STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335300	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Hudson Nursing Center Inc	319 Upper Broadway Fort Edward, NY 12828

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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** 51317 Based on observation, record review, and interviews during a recertification survey, the facility did not ensure residents could safely self-administer medication when clinically appropriate for 2 (Residents #35 and #168) of 2 residents reviewed for medication administration. Specifically, (a) Resident #35 was observed with their prescribed Albuterol inhaler on their overbed table on 12/02/2024 and 12/04/2024, and (b) Resident #168 was observed changing their empty oxygen tank to a full oxygen tank on 12/03/2024 and setting the flow rate. There was no documented evidence that Resident #'s 35 and 168 were assessed to determine their ability to safely self-administer medications, or for physician orders for self-administration of medications. This is evidenced by: The facility Medication Self-Administration Policy, dated 9/2017, documented that staff and practitioners would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident upon request. Self-administered medications were to be stored in a safe and secure place that was not accessible by other residents. Resident #35 Resident #35 was admitted to the facility with diagnoses of Spina Bifida (a condition that occurs when the spine and spinal cord don't form properly), morbid obesity (a disorder that involves having too much body fat), and paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). The Minimum Data Set (an assessment tool) dated 10/18/2024 documented that the resident was cognitively intact, could be understood, s and understand others. During an observation on 12/02/2024 at 2:21 PM, Resident #35 was observed to have Proventil inhaler (a medication used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases such as asthma and chronic obstructive pulmonary disease) on their overbed table. A review of Resident #35's medical record did not include documentation that the resident was assessed for their ability to self-administer their medications. A review of Resident #35's medical record did not include documentation from the resident's physician that the resident could self-administer their medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #35's care plan did not include documentation the resident could self-administer their medications. A review of the physician orders for Resident #35 dated 10/25/2024 documented Proventil Inhalation to be taken every 4 hours as needed for shortness of breath or wheezing. May keep at bedside and self-administer. The medication orders further documented do not leave medications on Resident #35 table, please wait and observe resident taking it every shift for medication safety. During an interview on 12/05/2024 at 2:13 PM, Licensed Practical Nurse #1 stated that the resident could not self-administer medication. They stated that the resident was to be observed taking their medications and they had always left the inhaler at her bedside as the order stated it could be. When asked to review the medications orders they acknowledged that the Medication Administration Record stated that medications should not be left at the resident's bedside. They stated the order was for resident's administration of pill medications as they had a history of hoarding and hiding their medications. In asking Licensed Practical Nurse #1 if the resident's inhaler was a medication they stated that it was and probably should not be left at the bedside per the specific order. When asked if the resident had a specific order allowing them to self-administer medications they stated the resident did not have an order and should have orders for self-administration of the inhaler. During an interview on 12/05/2024 at 2:40 PM, Registered Nurse #1 stated Resident #35 did not have an order for self-administration of medications. They stated that they believed there was an assessment done for the resident to be able to self-administer their medications. When asked to review the medications orders they acknowledged that the Medication Administration Record stated that medications should not be left at the resident's bedside. They stated that the order was for resident's administration of pill medications as they had a history of hoarding and hiding their medications. During an interview on 12/06/2024 at 10:02 AM, Assistant Director of Nursing #1 stated for a resident to self-administer medications, there should be a care plan in place and an assessment completed to demonstrate feedback had occurred and the resident could safely administer medications on their own. They stated that they were not sure of the policy off the top of her head and would have to review it to determine what it stated. They stated that the resident did not have a self-administration assessment done. Resident #168 Resident #168 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), end-stage renal disease (a terminal illness that occurs when the kidneys can no longer function properly), and chronic systolic heart failure (a condition that occurs over time and prevents the heart from pumping enough blood). The Minimum Data Set, dated dated dated [DATE] documented that the resident was cognitively intact, could be understood, and understand others. During an observation on 12/03/2024 at 10:23 AM, Resident #168 was observed to have an empty oxygen tank in the basket of their motorized scooter. The resident had an additional oxygen tank in the basket and proceeded to change their oxygen tubing from the empty tank to the full one and set the flow rate on their own. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #168's medical record did not include documentation that the resident was assessed for their ability to self-administer their medications. A review of Resident #168's medical record did not include documentation from the resident's physician that the resident could self-administer their medications. A review of Resident #168's care plan did not include documentation the resident could self-administer their medications. During an interview on 12/05/2024 at 12:22 PM, Certified Nurse Aide #1 stated that the residents were not allowed to self-regulate or change their oxygen tanks. They stated that it was the job of the nurses to change the tanks of residents if they were empty and adjust the oxygen flow rate. They stated that to check the amount of oxygen in the system they have to lift the bottle up and the gauge would read the correct amount of oxygen that was in the tank. Certified Nurse Aide #1 stated that if the tank was empty then they would notify the nursing staff that it would need to be changed. They stated that they were unable to get the tanks as they were locked up in the medication room. During an interview on 12/05/2024 at 2:13 PM, Licensed Practical Nurse #1 stated that residents were not allowed to change their own tanks when they were empty or adjust their flow rates. They stated that the responsibility of changing tanks and adjusting the flow rates lay solely on the nurses of the unit. They stated that oxygen is a medication, and residents should be assessed to self-administer and self-regulate just like any other medication. They stated that they were unsure if the resident had an assessment done as they were not a resident on their assignment. During an interview on 12/05/2024 at 2:40 PM, Registered Nurse #1 stated that residents were not to change their own tank and that the nursing staff should be doing it as oxygen is considered a medication. They stated that residents should not be setting their own flow rate unless there was an order for them to do so. Resident #161 did not have an order for self-administration of medications. They stated that they believed there was an assessment done for the resident to be able to self-administer their medications. During an interview on 12/06/2024 at 10:02 AM, Assistant Director of Nursing #1 stated that for a resident to self-administer medications, there should be a care plan in place and an assessment completed to demonstrate feedback has occurred and the resident can safely administer medications on their own. They stated that they were not sure of the policy off the top of her head and would have to review it to determine what it stated. They stated that the resident did not have a self-administration assessment done. 10 New York Codes, Rules, and Regulations 415.3(e)(1)(vi)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51609 Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 (Residents #334) of 35 residents reviewed. Specifically, Resident #334 received oxygen that was not noted in the care plan. This is evidenced by: The Policy titled Care Planning dated 09/21/2017, documented the purpose of the policy was to have a written plan for staff to follow to provide care to a resident of the facility. Upon admission the 48-hour care plan would be developed and reviewed with the resident and/or the health care proxy within 48 hours. The care plan would be completed by the first care plan meeting within 14 days of admission. The care plan will be added to as new issues arise and when recognized plans have been resolved. Resident #334 was admitted to the facility with the diagnoses of hypertension, paroxysmal atrial fibrillation (irregular heartbeat), and supraventricular tachycardia (a faster than normal heart rate beginning above the heart's two lower chambers). The Minimum Data Set (an assessment tool) dated 11/28/2024 documented the resident could understand and be understood by others; resident was cognitively intact. Resident #334 used oxygen at 2 liters per minute continuously at the facility. The Comprehensive Care Plan dated 11/21/2024, did not have documented evidence of Resident #334's use of oxygen and nebulizer. The electronic health record documented an order on 11/25/2024 for oxygen at 2 liters per minute continuously, Ipratropium-Albuterol inhalation solution via nebulizer four times a day and every 6 hours as needed. The progress note dated 11/21/2024 documented Resident #334 arrived at the facility with oxygen in place at 2 liters per minute via nasal cannula. On 12/04/2024 at 8:39 AM, Resident #334 was observed with oxygen in place at 2 liters per minute. During an interview on 12/06/2024 at 9:24 AM, Licensed Practical Nurse #3 stated the registered nurse unit managers would update the care plans. They would receive some orders and process them into the electronic health record and call to pharmacy when needed but the registered nurse would update the care plan. During an interview on 12/06/2024 at 9:59 AM, Assistant Director of Nursing #1 confirmed there was no care plan for oxygen for Resident #334, stated they would expect the oxygen to be on the care plan. 10 New York Codes, Rules, and Regulations 415.11(c)(2) (i-iii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 51317 51742 Based on observation, record review, and interviews during the recertification, the facility did not ensure provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility's minimum staffing levels of Certified Nursing Aides and Licensed Practical Nurses were not met every day on multiple shifts and multiple units, from 12/01/2024 - 12/05/2024. In addition, record review indicated resident grievances related to staffing shortages, there were observations of delayed call light responses times, and resident complaints of low staffing. This is evidenced by: Based on the facility assessment, dated 8/28/2024, the following was the current staffing plan, presented as the number of Full Time Employees by position by shift. 6 AM-2 PM (days) 2 PM-10 PM(evenings) 10 PM-6 AM (nights) Registered Nurse 11 2 1 Licensed Practical Nurse 10 10 5 Certified Nursing Assistant 23 20 10 Review of the facility daily staffing guidelines dated 12/01/2024, the following were missing from the evening shift: A-wing was missing 1.375 Certified Nurse Aides, 1 Licensed Practical Nurse B-wing was missing 1 Certified Nurse Aide, 1 Licensed Practical Nurses D-wing was missing 1.5 Certified Nurse Aides, 1.5 Licensed Practical Nurse G-wing was missing 0.5 Certified Nurse Aide, 1 Licensed Practical Nurses S-wing (secure) was missing 2.125 Certified Nurse Aides, 1 Licensed Practical Nurse Review of the facility daily staffing guidelines dated 12/01/2024, the following were missing from the night shift: B-wing was missing 1 Certified Nurse Aide D-wing was missing 1 Certified Nurse Aide, 0.5 Licensed Practical Nurse (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility daily staffing guidelines dated 12/02/2024, the following were missing from the day shift: A-wing was missing 1 Certified Nurse Aide B-wing was missing 1 Licensed Practical Nurses D-wing was missing 2 Certified Nurse Aides G-wing was missing 1 Certified Nurse Aides, 1 Licensed Practical Nurses S-wing (secure wing) was missing 2.5 Certified Nurse Aides Review of the facility daily staffing guidelines dated 12/02/2024, the following were missing from staff from the evening shifts: A-wing was missing 2 Licensed Practical Nurses B-wing was missing 1 Certified Nurse Aide, 2 Licensed Practical Nurses D-wing was missing 2.25 Certified Nurse Aides, 2 Licensed Practical Nurses G-wing was missing 1.5 Certified Nurse Aides, 1 Licensed Practical Nurse S-wing was missing 3 Certified Nurse Aides, 1 Licensed Practical Nurse Review of the facility daily staffing guidelines, dated 12/02/2024, documented the following were missing from the night shifts: B-wing was missing 0.5 Certified Nurse Aides D-wing was missing 0.1876 Certified Nurse Aides, 1 Licensed Practical Nurse G-wing was missing 0.5 Certified Nurse Aide S-wing was missing 1.5 Certified Nurse Aides From 10:00 PM - 11:00 PM there was not a Registered Nurse working at the facility. Review of the facility daily staffing guidelines, dated 12/03/2024, documented the following were missing from the day shifts: A-wing was missing 2 Certified Nurse Aides B-wing was missing 1.5 Certified Nurse Aides, 1 Licensed Practical Nurse D-wing was missing 2.5 Certified Nurse Aides (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	G-wing was missing 2 Certified Nurse Aides S-wing was missing 1.5 certified Nurse Aides Review of the facility daily staffing guidelines, dated 12/03/2024, documented the following were missing from the evening shifts: A-wing was missing 0.5 certified nurse aides, 1.5 Licensed Practical Nurses B-wing was missing 1 Certified Nurse Aide, 1 Licensed Practical Nurse D-wing was missing 2 Certified Nurse Aides, 1.5 Licensed Practical Nurses G-wing was missing 2 Certified Nurse Aides, 1 Licensed Practical Nurse S-wing was missing 1.5 certified nurse aides, 0.5 licensed Practical Nurse Review of the facility daily staffing guidelines, dated 12/03/2024, documented the following were missing from the night shifts: A-wing was missing 1 Certified Nurse Aide B-wing was missing 0.5 Certified Nurse Aide D-wing was missing 0.5 Certified Nurse Aides Review of the facility daily staffing guidelines, dated 12/04/2024, documented the following were missing from the day shifts: A-wing was missing 2.5 Certified Nurse Aides B-wing was missing 1 Certified Nurse Aide D-wing was missing 1.5 Certified Nurse Aides G-wing was missing 1 Certified Nurse Aide, 1 Licensed Practical Nurse S-wing was missing 3 certified nurse aides, 0.5 Licensed Practical Nurse Review of the facility daily staffing guidelines, dated 12/04/2024, documented the following were missing from the evening shifts: A-wing was missing 0.5 Certified Nurse Aide, 1.5 Licensed Practical Nurses B-wing was missing 1.5 Certified Nurse Aide, 2 Licensed Practical Nurses D-wing was missing 2 Certified Nurse Aides (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	G-wing was missing 0.5 Certified Nurse Aide, 1 Licensed Practical Nurse S-wing was missing 1.5 certified nurse aides, 2 Licensed Practical Nurses Review of the facility daily staffing guidelines, dated 12/04/2024, documented the following were missing from the night shifts: A-wing was missing 1 Certified Nurse Aide B-wing was missing 1 Certified Nurse Aide D-wing was missing 0.5 Certified Nurse Aide G-wing was missing 0.5 Certified Nurse Aide S-wing was missing 1 Certified Nurse Aide Review of the facility daily staffing guidelines, dated 12/05/2024, documented the following were missing from the day shifts: A-wing was missing 2.5 Certified Nurse Aides, 1.5 Licensed Practical Nurses, 1 Registered Nurse B-wing was missing 1.5 Certified Nurse Aides D-wing was missing 0.5 Certified Nurse Aides G-wing was missing 2.5 Certified Nurse Aides, 1.5 Licensed Practical Nurses S-wing was missing 2.5 certified nurse aides, 1 Registered Nurse Review of the facility daily staffing guidelines, dated 12/05/2024, documented the following were missing from the evening shifts: A-wing was missing 1.5 certified nurse aides, 2 Licensed Practical Nurses B-wing was missing 2 Licensed Practical Nurses D-wing was missing 2.5 Certified Nurse Aides, 1 Licensed Practical Nurse G-wing was missing 2.5 Certified Nurse Aides, 2 Licensed Practical Nurses S-wing was missing 1.5 certified nurse aides, 1 Licensed Practical Nurse Review of the facility daily staffing guidelines, dated 12/05/2024, documented the following were missing from the night shifts: A-wing was missing 0.5 Licensed Practical Nurses (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	G-wing was missing 1 Certified Nurse Aides Review of the facility grievance sheets documented 10 grievances related to staffing levels between 02/2024 - 09/2024. A grievance dated 2/05/2024 regarded poor care from a Certified Nurse Aide with the facility response of, there was only 1 Certified Nurse Aide on the unit between 2 PM - 4 PM. .A grievance dated 2/14/2024 regarded toileting with the facility response of, staffing was minimal. A grievance dated 2/12/2024 - 02/13/2024 regarded long wait for assistance with the facility response of, .is waiting a long time for BR [bathroom], as is every other resident. A grievance dated 2/13/2024 regarded a 2.5- hour call light wait by a resident that led to incontinence with the facility response of, 2 Certified Nursing Assistants and 1 Licensed Practical Nurse, looking at adding 2 agency Certified Nursing Assistants. A grievance dated 6/25/2024 regarded a resident asking to use the restroom and staff saying no with the facility response of, because that means not helping others that are needing help at that time. A grievance dated 8/11/2024 regarded a resident who waited over 30 minutes and had an accident with the facility response of, this was right after supper. A grievance dated 8/26/2024 regarded a resident being left by the nursing station without staff interaction with the facility response of social worker decided to have resident out in the lobby watching TV with other residents to promote social interaction. A grievance dated 9/19/2024 regarded a resident not being toileted and the facility response of the family member attempted to assist the resident with toileting at 1:00 PM and 2:00 PM. A grievance dated 9/25/2024 regarded a resident that wished to go back to bed after care at 5:00 - 6:00 AM and a Certified Nurse Aide told the resident they had to stay up because there were 22 other residents who needed assistance. A grievance dated 10/06/2024 regarded a resident engaging a call light without a timely response to the point that the resident used the waste bin to urinate with a facility response of, only 1 Certified Nursing Assistant and 1 Licensed Practical Nurse from 2200 [10:00 PM] - 0600 [6:00 AM]. During an observation in the G wing on 12/02/2024 at 12:01 PM, a call light was active in room [ROOM NUMBER] and was answered at 12:23 PM for a response time of 22 minutes. During an observation on the G wing on 12/02/2024 at 1:01 PM a call light was on in room [ROOM NUMBER] and was answered at 1:23 PM for a response time of 22 minutes. During an observation on the G wing on 12/03/2024 at 11:38 AM, a call light was on in room [ROOM NUMBER] and was answered at 11:52 AM for a response time of 14 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on the G wing on 12/04/2024 at 7:30 AM, a call light was on in room [ROOM NUMBER] and was answered at 8:23 AM for a response time of 53 minutes. During an observation in the D wing on 12/05/2024 at 6:05 AM, a foul odor was noted by room [ROOM NUMBER] and a separate foul odor beyond room [ROOM NUMBER]. During an observation on the D wing on 12/05/2024 at 6:32 AM, a strong urine smell was still noted when first entered the unit by room [ROOM NUMBER], and a separate urine smell by room [ROOM NUMBER] was still present. During an observation on the D wing on 12/05/2024 at 6:55 AM the foul odor by room [ROOM NUMBER] and separate odor on other side of 24 were still present. During an observation on 12/05/2024 at 6:13 AM, the call light G wing room [ROOM NUMBER] was engaged and it was still on at 6:53 AM for a 40- minute call light time. During an observation on 12/05/2024 at 6:16 AM, there was an odor of urine outside of room G-18. During an observation on 12/05/2024 at 6:27 AM on the S Wing, there were 3 residents in recliners in the television room with no staff around, and at 6:48 AM 2 of the same residents were in the same place in the television room. At 6:46 AM, 2 residents were in recliners in the living room area with the lights off and no staff present. During an observation on 12/05/2024 at 7:00 AM on A Wing, the call light was engaged in room [ROOM NUMBER] and remained on until 7:46 AM for a 46- minute call light response time. During an observation on 12/05/2024 at 7:00 AM on A Wing, 6 residents in geri chairs were lined up in the hall by lower numbered rooms with 1 resident calling for help from the chair, and 3 residents in geri chairs were across the nurses' station area in the hall; 1 resident had an electronic device, and the rest had no music, television, or staff interaction in the hall. At 7:30 AM the same residents were in the same positions in the hallway around the nurses' station. During an interview on 12/02/2024 at 12:01 PM, Resident #35 stated the facility needed more help and the roommate had waited over 30 minutes for help after engaging the call light. During an interview on 12/02/2024 at 12:08 PM, Resident #334 stated they screamed until their throat hurt after their call light wait was on too long and the resident wet themselves and then staff tell the resident to stop shouting. On 12/03/2024 at 11:30 AM during a resident council meeting, several residents stated that multiple times residents had waited for a long period of time for staff to answer the call lights. In addition, it was stated that sometimes staff were too busy to help residents eat. Everyone stated that there was not enough staff to help and take care of daily needs. During an interview on 12/03/2024 at 12:35 PM, Resident #21 stated the facility was short on staff and sometimes the resident had to wait for a long time to get help, easily over an hour on average. The wait time was the most around mealtimes because staff were with other residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/05/2024 at 6:13 AM, Licensed Practical Nurse #5 stated there was only one Certified Nurse Aide for the second half of the night shift. During an interview on 12/06/2024 at 11:48 AM, Registered Nurse #3 stated that it was difficult when all shifts were not filled; they stated that staff from other units would sometimes cover but those filler staff did not know the residents as well, so it took longer to provide care when it was not the staff assigned to the unit. During an interview on 12/06/2024 at 12:00 PM, Licensed Practical Nurse #6 stated that they had experienced understaffing on several units, and it tended to slow down care of the residents when the staff were stretched too thin. During an interview on 12/06/2024 at 1:12 PM, Assistant Director of Nursing #1 stated that call lights were answered as quick as possible, and it was unrealistic to expect a light to be answered in a specific time frame. They stated that 36 of 40 residents on Unit A required a mechanical lift to get out of bed and that was why residents were lined up along the nurse's station, there was nowhere else to put the residents first thing in the morning. They also stated it was acceptable for a call light to be engaged for over 50 minutes on this unit in the morning and at different times on different units call light times of over 30 minutes was expected. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Hudson Nursing Center Inc	319 Upper Broadway Fort Edward, NY 12828

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on records review and interviews during the recertification survey, the facility did not ensure each resident's drug/medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for 2 (Residents #59 and #86) of 6 residents reviewed for unnecessary medications. Specifically, for Residents #59 and #86, as-needed psychotropic medication orders did not include stop dates. This is evidenced by: The policy and procedure titled Psychotropic Medication Use, dated 6/2024, stated as needed orders for psychotropic medications would be time limited. Resident #59 Resident #59 was admitted to the facility with diagnoses of dementia, anxiety disorder and depression. The Minimum Data Set, dated dated dated [DATE] documented the resident was usually able to be understood and could usually understand others; the resident was severely cognitively impaired. Resident #59 had an order for lorazepam (a sedative), 0.5 milligrams by mouth every 6 hours as needed for agitation, which was ordered 11/12/2024 and started 11/13/2024, and there was no end date for the order. Resident #59's Medication Administration Record dated 11/2024 and 12/2024 documented that the as needed lorazepam was administered on the following dates and times: 11/15/2024, 5:40 PM 11/16/2024, 11:45 AM 11/21/2024, 10:59 AM 11/23/2024, 10:38 AM 11/25/2024, 1:47 PM 11/30/2024, 10:16 AM 12/3/2024, 10:44 AM 51742 Resident #86 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #86 was admitted to the facility with diagnoses of dementia, anxiety disorder, and depression. The Minimum Data Set (an assessment tool) dated 10/04/2024 documented the resident was able to be understood, could understand others, and was severely cognitively impaired. Resident #86 had an order for Risperidone oral tablet (an antipsychotic) 0.5 milligram every 4 hours as needed for agitation/anxiety. The order start date was documented as 12/04/2024. There was no end date documented; the end date was documented as indefinite. A Medication Regimen Review was completed on 12/03/2024. The pharmacy consultant recommended an end date be applied to the Risperidone order. Nurse Practitioner #1 documented disagreement with the recommendation and no end date was added to the order. During an interview on 12/06/2024 at 12:49 PM, Nurse Practitioner #1 stated there was a fear that if the medication had an end date, it might not be renewed. They understood that it was a Centers for Medicare and Medicaid requirement that psychotropic medications given on an as needed basis had an end date in the order. 10 New York Codes, Rules, and Regulations 415.18 (c)(2)

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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. 51609 Based on observations, record review, and interviews during the recertification survey, the facility did not ensure that each resident received accommodated resident choices, intolerances, and preferences. This was identified for one (Resident #82) of 35 residents reviewed. Specifically, Resident #82 had a dietician recommendation, signed by the physician, to discontinue a collagen supplement. For 35 days after the recommendation, the collagen was still ordered. This is evidenced by: The Policy titled Pressure Injury (PI)/ and Wound Care dated 11/15/2024 documented the facility was to ensure that the residents would receive wound care consistent with resident needs, goals, and recognized standards of practice. The procedure was that the nurse manager or designated registered nurse, dietician, physical therapist, and other interdisciplinary team members as needed would evaluate resident's clinical condition and pressure ulcer risk factors. The interdisciplinary team would define and implement interventions as appropriate. The facility would maintain a system to assure that the procedure for monitoring and documentation were implemented consistently throughout the facility. Resident #82 was admitted with diagnoses including hypertension and a fracture of the femur (broken leg). The Minimum Data Set (an assessment tool) dated 10/04/2024 documented Resident #82 could understand others and be understood by others, and was cognitively intact. The Comprehensive Care Plan titled, Eating initiated on 10/30/2024, documented Resident #82 received a collagen supplement, revised on 11/04/2024, documented the resident had the collagen supplement discontinued. A physician's order dated 10/01/2024 documented an order for collagen supplement 60 cubic centimeters daily. The medication administration record for November 2024 documented that Resident #82 had the 60 cubic centimeter collagen supplement administered each day all month. The medication administration record for December 2024 documented the 60 cubic centimeter collagen supplement continued to be administered up until the 5th of December 2024. The progress note dated 11/04/2024 documented Resident #82 would like to discontinue the collagen supplement, the provider was agreeable, and Registered Nurse unit manager #2 was notified and the care plan was updated. The progress note dated 12/04/2024 documented requested discontinue collagen supplement at last follow up. The order was still in place, Registered Nurse unit manager #2 was notified. On 12/05/2024 a 7:33 AM, Resident #82 was observed in their room on precautions and in no apparent distress. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 8:08 AM, Registered Nurse unit manager #2 stated that new orders were processed by them and put in the electronic medical record, then placed in the paper medical record. They confirmed that the order was in the paper record and not processed in the electronic record for the administration record. Registered nurse unit manager #2 stated that they missed this one and would take care of it right away. During an interview on 12/05/2024 at 10:07 AM, Director of Nursing #1 stated they would expect the signed dietary recommendation signed by the provider to be followed and discontinued as ordered. 10 New York Codes, Rules, and Regulations 415.14(d)(4)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51317 Based on observation, record review, and interviews during the recertification survey, the facility did not maintain medical records in accordance with accepted professional standards and practices that were accurately documented and completed for 3 (Residents #21, 144. and #171) of 35 residents reviewed. Specifically, (a.) for Resident #21, the facility incontinence care provided was not documented; (b.) for Residents #144 and #171 the care provided by Certified Nurse Aides were not consistently documented, including the amount of meals consumed, consumption of supplements, and nourishment for bedtime snacks. This is evidenced by: A review of policy titled Documentation for Certified Nursing Assistants dated 11/22/2010 documented all documentation of care delivered to a resident by a Certified Nursing Assistant would be done using the Point Click Care (PCC) kiosks. The policy stated care should be entered as close as possible after the care had been rendered and staff was to enter information at the kiosk at various times during their tour of duty, not waiting until the end of a shift. The policy also documented all documentation was to be completed accurately prior to the completion of the Certified Nursing Aide's tour of duty. Resident #21 Resident #21 was admitted to the facility on [DATE] with a diagnoses of unspecified dementia, mild, without behavioral disturbance, paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and muscle wasting and atrophy. The Minimum Data Set (an assessment tool) dated 10/18/2024, documented the resident was able to make themself understood and had the ability to understand others. Resident #21 had a moderate cognitive impairment for activities of daily living. A review of Resident #21's Minimum Data Set, dated dated dated [DATE] indicated for Resident #21, a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) had been attempted and was currently being used to manage the resident's urinary continence. Resident #21 was listed as being frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) for urinary continence. A review of Resident #21's care plan initiated 08/17/23 with focus, Resident #21 has bladder incontinence related to impaired mobility listed an intervention as, Check me every 2-4 hours and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN and after incontinence episodes. A review of task log for Resident #21 listed task as, Individualized toileting schedule: toilet before meals, then walk to D-wing dining room. Must wake up and take to toilet during the overnight shift even if already incontinent. This task log indicated Resident #21 was checked to see if they voided on the following dates at the following times: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/08/2024: Documented care was performed at 1:04 AM; 10:18 AM, 1:41 PM, 8:54 PM, 8:54 PM (8:54 PM was listed twice). 11/09/2024: Documented care was performed at 2:15 AM, 4:56 AM, and 10:00 AM. 11/10/2024: Documented care was performed at 7:00 AM and 8:00 PM. 11/11/2024: Documented care was performed at 9:06 PM and 9:06 PM (9:06 PM was listed twice). 11/12/2024: Documented care was performed at 1:24 AM, 7:24 PM and 7:24 PM (7:24 PM was listed twice). 11/13/2024: Documented care was performed at 1:34 PM. 11/14/2024: Documented care was performed at 12:00 PM. 11/15/2024: Documented care was performed at 8:00 AM, 12:00 PM, 9:45 PM, 9:45 PM (9:45 PM was listed twice). 11/16/2024: Documented care was performed at 10:42 AM, 1:49 PM, 7:32 PM, 7:32 PM (7:32 PM was listed twice). 11/17/2024: Documented care was performed at 10:43 AM, 1:46 PM, 7:13 PM, 7:13 PM (7:13 PM was listed twice). 11/18/2024: Documented care was performed at 11:23 PM. 11/19/2024: Documented care was performed at 5:54 AM. 11/20/2024: Documented care was performed at 4:12 AM. 11/21/2024: Documented care was performed at 3:42 PM. 11/22/2024: Documented care was performed at 9:02 PM. 11/23/2024: Documented care was performed at 1:32 AM, 11:01 AM, 12:00 PM. 8:43 PM, and 8:44 PM. 11/24/2024: Did not document care was performed. 11/25/2024: Documented care was performed at 3:22 AM, 4:08 PM, 7:01 PM. 11/26/2024 through 11/29/2024: Resident #21 was unavailable for voiding review due to being hospitalized and out of the facility. 11/30/2024: Documented care was performed at 5:00 PM and 8:00 PM. 12/01/2024 Documented care was performed at 1:49 AM, 9:38 PM and 9:38 PM (9:38 PM was listed twice). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/02/2024: Documented care was performed at 1:28 AM, 8:00 AM, 12:00 PM, 8:05 PM, and 8:05 PM (8:05 PM was listed twice). 12/03/2024: Documented no care was performed. 12/04/2024: Documented care was performed at 10:56 AM, 1:49 PM, 9:42 PM, and 9:42 PM (9:42 PM was listed twice). 12/05/2024: Documented care was provided 7:47 PM and 7:47 PM (7:47 PM was listed twice). During an interview on 12/05/24 at 1:32 PM, Certified Nurse Aide #1 stated they used a peri wash, wipe the resident from front to back, and clean Resident #21 every time they go to the bathroom. Certified Nurse Aide #1 stated they documented the toileting of Resident #21 on the kiosk. Certified Nurse Aide #1 stated they tried to document services provided when they occurred, but t was not always possible, and they may document the services provided at the end of their shift. During an interview on 12/05/24 at 11:57 AM, Licensed Practical Nurse #1 stated that after the Certified Nurse Aides provided care relating to toileting/continence for Resident #21, they should document they provided care. Licensed Practical Nurse #1 stated they would expect to see a check on the report every 4 hours for Resident #21. During an interview on 12/05/24 at 2:40 PM, Registered Nurse #1 stated they did not know if there was a place for Certified Nurse Aides to document they had provided care for a resident. When Registered Nurse #1 was shown the task log mentioned above, they stated they never saw it before and would have to look into it further. During an interview on 12/06/24 at 10:02 AM, Assistant Director of Nursing #1stated if a resident was care planned to be checked and changed for toileting, there should be a task for it to allow Certified Nurse Aides to document the care provided. The Certified Nurse Aides documented tasks on the kiosk when care was performed, but they may wait to document that care was performed because they may not have a chance to document when they performed the actual care. If a resident was to be checked/changed every 4 hours, it should be documented that it occurred every 4 hours. When the Assistant Director of Nursing was shown the above referenced task log, they stated, There is a documentation issue. Resident #144 Resident #144 was admitted with diagnoses of Alzheimer's disease, anxiety disorder, and severe protein-calorie malnutrition. The Minimum Data Set (an assessment tool) dated 10/11/2024 documented the resident was understood, was able to be understood, and severely cognitively impaired. Resident #144's comprehensive care plan documented the resident was at nutritional risk. The documented interventions included: offer a bedtime snack nightly and provide health shakes three times a day. The Point of Care Response History for Supplement consumed - health shake three times a day? (11/5/2024-12/5/2024) documented incomplete or missing documentation for the following dates: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/7/2024: two health shakes documented at 8:30 AM and 12:00 PM 11/8/2024: no health shakes documented. 11/11/2024: one health shake documented at 8:48 PM 11/12/2024: no health shakes documented. 11/14/2024L two health shakes documented at 8:30 AM and 12:00 PM 11/15/2024: one health shake documented at 9:04 PM 11/18/2024: one health shake documented at 8:30 AM and 12:00 PM 11/19/2024: no health shakes documented. 11/20/2024: two health shakes documented at 11:05 AM and 7:30 PM 11/21/2024: one health shakes documented at 6:32 PM 11/22/2024: one health shake documented at 8:48 PM 11/23/2024: two health shakes documented, both at 1:53 PM 11/24/2024: two health shakes documented at 12:00 PM and 9:39 PM 11/25/2024: one health shakes documented at 8:37 PM 11/26/2024: two health shakes documented at 1:45 PM and 8:25 PM 11/27/2024: one health shake documented at 9:42 PM 11/28/2024: no health shake documented. 11/29/2024: one health shake documented at 9:33 PM 12/1/2024: one health shake documented at 8:29 PM 12/3/2024: one health shake documented at 9:29 PM 12/4/2024: one health shakes documented at 9:31 PM 12/5/2024: two health shakes documented at 1:31 PM and 1:32 PM The Point of Care Response History for what percentage of the meal was eaten? (11/5/2024-12/5/2024) documented incomplete or missing documentation for the following dates: 11/8/2024: no meals documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/11/2024: one meal documented at 6:21 PM 11/12/2024: no meal documented. 11/14/2024: two meals documented at 8:30 AM and 12:00 PM 11/15/2024: one meal documented at 9:04 PM 11/18/2024: two meals documented at 8:30 AM and 12:00 PM 11/19/2024: no meals documented. 11/20/2024: two meals documented at 11:05 AM and 7:30 PM 11/21/2024: one meal documented at 6:32 PM 11/23/2024: one meal documented at 1:53 PM 11/24/2024: two meals documented at 12:00 PM and 9:19 PM 11/25/2024: no meals documented. 11/26/2024: one meal documented at 8:24 PM 11/27/2024: one meal documented at 9:42 PM 11/28/2024: no meals documented. 11/29/2024: one meal documented at 9:33 PM 12/1/2024: one meal documented at 8:29 PM 12/3/2024: one meal documented at 9:29 PM 12/4/2024: one meal documented at 9:24 PM Point of Care Response History for offer nourishing snack: task completed (11/5/2024-12/5/2024) documented missing documentation for the following dates: 11/14/2024 11/18/2024 11/19/2024 11/20/2024 11/23/2024 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/28/2024 12/02/2024 12/05/2024 During an interview on 12/5/2024 at 12:16 PM, Licensed Practical Nurse #4 stated the registered nurses checked for documentation completion. During an interview on 12/5/2024 at 12:23 PM, Registered Nurse #3 stated the licensed practical nurses were to check the electronic medical record dashboard for the completion of certified nurse aide tasks before the certified nurse aides leave at the end of the shift. Resident #171 Resident #171 was admitted with diagnoses that included dysphagia (trouble swallowing), difficulty walking, and muscle wasting and atrophy (muscle loss). The Minimum Data Set (an assessment tool) dated 9/26/2024 documented the resident was able to be understood and could understand others; the resident was severely cognitively impaired. It further documented that the resident was totally dependent on assistance to eat, toilet, and lower body dressing. On 06/26/2024, the resident weighed 151.4 pounds. On 12/02/2024, the resident weighed 130.8 pounds which is a -13.61 % Loss in 6 months. Resident #171's care plan documented that the resident had a potential for weight loss, initiated 9/13/2024, and the intervention was to monitor and record food intake at each meal if applicable (also initiated 9/13/2024). Resident #171's amount of food eaten from 11/4/2024 - 12/2/2024, printed 12/3/2024, was missing meal documentation as follows: 11/4/2024 - 1 meal documented at 5:00 PM 11/5/2024 - 1 meal documented at 5:00 PM 11/6/2024 - 1 meal documented at 6:18 PM 11/7/2024 - 1 meal documented at 7:36 PM 11/8/2024 - all 3 meals documented. 11/9/2024 - 1 meal documented at 5:00 PM 11/10/2024 - all 3 meals documented. 11/11/2024 - all 3 meals documented. 11/12/2024 - 2 meals documented at 10:39 AM and 1:45 PM 11/13/2024 - 1 meal documented at 5:00 PM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/14/2024 - 1 meal documented at 7:03 PM 11/15/2024 - 2 meals documented at 8:30 AM and 12:00 PM 11/16/2024 - all 3 meals documented. 11/17/2024 - 1 meal documented at 8:33 PM 11/18/2024 - all 3 meals documented 11/19/2024 - 1 meal documented at 9:53 PM 11/20/2024 - 1 meal documented at 9:37 PM 11/21/2024 - 1 meal documented at 9:38 PM 11/22/2024 - 2 meals documented at 8:30 AM and 12:00 PM 11/23/2024 - 1 meal documented at 9:45 PM 11/24/2024 - 1 meal documented at 5:00 PM 11/25/2024 - 1 meal documented at 9:08 PM 11/26/2024 - all 3 meals documented. 11/27/2024 - 1 meal documented at 5:00 PM 11/28/2024 - 1 meal documented at 9:16 AM 11/29/2024 - 1 meal documented at 9:27 PM 11/30/2024 - 1 meal documented at 9:41 PM 12/1/2024 - all 3 meals documented. 12/2/2024 - all 3 meals documented. During an interview on 12/5/2024 at 12:25 PM, Certified Nurse Aide #2 stated all care was to be documented after it was given. This included meals, supplements, and snack consumptions. They stated if the task read for a supplement to be given three times a day, it should be documented that it was given three times a day. During an interview on 12/6/2024 at 10:00 AM, Assistant Director of Nursing #1 stated that documentation should be completed as ordered. They stated the amount of meals consumed should be documented with each meal. The licensed practical nurses were able to access the dashboard in the electronic medical record to check if documentation was completed with the expectation that it was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules, and Regulations 483.70 (h)(2)(ii)