Resident #168's Significant Change Minimum Data Set, Resident #126's Annual Minimum Data Set, and Resident # 181's Discharge Minimum Data Set Assessments were not completed within 14 days of the assessment reference date. The findings are: The facility's policy and procedure for Minimum Data Set, last revised on 8/2023 documented a Registered Nurse shall be designated for conducting and coordinating each resident's assessment. The Assessment Coordinator must date and sign each assessment to certify that the assessment has been completed. Each individual who completes a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying that each section was completed. The policy did not include the timeframe for the completion of the assessment. Resident #168's Significant Change Minimum Data Set with an assessment reference date of 7/12/2024 documented a completion date of 8/27/2024, 32 days past the due date of 7/26/2024. Resident #126's Annual Minimum Data Set with an assessment reference date of 8/16/2024 documented a completion date of 9/17/2024, 18 days past the due date of 8/30/2024. Resident #181's Discharge Minimum Data Set with an assessment reference date of 5/21/2024 documented a completion date of 6/18/2024, 14 days past the due date of 6/4/2024. During an interview on 9/25/2024 at 1:20 PM with the Minimum Data Set Coordinator they stated they are responsible for ensuring the timely completion of the Minimum Data Set assessments. The Minimum Data Set Coordinator stated they are aware of the late completion of the Minimum Data Set assessments. The Minimum Data Set Coordinator stated the Dietary Department was not completing their respective sections timely which resulted in a delay in the completion of the Minimum Data Sets. During an interview on 9/25/2024 at 1:49 PM the Administrator stated they are aware of the late completion of the Minimum Data Set assessments. The lateness was related to a dietary contractor who failed to complete their assessments on time, which delayed the completion of the assessments. 10 NYCRR 415.11(a)(3)(i)

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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 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 28173 Based on interviews and record review during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024 the facility did not ensure residents were assessed using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services not less frequently than once every three months. This was identified for eight (Resident #92, Resident #161, Resident #170, Resident #120, Resident #135, Resident #194, Resident #153, and Resident #155) of 11 residents reviewed for the Resident Assessment Task. Specifically, the Quarterly Minimum Data Set assessments for Resident #92, Resident #161, Resident #170, Resident #120, Resident #135, Resident #194, Resident #153, and Resident #155 were not completed within 14 days of the assessment reference date. The findings are: The facility policy titled Minimum Data Set Completion and Submission Timeframes dated 1/2024 documented that the timeframes for completion and submission of the assessments are based on the current requirements published in the Resident Assessment Instrument Manual. Resident #92's Quarterly Minimum Data Set with an assessment reference date of 8/16/2024 documented a completion date of 9/17/2024, 18 days past the due date of 8/30/2024. Resident #161's Quarterly Minimum Data Set with an assessment reference date of 7/13/2024 documented a completion date of 8/28/2024, 32 days past the due date of 7/27/2024. Resident #170's Quarterly Minimum Data Set with an assessment reference date of 8/16/2024 documented a completion date of 9/17/2024, 18 days past the due date of 8/30/2024. Resident #120's Quarterly Minimum Data Set with an assessment reference date of 8/9/2024 documented a completion date of 9/16/2024, 24 days past the due date of 8/23/2024. Resident #135's Quarterly Minimum Data Set with an assessment reference date of 8/16/2024 documented a completion date of 9/17/2024, 18 days past the due date of 8/30/2024. Resident #194's Quarterly Minimum Data Set with an assessment reference date of 8/2/2024 documented a completion date of 9/14/2024, 29 days past the due date of 8/16/2024. Resident #153's Quarterly Minimum Data Set with an assessment reference date of 7/26/2024 documented a completion date of 9/12/2024, 34 days past the due date of 8/9/2024. Resident #155's Quarterly Minimum Data Set with an assessment reference date of 8/16/2024 documented a completion date of 9/17/2024, 18 days past the due date of 8/30/2024. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 9/25/2024 at 1:20 PM with the Minimum Data Set Coordinator they stated they are responsible for ensuring the timely completion of the Minimum Data Set assessments. The Minimum Data Set Coordinator stated they are aware of the late completion of the Minimum Data Set assessments. The Minimum Data Set Coordinator stated the Dietary Department was not completing their respective sections timely which resulted in a delay in the completion of the Minimum Data Sets. During an interview on 9/25/2024 at 1:49 PM the Administrator stated they are aware of the late completion of the Minimum Data Set assessments. The lateness was related to a dietary contractor who failed to complete their assessments on time, which delayed the completion of the assessments. 10 NYCRR 415.11(a)(4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on record review and interviews during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024, the facility did not ensure an assessment was completed to accurately reflect the resident's status. This was identified for one (Resident #167) of one resident reviewed for Hospice and End of Life. Specifically, the Quarterly Minimum Data Set assessment dated [DATE] did not reflect that Resident #167 received Hospice care. The finding is: The facility's policy titled MDS Assessment Coordinator, last reviewed on 1/2024 documented a Registered Nurse should be designated the responsibility of conducting and coordinating each resident's Minimum Date Set assessment. Each individual who completes a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. Resident #167 was admitted with diagnoses including Palliative Care, Cerebrovascular Disease, and Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status was not conducted because the resident had severely impaired skills for daily decision-making. The Minimum Data Set did not include that Resident #54 received Hospice Services while a resident at the facility. A Comprehensive Care Plan titled Resident is at End of Life/Diagnosis of Terminal Illness, dated 9/1/2024 and last revised on 9/17/2024 documented that the resident received Hospice care. The care plan interventions included providing comfort measures, honoring preferences when possible, and referring the resident to the Hospice program per the physician's orders. A Physician's Order dated 5/1/2024 documented Hospice care. During an interview on 9/23/2024 at 12:07 PM, Registered Nurse #3, the Minimum Data Set assessment nurse, stated they were responsible for completing the Minimum Data Set assessment Section O (Special Treatments). Registered Nurse #3 stated when they completed the assessment dated [DATE], the resident was receiving Hospice care. Registered Nurse #3 further stated they made an error and did not document the resident received Hospice care under the Special Treatments section of the Minimum Data Set assessment. During an interview on 9/23/2024 at 12:38 PM, the Minimum Data Set Assessment Coordinator stated the Quarterly Minimum Date Set assessment for Resident #167 should have documented that the resident received Hospice care. The Minimum Data Set Assessment Coordinator stated this was an error and an oversight. During an interview on 9/25/2024 at 11:40 AM, the Director of Nursing Services stated Resident #167 received Hospice care and the Quarterly Minimum Data Set assessment dated [DATE] should have documented Hospice care. 10 NYCRR 415.11(b)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024, the facility did not ensure that each resident received adequate supervision to prevent accidents and the resident environment remained as free of accident hazards as is possible. This was identified for two (Resident #51 and Resident #165) of ten residents reviewed for Accidents. Specifically, 1) Resident #51 had a history of falls and wandering behavior and the Comprehensive Care Plan directed staff to place the resident in a supervised area when awake. Resident #51 was left unsupervised in the hallway on 7/24/2024 at 1:10 AM and was found on the floor with injuries to the right side of their forehead and mouth. Subsequently, the resident was transferred to the hospital and was diagnosed with Traumatic Subdural Hemorrhage (brain bleed) and a Cervical Fracture (spine). 2) Resident #165, with a history of Suicidal Ideation was observed with an unattended disposable shaving razor in their room. This resulted in actual harm to Resident #51 that is not Immediate Jeopardy. The findings are: 1) The Falls Prevention Policy and Procedure last updated in January 2024 documented that as part of the initial assessment, the interdisciplinary team will help identify the individuals with a history of falls and risk factors for subsequent falling. The staff, with the support of the attending Physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition. The staff and attending Physician will collaborate to identify fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. Resident #51 had diagnoses that included Dementia, Insomnia, and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severely impaired cognitive skills for daily decision-making. The Minimum Data Set documented that the resident needed partial/moderate assistance of one person to walk 10 feet. The Minimum Data Set documented that the resident had a history of falling and had no behaviors. The Fall Risk Evaluation dated 2/11/2024 documented a score of 21 indicating the resident was a high risk for falls. The Comprehensive Care Plan for Falls initiated on 1/22/2023, updated 1/24/2024, documented interventions to place the resident in a supervised area when awake and monitor the resident every 15 minutes for frequent falls Updated 1/22/2024, documented provide redirection and encourage the resident to utilize one-person assistance for ambulation with a rolling walker for safe ambulation and for fall prevention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan for Behaviors dated 2/2/2023 documented the resident had potential risks for exhibiting behavior symptoms such as verbally aggressive/abusive, physically aggressive/abusive, and wandering behavior related to cognitive impairment secondary to Dementia. The interventions included administering medications, distracting the resident from wandering and modifying the environment to reduce episodes of negative behavior and risk for falls or injury. There was no documented evidence the current Certified Nursing Assistant Kardex (care instructions for Certified Nursing Assistants) did not include interventions indicated in the Comprehensive Care Plan to place the resident in a supervised area when out of bed. The Nursing Progress Note dated 7/24/2024 at 6:53 AM, by the Registered Nurse Supervisor #6, documented that the resident was observed sitting on the floor hallway around 1:10 AM. The resident had a bump on the right side of their forehead and a swollen upper lip with blood inside their mouth. The resident denied pain and the range of motion (ROM) was within normal limits. The resident stated, I am going home. The resident's Physician was called and ordered to transfer the resident to the emergency room for a head Computed Tomography (CT) scan. The Occurrence Report/Investigation dated 7/31/2024 documented Certified Nursing Assistant #3, who was assigned to the resident, reported that while they attended to another resident, Resident #51 got up (from their wheelchair) and fell to their right side in the hallway. The investigation concluded that the resident was confused, had a history of Dementia, Depression, poor sleeping patterns, and needed constant reminders. The resident was non-compliant with the use of their call bell and ambulated without assistance at times despite redirection. The resident was to remain on close monitoring, and for the staff to not leave the resident unattended and maintain safety visual checks. During an interview on 9/20/2024 at 11:35 AM, Certified Nursing Assistant #3 stated when they came on duty for their 11:00 PM-7:00 AM shift on 7/24/2024 (their shift started on 7/23/2024), Resident #51 was already seated in the hallway in their wheelchair. Certified Nursing Assistant #3 stated Resident #51 was agitated and wanted to go home. Resident #51 had packed a bag using a pillowcase in which the resident had put their belongings. Certified Nursing Assistant #3 stated that Resident #51 had a history of getting up from their wheelchair and going to the bathroom without assistance if they were left alone. Certified Nursing Assistant #3 stated they sat with the resident in the hallway because someone had to be there to watch the resident. Certified Nursing Assistant #3 stated they had to leave Resident #51 in the hallway to help Certified Nursing Assistant #9 with another resident in a room. Certified Nursing Assistant #3 stated they did not expect Resident #51 to get up from their wheelchair by the time they got back from helping Certified Nursing Assistant #9 in a room with another resident. During an additional interview on 9/23/2024 at 12:00 PM, Certified Nursing Assistant #3 stated they left Resident #51 in the hallway to help another Certified Nursing Assistant #9 break up a fight between two residents in their room. Certified Nursing Assistant #3 stated Licensed Practical Nurse #10 also got up from the Nurse's Station and went into the same room, leaving Resident #51 alone in the hallway. Certified Nursing Assistant #3 stated they heard a noise in the hallway, ran out of the room, and saw Resident #51 lying on the floor. Licensed Practical Nurse #10 was unavailable for an interview. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/24/2024 at 12:55 PM, the Assistant Director of Nursing Services/Risk Manager stated the resident always has to stay in someone's line of vision because you could not tell when the resident would get up so you would have to be able to see the resident. The Assistant Director of Nursing Services/Risk Manager stated Resident #51 fell on [DATE] at 1:10 AM during the night when Certified Nursing Assistant #3 left Resident #51 in the hallway to assist another Certified Nursing Assistant #9. The Assistant Director of Nursing Services/Risk Manager stated that Certified Nursing Assistant #3 should have called for help so they could have stayed with Resident #51 while someone else went to help the other Certified Nursing Assistant #9. The Assistant Director of Nursing Services/Risk Manager stated the resident's care plan was not followed and Certified Nursing Assistant #3 should have stayed with Resident #51. During an interview on 9/24/2024 at 1:23 PM, the Director of Nursing Services stated there was a break in the resident's plan of care. Certified Nursing Assistant #3 or Licensed Practical Nurse #10 should not have left Resident #51 alone in the hallway. During an interview on 9/24/2024 at 1:50 PM, the Medical Director stated that someone should have at least been there, some responsible party, to stay with the resident. Both the Certified Nursing Assistant and Licensed Practical Nurse should not have left the resident alone. A responsible party should have relieved the individual watching the resident, unless it was an emergency or urgent situation, such as a resident having a cardiac arrest. 48827 2) The facility's Hazardous Area, Devices, and Equipment policy last reviewed on 1/2024 documented a hazard is defined as anything in the environment that has the potential to cause injury or illness. The policy identified hazards including sharp objects that are accessible to vulnerable residents. The policy further documented that any element of the resident environment that has the potential to cause injury and is accessible to a vulnerable resident is considered hazardous. Resident #165 was admitted with diagnoses including Bipolar Disorder, Schizophrenia, and Major Depressive Disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Minimum Data Set documented the resident had potential indicators for Hallucinations (a false perception of objects or events involving your senses: sight, sound, smell, touch, and taste). The Minimum Data Set documented the resident used a manual wheelchair and walker for mobility and could walk 150 feet with supervision. A Comprehensive Care Plan titled Behavior Symptoms initiated on 1/06/2024 and revised on 9/23/2024, documented interventions that included 15-minute monitoring for suicidal ideation initiated on 1/06/2024 and modifying the environment to reduce episodes of negative behavior and risk for falls or injury. A nursing progress note, written by Registered Nurse Unit Supervisor #2, dated 6/04/2024 documented Resident #165 was exhibiting behavioral symptoms such as repeated movements and wandering. The resident complained of hearing voices to hurt themselves but had no plan. The physician's order dated 6/04/2024 documented to monitor Resident #165 every 15 minutes for Suicidal Ideation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Psychiatry Consult note dated 6/05/2024 documented Resident #165 had a history of Depression and Schizophrenia. Resident #165 reported auditory Hallucinations (hearing voices that were not there). The nursing progress note, written by Registered Nurse Unit Supervisor #2, dated 6/07/2024 documented Resident #165 complained of hearing voices and could not control the voices in their head anymore. The resident reported they have a plan to kill themselves. The resident was transferred to the hospital. The medical progress note, written by Physician's Assistant #1, dated 6/07/2024 documented Resident #165 was seen for a weekly follow-up and for continued monitoring of chronic and acute conditions including Suicidal Ideation. The resident was sent to the hospital for Suicidal Ideation. The hospital discharge summary dated 6/07/2024 documented Resident #165 was seen in the emergency room for Psychiatric evaluation for Suicidal Ideation. A review of the medical record from 6/07/2024 to 9/19/2024 indicated no behaviors of Suicidal ideation or a plan for self-harm. A review of the 15-minute monitoring sheets from 8/22/2024 to 09/23/2024 documented that staff monitored the resident every 15 minutes. Resident #165 was observed sleeping in their bed on 9/17/2024 at 10:28 AM. A disposable shaving razor was observed at the sink in the resident's room. During an interview on 9/19/2024 at 9:34 AM, Resident #165 was in their room lying in bed and stated they just had breakfast, enjoyed the breakfast, and had no concerns with the facility. During an observation on 9/23/2024 at 10:47 AM, Resident #165 was observed sleeping in their bed. A disposable shaving razor was observed at the sink in the resident's room. During an interview on 9/23/2024 at 10:48 AM, Certified Nursing Assistant #4 stated they were the assigned Certified Nursing Assistant for Resident #165, and the razor that was observed in Resident #165's room belonged to the resident's roommate. Certified Nursing Assistant #4 stated the disposable shaving razor should not be left in the resident's room. Certified Nursing Assistant #4 then removed the disposable shaving razor from the resident's room. During an interview on 9/23/2024 at 10:49 AM, Registered Nurse Supervisor #2 stated Resident #165 was on every 15-minute monitoring for suicidal ideation and should not have access to the disposable shaving razor. During an interview on 9/23/2024 at 11:36 AM, Psychiatrist #1 stated Resident #165 should not have access to a razor because in the past Resident #165 had expressed thoughts of self-harm. During an additional interview on 9/24/2024 at 10:29 AM, Registered Nurse Supervisor #2 stated Resident #165 has not been verbalizing thoughts of suicidal ideation since their return from the hospital in June 2024. Resident #165 is monitored every 15 minutes for a history of auditory hallucinations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an additional interview on 9/24/2024 at 10:58 AM, Certified Nursing Assistant #4 stated the resident has been much more pleasant since they returned from the hospital and has not expressed thoughts of hurting self. During an interview on 9/24/2024 at 1:25 PM, the Director of Nursing Services stated that no razors should have been kept in any resident's room. Resident #165 had the potential to self-harm. 10 NYCRR 415.12(h)(1)(2)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and interviews during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure that a qualified Dietician is licensed or certified as a nutrition professional by the state in which the services are performed. This was identified for one (Registered Dietitian #1) of five employees reviewed for the Criminal History Record Check task. Specifically, part-time Registered Dietitian #1 did not have an active license or certification issued by the New York State as a Dietitian or nutrition professional since [DATE]. Registered Dietician #1 was hired by the facility on [DATE] and continued to work directly with the residents without documented evidence of being supervised by a qualified professional. The finding is: A review of Registered Dietitian #1's personnel file revealed that they were hired by the facility on [DATE] and their Dietetics-Nutrition license from New York State had expired on [DATE]. There was no documented evidence that Registered Dietician #1 was supervised by a qualified professional from [DATE] until [DATE]. The Director of Human Resources was interviewed on [DATE] at 12:30 PM and stated that registered Dietician #1 was hired by the facility on [DATE] and they (the Director of Human Resources) overlooked the fact that Registered Dietitian #1's professional license for Dietetics-Nutrition was expired as of [DATE]. The Administrator was interviewed on [DATE] at 2:20 PM and stated the Director of Human Resources should have ensured that part-time Registered Dietitian #1's Dietetics-Nutrition license was current. 415.14(a)(1)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on observations, interviews, and record review during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024, the facility did not ensure that each resident received food that accommodated resident allergies, intolerances, and preferences. This was identified for one (Resident #39) of eighteen residents reviewed during the dining task. Specifically, Resident #39 had a physician's order for a gluten-free diet (gluten is a protein found in grains like wheat, rye, and barley). During observations on 9/17/2024 and 9/19/2024, the resident was served white bread with their meal for lunch. The finding is: Resident #39 was admitted with diagnoses including Hypertension and Chronic Obstructive Pulmonary Disease. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Minimum Date Set assessment documented the resident was on a therapeutic diet. The Comprehensive Care Plan titled Resident has or is at Risk for Impaired Gastrointestinal Function dated 3/22/2023 revised on 2/12/2024, documented the resident had a non-celiac gluten sensitivity. Interventions included referring the resident to dietary for a modification to the resident's diet. The Comprehensive Care Plan titled The Resident has Actual or Potential for Fluid Deficit dated 4/18/2023 revised on 2/12/2024, documented the resident had a food limitation with wheat and gluten. A physician's order dated 2/4/2023 documented to provide the resident with no wheat (gluten-free) products. Resident #39 was observed eating lunch in their room on 9/17/2024 at 12:49 PM. The items on the resident's meal tray included a turkey sandwich with white bread, cooked string beans, coffee, and two containers of apple juice. The meal ticket, included with the resident's meal tray, indicated highlighted words gluten-free. The resident was observed eating the turkey from the sandwich and leaving the white bread aside. A subsequent observation was completed on 9/19/2024 at 1:08 PM. Resident #39 was observed in their room during the lunch meal service. The resident's meal tray included a pastrami sandwich with white bread and assorted cooked vegetables. The resident stated they usually leave the white bread on the side and knew not to consume the bread. The meal ticket included with the meal tray documented gluten-free which was observed to be highlighted on the meal ticket. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Food Services was interviewed on 9/19/2024 at 1:08 PM and stated Resident #39 should not have had white bread included with their meal. The Director of Food Services stated it was an oversight. The Director of Food Services stated they highlight any pertinent information on a resident's meal ticket such as allergies, intolerances, and preferences. The Director of Food Services stated they were responsible for ensuring each resident's meal followed the resident's diet, preferences, allergies, and intolerances. The resident should have received gluten-free meals and substitutes. Dietary Supervisor #1 was interviewed on 9/19/2024 at 1:54 PM and stated they were responsible for ensuring each resident's meal followed the specified diet, allergies, intolerances, and preferences. Dietary Supervisor #1 stated Resident #39 should not have had a pastrami sandwich with white bread included with their lunch because white bread is not gluten-free. Dietary Supervisor #1 stated the facility did not have gluten-free bread and the resident should have had pastrami with gluten-free options such as rice or mashed potatoes. Dietary Supervisor #1 stated that this was an oversight. An interview was conducted with Dietary Supervisor #2 on 9/24/2024 at 1:56 PM and stated Resident #39 should not have had any bread included with their meal and this was an oversight. The Director of Nursing Services was interviewed on 9/25/2024 at 11:31 AM and stated Resident #39 should not have had bread included with their meal. The resident's meal ticket should only include gluten-free foods. The Director of Nursing Services further stated the nurses on the unit were also responsible for checking each resident's meal tray and meal ticket to ensure the accuracy of the meal. 10 NYCRR 415.14(d)(4)

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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** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 9/17/2024 and completed on 9/25/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for 1) six (Resident #52, Resident #194, Resident #29, Resident # 32, Resident #1, Resident #50) of six residents reviewed for the Medication Storage and Labeling Task and 2) one (Resident #53) of three residents observed for infection Control Task. Specifically, Licensed Practical Nurse #6 did not use an Environmental Protection Agency approved cleaning agent to sanitize the glucometer (a handheld device used to measure the concentration of sugar in the blood) machine after using the glucometer machine for each resident. 2) Resident #53 was on contact precautions for a Vancomycin Resistant Enterococcus (a multi-drug resident organism) infection to the right lower extremity wound. During the initial tour of the second floor, the Case Manager was observed not wearing appropriate Personal Protective Equipment while in Resident #53's room. The finding is: The facility's policy and procedure titled, Cleaning and Disinfection of Glucometer, last revised on 1/2024 documented that glucometer cleaning should take place prior to and immediately after each use to prevent the spread of pathogens from blood or body fluids. In cases where the manufacturer has no cleaning recommendations, using an Environmental Protection Agency (EPA) registered high-level disinfectant is standard. Resident-care equipment including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standards. Blood Glucose Monitoring System Manual documented the use of an Environmental Protection Agency (EPA) registered disinfecting wipe for disinfecting the Blood Glucose Monitoring System. The disinfection process reduces the risk of transmitting infectious diseases. -Resident #52 was admitted with diagnoses including Type 2 Diabetes Mellitus, Bipolar Disorder, and Chronic Obstructive Pulmonary Disease (COPD). A Comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #52 had intact cognition. Resident #52's physician order dated 2/12/2024 documented Novolog Flex Pen Subcutaneous Solution Pen-injector 100 units per milliliter, inject per sliding scale before meals and at bedtime and notify the Physician of the blood sugar levels of below 60 milligrams/deciliter and above 400 milligrams/deciliter. -Resident #194 was admitted with diagnoses including Type 2 Diabetes Mellitus, Benign Prostatic Hyperplasia, and Alcohol Dependence. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #194 had moderately impaired cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #194's physician order dated 2/13/2024 documented Humalog Kwikpen Subcutaneous Solution Pen-injector 100 units per milliliter, inject per sliding scale before meals and at bedtime and notify the Physician of the blood sugar levels of below 60 milligrams/deciliter or above 400 milligrams/deciliter. -Resident #29 was admitted with diagnoses including Type 2 Diabetes Mellitus, Anemia, and Schizophrenia. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented no Brief Interview for Mental Status (BIMS) score as Resident #29 had severely impaired cognitive skills for daily decision-making. Resident #29's physician order dated 5/1/2024 documented Humalog Kwikpen Subcutaneous Solution pen injector 100 units per milliliter, inject per sliding scale before meals and at bedtime and notify the Physician of the blood sugar levels of below 60 milligrams/deciliter and above 400 milligrams/deciliter. -Resident #32 was admitted with diagnoses including Type 2 Diabetes Mellitus, Anemia, and Hypertension. A Comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #32 had moderately impaired cognition. Resident #32's physician order dated 2/4/2024 documented Novolog Injection Solution 100 units per milliliter, inject per sliding scale before meals and at bedtime and notify the Physician of the blood sugar levels of below 60 milligrams/deciliter and above 400 milligrams/deciliter. -Resident #1 was admitted with diagnoses including Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure. A Comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #1 had intact cognition. Resident #1's physician order dated 8/31/2024 documented Insulin Lispro 100 units per milliliter, inject insulin as per the sliding scale before meals and at bedtime, and notify the Physician of the blood sugar levels of below 60 milligrams/deciliter and above 400 milligrams/deciliter. -Resident #50 was admitted with diagnoses including Type 2 Diabetes Mellitus, Anemia, and Chronic Kidney Disease. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #50 had moderately impaired cognition. Resident #50's physician order dated 9/11/2024 documented Insulin Lispro Injection 100 units per milliliter, inject insulin as per the sliding scale before meals and at bedtime, and notify the Physician of the blood sugar levels of less than 70 milligrams/deciliter or greater than 400 milligrams/deciliter. During the Medication Storage Task observation, a medication cart was observed with Licensed Practical Nurse #6 on 9/20/2024 at 10:15 AM. A glucometer machine was observed in the medication cart. Licensed Practical Nurse #6 stated they always used the 70% isopropyl alcohol prep pads to wipe the glucometer machine between each resident because the Environmental Protection Agency approved cleaning wipes were not available, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse #4, the Unit Supervisor, was interviewed on 9/20/2024 at 10:30 AM with Licensed Practical Nurse #6 and stated the facility only uses the Environmental Protection Agency-approved disinfecting germicidal wipes for glucometer cleaning and disinfecting. Registered Nurse #4 stated that Licensed Practical Nurse #6 should not have used the alcohol prep pad to disinfect the glucometer because the alcohol pads would not disinfect any blood-borne pathogens on the glucometer. The Nurse Educator was interviewed on 9/20/2024 at 2:26 PM and stated all Nurses had a competency in-service regarding the use of the glucometer machine within the year which included cleaning and disinfection. The Nurse Educator stated it is not the facility's protocol to use alcohol pads to clean the glucometer machine because the alcohol does not effectively clean the bloodborne pathogens. The Infection Preventionist was interviewed on 9/20/2024 at 2:47 PM and stated the facility uses Environmental Protection Agency approved germicidal wipes to clean the glucometer machines and the facility has plenty of supply. Licensed Practical Nurse #6 should have requested the germicidal wipes for cleaning and disinfecting the glucometer machine. The Infection Preventionist stated that germicidal wipes are effective against bloodborne pathogens (Hepatitis B, Human Immunodeficiency Virus, and Hepatitis C). The Director of Nursing Service was interviewed on 9/24/2024 at 8:46 AM and stated it is unacceptable to use any cleaning wipes except for the approved germicidal wipes to clean and disinfect the glucometer machine. 28173 2) The facility's policy titled Isolation-Categories of Transmission-Based Precautions, last reviewed 1/2024, documented contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Staff and visitors will wear gloves and a disposable gown upon entering the room, remove the gloves and gown before leaving the room, and avoid touching potentially contaminated surfaces with clothing after the gown is removed. Resident #53 was admitted with diagnoses including a Right Lower Leg Wound and Skin Infection. The 7/12/2024 Minimum Data Set assessment documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Physician's order dated 7/18/2024 documented to place the resident on contact precautions for positive Vancomycin-Resistant Enterococcus infection of the right lower extremity. Current Physician's orders as of 9/5/2024 documented to administer Piperacillin Sod-Tazobactam Solution (antibiotic medication) 3.375 gram intravenously every 6 hours for Infected Wound with positive wound culture for 14 days and Bactrim DS (antibiotic medication) Tablet 800-160 milligrams, give one tablet by mouth every 12 hours for infected wound with positive wound culture for 14 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an initial tour of the second floor on 9/17/2024 at 11:11 AM, Resident #53's door was observed with a contact precautions sign. The contact precautions sign documented: everyone must put on gloves before room entry and discard gloves before room exit; put on a gown before room entry and discard the gown before room exit; clean hands before entering and when leaving the room. Case Manager #1 was observed inside the resident's room, standing in very close proximity to the resident. Case Manager #1 was not wearing Personal Protective Equipment including a gown or gloves. During an interview on 9/17/2024 at 11:17 AM, Case Manager #1 stated that they did not see the signage outside the resident's room and were not aware that Resident #53 was on contact precautions. Case Manager #1 stated they now know that they should have put on a disposable gown and gloves while in the room with the resident. During an interview on 9/19/2023 at 8:34 AM, the Infection Preventionist stated Case Manager #1 should have put on a gown and gloves when they entered the resident's room in accordance with the facility's infection control policies. During an interview on 9/25/2024 at 1:46 PM, the Director of Nursing Services stated Case Manager #1 should have put on appropriate Personal Protective Equipment as per the facility's infection control program and the signage that was posted outside the resident's room before entering. 10 NYCRR 415.19(a)(1-3)