STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335311	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tolstoy Foundation Rehabilitation and Nrsg Center	100 Lake Road Valley Cottage, NY 10989

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47626 Based on record reviews and interviews during the recertification and abbreviated surveys(NY00308566) from 5/28/24 to 6/4/24, the facility did not ensure that a resident's representative was immediately notified of the presence of an unstageable sacral pressure ulcer. This was evident for 1 of 6 residents (Resident #229) reviewed for pressure ulcers. Specifically, Resident #229's representative was not made aware the resident developed a pressure ulcer in the facility. Findings include: Resident #229 was admitted with diagnoses which included urinary tract infection, metabolic encephalopathy, and a history of brain tumor. The Admission Minimum Date Set (an assessment tool) dated 10/31/22, documented modified independence for decision making. The resident required limited assistance with eating, and was dependent with all other areas of activities of daily living. No pressure ulcer was documented on the admission assessment. A review of the Care Plan, Potential for Skin Breakdown dated 11/8/2022, documented an intervention to inform resident/family of any new areas of skin breakdown. The care plan was updated on 12/5/2022 with documentation of sheer injury with new treatment of Xeroform. A review of the nurses note dated 12/5/2022 documented Certified Nurse Aide reported an open area to the sacrum. A sheer injury to the sacrum was noted and treatment to cleanse with normal saline apply Xeroform and protective dressing. A review of the physician consultant wound note dated 12/7/2022 documented unstageable sacrum pressure ulcer measuring 5 centimeters x 3 centimeters x not measurable, with recommendations to turn and position every 1-2 hours. A review of a progress note dated 12/14/2022 documented the resident was discharged to another facility per the daughter's request. The resident's daughter was present at the time of discharge. A review of the medical record revealed no documentation that the family was notified when the resident developed a pressure ulcer on 12/5/23. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/31/24 at 10:44 AM, the Assistant Director of Nursing stated they normally did notify the family if a resident developed a pressure ulcer. They stated there was no documentation in the medical record that the family was notified. 10 NYCRR 415.3 (f)(2)(ii)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on record review and interviews during the recertification and abbreviated surveys (#NY00341484) from 5/28/24 to 6/4/24, the facility did not ensure an allegation of abuse was reported to the New York State Department of Health within 2 hours of becoming aware of the allegation for 1 (Resident #70) of 2 residents reviewed for abuse. Specifically, the facility did not ensure an allegation of sexual abuse involving Resident #70 was reported within 2 hours of becoming aware of the allegation on 5/6/24 and was not reported until 5/7/24. Findings include: Resident #70 was admitted to the facility on [DATE] with diagnoses of amyotrophic lateral sclerosis, cerebrovascular accident, dementia reflux and hypertension. The resident's Minimum Data Set (an assessment tool) dated 3/18/24 documented the resident had intact cognition and was dependent on staff for Activities of Daily Living, ambulated with supervision and was incontinent of bowel and bladder. An Incident and Accident report dated 5/7/24 documented the facility Administrator visited the resident on 5/6/24 to encourage them to take a shower. The resident informed the Administrator that they were not taking any more showers because the last time three women pulled off my clothes and dragged me down the hallway naked to take a shower. One of the women squeezed my genitals in the shower 12 times. The Health Electronic Response Data System report, used by the facility to document the reporting time of the incident to the New York State Department of Health documented the report of allegation of abuse was made on 5/6/24 at 2:15 PM, and reported by the Administrator to the Director of Nursing. The facility submission to the New York State Department of Health was dated 5/7/24 at 13:39 PM. During an interview on 05/31/24 at 10:19 AM, the Director of Nursing stated they first became aware of the resident's allegation on 5/6/24 after they were told by the Administrator of the incident. The Director of Nursing stated Resident #70 reported they were sexually abused but did not specify when or if they were nurses or Certified Nurse Aides. The Director of Nursing stated they began a full investigation of the prior three showers and obtained staff statements. The Director of Nursing stated they did not know they needed to report an allegation of abuse within a two-hour timeframe and thought they had 24 hours to report. The Director of Nursing stated they should have called sooner. 10 NYCRR 415.4 (b)(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 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. 43478 Based on record review and interviews conducted during the recertification and abbreviated surveys (NY00322083, NY00308566, NY00341484, NY00336441) conducted from 5/28/24 to 6/4/24, the facility did not ensure a comprehensive care plan that included measurable goals and interventions based on resident assessment was provided to maintain the resident's highest practicable physical well-being for 4 of 25 residents (Residents #42, #229, #70, #327) reviewed. Specifically, Resident #42 did not have a care plan which included the assistance they required for all their activities of daily living, Resident #229 did not have a care plan for activites of daily living or seizure disorder, Resident #70 did not have a care plan for activities of daily living or abuse prevention, and #327 did not have a care plan for activities of daily living. The findings are: The facility policy titled Care Plan Policy revised January 2024. Stated the purpose of the policy is to ensure that their residents receive personalized, comprehensive, and coordinated care. In addition, care plans are upmost in providing consistent, quality of care specialized to the residents' needs. However, the development of care plans should be done timely within seven days of the residents' admission. 1. Resident #42 was admitted with diagnoses which included thrombocytosis (low blood platelets), deficiency of immunoglobulin (antibody blood protein), and developmental disorders of speech and language. The quarterly Minimum Data Set (resident assessment tool) dated 4/8/24 documented Resident #42 required partial/moderate assistance with oral hygiene, bathing, dressing, personal hygiene, transfers, ambulation, and going up and down stairs. Resident #42 required substantial/maximal assistance with toilet hygiene and was dependent with picking up an object. No documented evidence could be located in Resident #42 electronic health record to document an active plan of care for Activities of Daily Living with resident centered goals and interventions to outline Resident #42 plan of care. On 6/3/24 at 3:55 PM during an interview with the Assistant Director of Nursing, they stated there was no documented evidence that an active plan of care for Activities of Daily Living existed for Resident #42. They stated the MDS Assessor and the Rehabilitation Department and the nurse supervisor who admitted Resident #42 were responsible for initiating the care plan for Activities of Daily Living. On 6/4/24 at 8:25 AM during an interview, the Director of Rehab stated they could not find documentation of a care plan which included interventions for bathing and dressing. The Director of Rehab stated Resident #42 is on maintenance therapy twice a week, not on restorative therapy and the rehab department is therefore not responsible for creating the Activities of Daily Living care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 8:45 AM during an interview, the MDS Nurse stated that a MDS quarterly/Medicare 5-day was completed on 4/8/24 for Resident #42. The MDS Nurse stated that the Director of Rehab completed section GG for all the activities of daily living. The MDS Nurse stated they are responsible to initiate care plans when they complete MDS admission assessments or MDS annual assessments. They stated for MDS quarterlies, the charge nurse who is responsible for the resident should review the care plans and update the care plans as needed. On 6/4/24 at 9:40 AM during an interview, Staff #6 (Licensed Practical Nurse Unit Manager lower level) stated they did not see documentation of a care plan for Activities of Daily Living. They stated they or the MDS Nurse were responsible to review and update Resident #42 care plan. They stated the MDS Nurse gives them a list of which residents need a care plan review and updates. They stated they are still learning about care plan reviews and updates, and they are unsure of how to do care plan reviews and updates. On 6/4/24 at 10:25 AM during an interview, the MDS Coordinator stated that for Resident #42, the admitting nurse was responsible for initiating the care plan on 4/6/24. On 6/4/24 at 10:36 AM during an interview, the Director of Nursing stated the Registered Nurse who completed the admission for Resident #42 on 4/6/24 was responsible for completing the care plan. On 6/4/24 at 10:42 AM during an interview, Staff #7 (Registered Nurse Supervisor) stated they completed the admission assessment for Resident #42 on 4/6/24 on the evening shift. They stated they review and update the care plans for new admissions and re-admissions if they have time. The Registered Nurse Supervisor stated that care plans are reviewed and updated the day after admission/re-admission by the MDS Coordinator or Licensed Practical Nurse Unit Manager if they do not have time. The Registered Nurse Supervisor stated that new admissions and re-admissions are communicated on report. 47626 2. Resident #229 was admitted with diagnoses which included urinary tract infection, metabolic encephalopathy, and seizure disorder. The Admission Minimum Data Set (an assessment tool) dated 10/31/22 documented the resident required modified independence for decision making. The resident requires limited assistance with eating and was dependent with all other areas of activities of daily living. No documented evidence could be located in Resident #229 electronic health record to document an active plan of care for Activities of Daily Living or Seizure Disorder with resident centered goals and interventions to outline Resident #229 plan of care. On 05/31/24 at 01:47 PM during an interview, Staff #1 (Registered Nurse) stated we put care plans in as part of the admission process for Fall, Pain, Skin, Diagnosis, and Medications, If we know what the Activities of Daily Living are we put a care plan in. When the new admission comes in therapy evaluates the resident and tells us what the residents level of assistance is, and a care plan should be developed. The discharge planner helps by reviewing charts to ensure the care plans are in. If someone is admitted with seizure disorder or on an anticoagulant the care plan should be developed right away. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/31/24 at 04:29 PM during an interview, the Director of Nursing stated they initiate a care plan to address residents needs, they are initiated on admission or as the need arises. They stated they should have an Activities of Daily Living care plan for each resident. They stated they expect to have a care plan to address seizures, medication, and diagnosis. 41666 3. Resident #70 was admitted to the facility with diagnoses which included amyotrophic lateral sclerosis (nervous system disease), cerebrovascular accident, and dementia. The resident's Minimum Data Set (an assessment tool) dated 3/18/24 documented the resident has intact cognition and is dependent on staff for Activities of Daily Living, ambulates with supervision and is incontinent of bowel and bladder. An Incident and Accident (I&A) report dated 5/7/24 documented the facility Administrator visited the resident on 5/6/24 to encourage them to take a shower. The resident informed the Administrator that They were not taking any more showers because the last time three women pulled off my clothes and dragged me down the hallway naked to take a shower. One of the women squeezed my genitals in the shower 12 times. Resident #70 electronic medical record did not document a plan of care with resident centered goals and interventions to address the resident's activities of daily living which would include showers, dressing and eating. Additionally, there was no plan of care in Resident #70 record with resident centered goals and interventions to address abuse prevention or abuse after the incident had occurred. On 06/04/24 at 09:09 AM during an interview, Staff #12 (Licensed Practical Nurse) stated interventions for showering, mouth care, dressing, and eating should be in a care plan. They stated that any Registered Nurse can put in care plans but if not, you can look at the resident then you will know what they need. The Certified Nurse Assistants just know what to do. On 06/04/24 at 09:19 AM during an interview, Staff #6 (Licensed Practical Nurse) stated every resident should have care plans to address all their needs. Care plans are initiated by the Registered Nurse, then updated by the Licensed Practical Nurse. Staff #6 did not know why Resident #70 did not have care plans for activities of daily living and abuse, but it was a good idea. On 06/04/24 at 09:24 AM during an interview, the Director of Nursing stated they were made aware there were no Activities of Daily Living or Abuse care plans in Resident #70 chart. The Director of Nursing stated they had been doing the investigation into the incident that Resident #70 was involved in recently and did not follow up. They didn't think about an abuse care plan but stated that every resident needs the basic care plan for basic needs and care plans need to be resident centered. 49364 4. Resident # 327 was admitted to the facility with diagnoses included schizoaffective disorder, gastro-esophageal reflux disease (GERD), and hypertension. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (an assessment tool) dated 1/15/24 documented the resident requires limited assistance with eating and oral hygiene, and was dependent on staff with all other areas of Activities of daily living to be carried out. No documented evidence of an Activities of Daily Living care plan in Resident # 327 electronic medical records with plans or goals for the resident in this care area. On 5/29/24 at 9:22 AM during an interview, Resident # 327 family member stated the resident did not receive any hygiene care and the resident was not allowed to use the phone because they were on isolation. The family member barely spoke to the resident during their stay at the facility. On 6/4/2024 at 8:31 AM during an interview, the Minimum Data Set Nurse/Staff Educator stated they are responsible for initiating care plans for new admissions and annual assessments when they complete the Minimum Data Set assessment, and the charge nurses are responsible for updating the care plans and the quarterly Minimum Data Set. On 6/4/2024 at 8:39 AM during an interview, the Minimum Data Set Coordinator/ Discharge Planner Staff stated, they did not see an Activities of Daily Living care plan for Resident #327. They stated there should have been an Activities of Daily Living care plan for Resident #327. On 6/4/2024 at 9:54 AM during a follow- up interview, the Director of Rehab stated they did not see an Activities of Daily Living care plan for Resident #327. 10NYCRR 415.11(c)(1)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 43478 Based on record reviews and interviews during the recertification survey from 5/28/24 to 6/4/24, the facility did not ensure that Certified Nurse Aide performance appraisals were completed at least once every 12 months. Specifically, performance appraisals were not documented every 12 months for 5 of 5 certified nurse aides (Staff #2, #4, #8, #10, #11) records reviewed. The findings are: On 06/04/24 at 11:11 AM during an interview with the Director of Human Resources, they stated that about one month ago, they started a project of updating performance appraisals for all employees and during the morning meeting, department heads were advised to complete performance appraisals. The Director of Human Resources stated the Nursing Department has not completed the performance appraisals for any nurse aides. On 6/4/24 at 11:15 AM, performance appraisals were requested from the Director of Human Resources. On 6/4/24 at 11:29 AM, the Director of Human Resources stated they could not find any recent performance appraisals for the selected nurse aides (Staff #2, #4, #8, #10, or #11). Facility documentation revealed the most recent performance appraisals were: Staff #2: 12/21/16, Staff #4: 12/16/16, Staff #8: 4/9/15, Staff #10: 11/18/16, Staff #11: no documentation of any performance appraisal was found. 10 NYCRR 415.26 (c)(2)(iii)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 43478 Based on record reviews and interviews conducted during a recertification survey from 5/28/24 to 6/4/24, the facility did not ensure that the certified nurse aides were provided the required 12 hours of training and annual in-services on dementia care management and resident abuse prevention, to ensure safe delivery of care. Specifically, the facility was unable to provide evidence that 2 of 5 certified nurse aides (Staff # 8 and #11), reviewed for Nurse Aide training, were provided 12 hours of mandatory training. The findings are: On 6/4/24 at 11:41 AM during an interview with the MDS Nurse/Staff Educator, they stated they are responsible for documentation of the nurse aide mandatory in-services. On 6/4/24 at 11:45 AM, nurse aide mandatory in-service documentation was requested from the MDS Nurse/Staff Educator. Review of the facility annual in-service training records revealed that the training documentation for Staff #8 and Staff #11 could not be located. On 6/4/24 at 12:13 PM, the MDS Nurse/Staff Educator stated they could not locate the 'Mandatory In-Service Sign-Off Sheets for Staff #8 or for Staff #11. 10 NYCRR 415.26 (c)(1)(iv)