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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on observation, interview, and record review during a recertification survey from 5/28/24 through 6/4/24, the facility did not ensure residents had the right to a dignified experience for 2 of 9 residents (Residents #328, and #46) reviewed for dining. Specifically, certified nurse aides were observed standing over Residents #328 and #36 while assisting the residents with their meals. The findings include: The facility's policy titled: Resident Feeding Program revised January 2020. Stated the feeding program was designed to assist the residents to regain lost feeding skill ability, restore self-esteem and promote a higher level of physical, social, and emotional wellbeing. 1. Resident # 328 was admitted to the facility with diagnoses including dementia, Parkinson's disease, and aspiration pneumonia. The Minimum Data Set, dated dated dated [DATE] (an assessment tool) documented that Resident #328 had severely impaired cognition and required extensive assistance with eating. The nutrition care plan dated 5/24/24 documented Resident #328 had weakness and swallowing problems and required assistance to complete their meals daily. On 05/28/24 at 12:34 PM, an observation was conducted of Staff #2 (Certified Nurse Aide) standing over Resident #328 while assisting with their lunch meal in Resident #328's room. On 5/31/24 at 8:35 AM during an interview, Staff #1 (Registered Nurse Unit Supervisor) stated that Staff #2 knew the protocols of assisting residents with their meals. Staff #2 had worked at the facility for more than 5 years, and they should have been sitting down facing Resident #328 while assisting them with their meal. On 6/4/2024 at 9:24 AM during an interview, Staff #2 (Certified Nurse Aide) stated they knew that they should have been sitting when assisting the resident with their meal. 2. Resident #46 had diagnoses of Osteoarthritis, Chronic Obstructive Pulmonary Disease and Dementia. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment and needed moderate amount of assistance with eating. During an observation on 05/28/24 at 10:19 AM Staff #9 (Certified Nurse Aide) was heard multiple times addressing Resident #46 as a feeder. Staff #9 stated that all residents that needed assistance with meals and were fed by hand were called feeders. During an interview with Staff #9 on 6/3/24 at 12:24 PM they stated they realized it was a mistake to call the resident a feeder and was not thinking. During an observation on 5/28/24 at 12:53PM in the dayroom of residents eating lunch. Resident #46 was at a table being fed by Staff #4 (Certified Nurse Aide) while standing over the resident during the entire lunch meal. Staff #4 was asked many times to sit down by Licensed Practical Nurse #12 but refused and remained standing. During another observation on 05/31/24 at 08:53 AM, Staff #4 was observed standing over Resident #46 while feeding them their breakfast meal. During an interview with Staff #4 they stated they should always be sitting in a chair to feed residents because it was better for the resident so they can see you when they are eating. They stated they were standing and feeding Resident #46 because there were no chairs available to sit on. 10 NYCRR 415.3.(c)(1)(i) 41666

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on record review and interview conducted during the recertification survey from [DATE] through [DATE], it was determined for 1 of 3 residents reviewed for advance directives, the facility did not ensure residents had the right to formulate advance directives. Specifically, there was no documented evidence that Resident #334 had a physician's order for advanced directives. The findings include: Resident #334 was admitted to the facility on [DATE] with diagnoses including anemia, malignant neoplasm of prostrate, and occlusion and stenosis precerebral arteries. The admission Minimum Data Set (resident assessment tool) dated [DATE] documented the resident had moderately impaired cognition. On [DATE] at 08:58 AM, a record review revealed Resident #334 had no advanced directives located in electric medical records and had no hard copy of medical orders for life sustaining treatment (MOLST). On [DATE] at 9:22 AM during an interview, Staff #1 (Registered Nurse Unit Supervisor) stated Resident #334 did not have any advanced directive. Staff #1 stated if there was a medical emergency, they would call the family and the physician, and they would send the resident out of the facility for evaluation. On [DATE] at 10:20 AM, review of Resident #334's Medical Orders for Life Sustaining Treatment (MOLST) form documented a checkmark for CPR, Do not intubate (DNI), no tube feeding, and an additional hand written comment No CPR if quality of life will be diminished. It was signed and dated by Resident #334 on [DATE], and was not signed by the physician. A physician's order dated [DATE] at 10:41 AM, documented Full Code. There was no documented evidence the physician was aware of the resident's other advance directives including restrictions on intubation or tube feeding, or clarification on the hand written comment regarding CPR and quality of life. On [DATE] at 10:58 AM during an interview, the Director of Social Services stated that Resident #334 had a medical order for life sustaining treatment (MOLST), dated [DATE], they needed the physician to sign it. 10 NYCRR 415.3(e)(1)(ii)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on record review and interviews conducted during the recertification survey from 5/28/24 to 6/4/24, the facility did not ensure that the resident and/or resident representative were notified in writing of the reason for the transfer/discharge to the hospital in a language that they understood, and the facility did not notify the Ombudsman for 2 of 3 residents (Residents #18 and #24) reviewed for hospitalization . Specifically, Resident #18 and Resident #24 were transferred to the hospital and the facility could not provide evidence that a written notice of transfer/discharge was provided to the residents or the resident representatives and that notification was sent to the Ombudsman. Findings include: The facility policy, 'Notice of Discharge / Transfer', revised February 2018 documented that the facility must issue a valid Notice of Discharge/Transfer to any resident prior to discharge for any reason and to their designated representative, family and/or legal representative and ombudsman. 1. Resident #18 was admitted with diagnoses which included diabetes mellitus, chronic kidney disease stage 3, and protein calorie malnutrition. The Minimum Data Set Significant Change (resident assessment tool) dated 2/19/24 documented Resident #18 had intact cognition. The Minimum Data Set discharge date d 3/19/24 documented discharge, return anticipated. The Nurse's Note dated 3/19/24 documented Resident #18 was transferred to the hospital and was admitted . Documentation could not be provided that the facility notified Resident #18 and their representative in writing of the reason for the transfer to hospital on 3/19/24 and sent a copy to the Ombudsman. On 5/31/24 at 11:36 AM during an interview, the Director of Social Work stated that no notice of transfer could be located in Resident #18 file for their transfer to the hospital on 3/19/24. The Director of Social Work stated the nurse on duty was responsible for completing the form when a resident was transferred after hours, and during business hours an administrative staff person was responsible. 2. Resident #24 was admitted with diagnoses which included Diabetes Mellitus, hemiplegia and hemiparesis affecting right side, and hypertension. The Minimum Data Set discharge date d 4/1/24 documented Resident #24 was discharged , return anticipated. The quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #24 had intact cognition. (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note dated 4/1/24 documented Resident #24 was transferred to the hospital and admitted . Documentation could not be provided that the facility notified Resident #24 and their representative in writing of the reason for the transfer to hospital on 4/1/24 and sent a copy to the Ombudsman. On 5/31/24 at 2:50 PM during an interview, the Director of Social Work stated that no notice of transfer could be located in Resident #24 file for their transfer to the hospital on 4/1/24. 10NYCRR 415.3 (i)(1)(ii)(a)(b)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on record review and interviews during the recertification survey from 5/28/24 to 6/4/24, the facility did not ensure that residents or resident's representatives were notified in writing of the facility policy for bed hold for 2 of 3 residents (Residents #18 and #24) reviewed for hospitalization . Specifically, the residents were transferred to the hospital and the facility was unable to provide evidence that written notice of the facility policy for bed hold was given to the residents or their representatives. The findings are: Resident #18 was admitted with diagnoses which included diabetes mellitus, chronic kidney disease stage 3, and protein calorie malnutrition. The Minimum Data Set Significant Change (resident assessment tool) dated 2/19/24 documented Resident #18 had intact cognition. The Minimum Data Set discharge date d 3/19/24 documented discharge, return anticipated. The Nurse's notes dated 3/19/24 documented Resident #18 was transferred to the hospital and was admitted . Documentation could not be provided that a notice of the facility policy for bed hold was given to Resident #18 or to the Resident's representative. On 5/31/24 at 11:36 AM during an interview, the Director of Social Work stated that no notice of the facility policy for bed hold could be located for Resident #18 for their transfer to the hospital on 3/19/24. 2.Resident #24 was admitted with diagnoses which included Diabetes Mellitus, hemiplegia and hemiparesis affecting right side, and hypertension. The Minimum Data Set discharge date d 4/1/24 documented Resident #24 was discharged , return anticipated. The quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #24 had intact cognition. The Nurse's Note dated 4/1/24 documented Resident #24 was transferred to the hospital and admitted . Documentation could not be provided that a notice of the facility policy for bed hold was given to Resident #24 or to the Resident's representative. (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 2:50 PM during an interview, the Director of Social Work stated that no notice of the facility policy for bed hold could be located for Resident #24 for their transfer to the hospital on 4/1/24. The Director of Social Work stated the nurse on duty was responsible for completing the form when a resident is transferred after hours, and during business hours an administrative staff person was responsible. 10NYCRR 415.3 (i)(3)(i)(a)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on record review and interviews conducted during the recertification survey from 5/28/24 through 6/4/24, the facility did not ensure the Minimum Data Set 3.0 comprehensive assessment was completed in a timely manner. Specifically, for 1 of 1 resident (Resident #30), the Minimum Data Set admission assessment was not completed within 14 calendar days from admission and/or by the required Assessment Reference Date. The findings include: The facility policy, 'Policy for Minimum Data Set (MDS) Completion' revised January 2024, documented the Resident Assessment Instrument (RAI) is used, in accordance with federal and state regulations for ensuring optimal care planning and quality of the resident's care. In addition, the assessment coordinator is responsible for ensuring the Interdisciplinary Team complete timely residents' assessments and reviews in accordance with CMS RAI Version 3.0 Manual, Chapter 2 assessment schedules: 1. Admission within 14 days of residents' admission to the facility. 2. Quarterly review at least 92 days. Resident #30 was admitted to the facility on [DATE] with diagnoses including diabetes, hypertension, and dementia. Review of the admission Minimum Data Set (a resident assessment tool) dated 1/9/24 revealed the resident had severely impaired cognition and received physical and occupational therapy. Further review of Resident # 30's electronic medical record revealed the Minimum Data Set Admission Assessement was completed on 1/24/24 and Facility validation report revealed the resident's Admission Assessment was more than 14 days after the entry date. On 5/31/24 at 11:25 AM during an interview, the Minimum Data Set/Discharge Planning Coordinator stated Resident #30 admitted was 1/7/24, the admission Minimum Data Set was scheduled for 1/9/24 and the Minimum Data Set Admission Assessment was completed on 1/24/24. They stated they were responsible for timely submissions. They stated the admission assessment was submitted late. 10NYCRR 415.11(a)(2) .

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 43478 Based on record review and interviews conducted during the recertification survey from 5/28/24 to 6/4/24, the facility did not ensure that each resident's screen for a mental disorder or intellectual disability was signed and included the required digital ID. This was evident for 3 of 25 residents reviewed. Specially, Residents #18, #35 and #46 did not have the required signatures and digital IDs documented on their pre-admission screening and resident review assessment prior to their admission to the facility. The findings are: The facility policy,' Pre-Admission Screen & Annual Resident Review (PASRR)' dated January 2024 documented that all Residents must have a PASRR Screen upon admission to the facility and thereafter when there is a significant change that has a bearing on the Resident's specialized service needs. The screen assesses Residents for mental illness, dementia and mental retardation. 1. Resident #18 was admitted with diagnoses which included diabetes mellitus, chronic kidney disease stage 3, and protein calorie malnutrition. Resident #18 electronic medical record revealed there was no documented evidence that a pre-admission screen and resident review assessment was signed and included the digital ID prior to admission to the facility. 2. Resident #35 was admitted with diagnoses which included metabolic encephalopathy, depression, and Type 2 Diabetes Mellitus. Resident #35 electronic medical record revealed there was no documented evidence that a pre-admission screen and resident review assessment was signed and included the digital ID prior to admission to the facility. 3. Resident #46 was admitted with diagnoses which included Osteoarthritis, Dementia, and Chronic Obstructive Pulmonary Disorder. Resident #46 electronic medical record revealed there was no documented evidence that a pre-admission screen and resident review assessment was signed and included the digital ID prior to admission to the facility. On 6/3/24 at 9:50 AM during an interview, the Director of Social Work stated the Director of Admissions was responsible for receiving and printing all pre-admission paperwork and the I.T. Director scanned the documents and loaded them to the resident's electronic health record. The Director of Social Work stated they did not know who was responsible for assuring that all residents' screens were signed and include a digital ID prior to admission. (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 10:08 AM during an interview, the facility Administrator stated the Director of Admissions, or the Outreach Coordinator were responsible for receiving and reviewing screens to assure completion of all screens prior to a resident's admission. The facility Administrator stated that if a screen was not sent or was incomplete, the Director of Admissions or the Outreach Coordinator were responsible to call the transferring facility for a completed screen. The facility Administrator stated that if a screen was incomplete, they could not accept the resident. On 6/3/24 at 10:25 during an interview, the Outreach Coordinator stated they were currently filling in for the Director of Admissions. The Outreach Coordinator stated that the Director of Admissions was responsible to assure that all residents had completed and signed screens prior to admission. The Outreach Coordinator stated that while they were filling in for the Director of Admissions, they were responsible for assuring that all screens were completed and signed prior to a resident's admission. 10NYCRR 415.11 (e) 41666

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49255 Based on observation, record review and interviews conducted during the recertification survey from 5/28/24 to 6/4/24, it was determined for 1 of 6 residents (Resident #280) reviewed for Pressure Ulcers, the facility did not ensure a Baseline Care Plan was developed and implemented for a newly admitted resident that included the instructions needed to provide effective care within 48 hours of a resident's admission and that a summary of the Baseline Care Plan was provided to the resident. Specifically, Resident #280's baseline care plan was not developed. Findings include: The facility policy and procedure Resident's Baseline Care Plan revised January 2024 documented it is the policy of the facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and to comply with CMS regulations F483.21(a). Resident #280 was admitted with diagnoses which included Pressure Ulcer of Sacral Region Unstageable, Local Infection of the Skin and Subcutaneous Tissue, and [NAME] (darkened skin). The 5-day Minimum Data Set (resident assessment tool) dated 5/18/24 documented the resident was cognitively intact, dependent on assistance with toileting hygiene, shower/bathing, and upper and lower body dressing. A review of the resident's electronic record on 6/3/24 documented there was no baseline care plan documented. On 6/4/24 at 10:52 AM during an interview, the Assistant Director of Nursing stated that there was no baseline care plan completed for the Resident #280. They stated that the Registered Nurse should have completed a baseline care plan within the first 48 hours after admission. They could not explain why the baseline care plan was not documented. On 6/4/24 at 2:17 PM during an interview, Staff #1 (Registered Nurse Supervisor) stated they knew that for every newly admitted resident, a baseline care plan needed to be initiated and completed within 48 hours. They stated that their responsibility as a Registered Nurse was to complete the baseline care plan. They stated that they did not complete it because they were the only Registered Nurse on the floor and they did not have enough time to do it. 10NYCRR 415.11

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 49255 Based on observation, interview, and record review during the recertification survey from 5/28/24-6/4/24, the facility did not properly establish and/or maintain an infection prevention and control program designed to provide a safe and sanitary environment. Specifically, 1) The facility did not ensure cleans linens were transported throughout facility in a clean manor, or that hand hygiene was practice after handling dirty linens. 2) The facility did not have a current Water Management Plan in place; 3) Contact Precautions were not implemented for a resident with Clostridium Difficile infection (Resident#280) and staff were observed breaching infection control precautions. The findings are: The facility policy and procedure titled Infection Control Program dated 1/10/2024, documented the Infection Control and Prevention program aims to provide a clean, safe environment for the patients, nursing staff, medical staff ancillary staff visitors and the surrounding community by monitoring, controlling and preventing nosocomial infections through as comprehensive, multidisciplinary control program involving all departments. 1. An observation was made on 5/28/24 at 12:08 PM, on the lower level, of maintenance staff pushing a cart of clean sheets, towels, and other linen, uncovered. During an interview with Staff #17 (maintenance worker) they stated they received clean linens from an outside company which came with plastic covers. They took the covers off and left the linen in large bins in the hallway. From there they used a smaller cart and distributed linens throughout the building without a cover. The Staff #16 stated they had not been instructed to cover the cart and did not know it was supposed to be covered. During an interview with the Director of Maintenance on 5/28/24 at 1:23 PM they stated linen carts and bins needed to be covered to maintain Infection Control and the Staff #16 had been told that before. The Director of Maintenance did not know why that had not been done. During an observation on 5/30/24 09:16 AM, Staff#9 (Certified Nurse Aide) was wearing gloves and picked up a plastic bag of dirty linen from the floor and placed it on top of Resident #46's bed. They added more dirty linen to the bag then placed it back on the floor. While wearing the same gloves, Staff #9 then made the Resident #46's bed, touching the sheets, moving gloved hand over the pillowcase and pulling up the blanket. During an interview with Staff#9 on 5/30/24 at 09:28 AM, they stated they did not realize they could not put the dirty bag on the bed but could see the problem now. They further stated they were aware they should have changed their gloves between handling dirty laundry and making the bed. (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility policy for The Prevention and Management of Legionella dated 1/10/24 documents the facility is committed to preventing Legionella infections through comprehensive water management practices, regular monitoring, and prompt response to potential outbreaks. The Water Management Plan is to develop and maintain a comprehensive plan that outlines the control measured for preventing Legionella growth and spread within the facility's water systems. The Water Management Plan will be reviewed and updated annually or more frequently if significant changes occur in the water system or facility usage. The facility did not provide a Water Management Plan which details the Water Management Team, flow diagrams, control measures based on the Environmental Assessment. The Director of Maintenance was not able to verbalize a plan or next steps if test results came back from the lab positive. During an interview with the Director of Maintenance on 5/31/24 03:30 PM they stated they were not aware of a Water Management Plan and presented documentation of test results only. The Director of Maintenance stated they had been at the facility for three years and knew there was an outside company that did the assessment, did testing and sent results. During an interview 6/3/24 at 11:30 AM with the Assistant Director of Nursing, who was also the Infection Preventionist, they stated they were responsible for educating the Director of Maintenance about the Legionella Plan. They stated they had not provided education before about past Legionella problems but provided education after 5/31/24. They stated now the Director of Maintenance should have been education when they were hired three years ago. 3. The facility policy and procedures titled Clostridiodes difficile (c-diff) reviewed in January 2024 documented guidelines for the prevention, identification, and management of Clostridiodes difficile (C. diff) infections among residents at the facility to prevent the spread of Clostridium difficile. This policy outlined isolation procedures placing residents with confirmed or suspected Clostridium difficile on contact precautions immediately. Use private rooms for residents with Clostridium difficile whenever possible. If a private room is not available, cohort residents with Clostridium difficile together. Resident #280 was admitted to the facility on [DATE] with diagnoses including Pressure Ulcer of Sacral Region, Unstageable, Local Infection of the Skin and Subcutaneous Tissue, Unspecified, Melena. The 5-day Minimum Data Set (resident assessment tool) dated 5/18/24 documented the resident was cognitively intact, dependent on assistance with toileting hygiene, shower/bathe self, upper and lower body dressing. Laboratory test results documented stool was obtained for Clostridium Difficile testing on 5/22/24, and positive results were received on 5/24/24. The physician order dated 5/24/24 documented contact isolation for Clostridium difficile (c-diff) in stool. The Comprehensive Care Plan titled The resident has C. Difficile related to use of antibiotics effective 5/24/24 documented staff will wear gowns and masks when changing contaminated linens, disinfect all equipment used before it leaves the room, educate resident/family/staff regarding preventive measures to contain the infection. (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/28/2024 at 2:09 PM Resident #280 was observed sitting outside their room in the hallway next to the nursing station. An observation was made on 5/29/24 at 10:29 AM and at 1:45 PM of Resident #280 in their room with a sign on the right side of door that documented Enhanced Barrier Precautions. There was no cart containing personal protective equipment outside the resident room. An observation was made on 5/29/24 at 2:55 PM of Certified Nurse Aide #18 in Resident #280's room, not wearing a gown, walking around the resident's bed, then washed hands at the sink and left the room. During an interview at the time of observation, Certified Nurse Aide #18 stated Resident #280 was on Enhanced Barrier Precautions because they had a wound, and they only needed a gown while giving care. Staff #18 also stated the resident had a lot of diarrhea. On 5/29/24 at 3:03 PM during an interview, Staff #19 (Licensed Practical Nurse) stated they were told the resident had a wound infection and had to wear a gown and gloves, and they were not aware of anything else. They stated when they left the room, they used hand sanitizer for hand hygiene. An observation was made on 5/29/24 at 3:15 PM of the Director of Rehabilitation in Resident #280's room, while not wearing a gown or gloves, was rubbing the residents legs over a blanket with bare hands and leaning on the side rails. On 5/29/24 at 3:28 PM during an interview the Director of Rehab they stated they were aware the resident was being treated for Clostridium Difficile and only needed a gown and gloves when helping to change the resident. They were not aware that a gown was required for all the time while in room. On 5/29/24 at 03:18 PM an interview was conducted with the Director of Nursing who stated they were aware the resident was on Contact Precaution from morning report. The supervisors are supposed to put up signs and set up Personal Protective Equipment tables outside the room. The Director of Nursing stated there should be a Contact Isolation sign on the door for Clostridium Difficile and did not know why it had not been placed earlier. On 05/29/24 at 03:56 PM during an interview, Staff #5 (Licensed Practical Nurse) helped the surveyor to locate the personal protective equipment, which was not readily available to staff. On 5/31/24 at 10:33 AM an interview was conducted with the Assistant Director of Nursing who stated they attend a clinical meeting everyday and goes over residents who are on precautions. They stated they are not sure why the Contact Isolation sign was not up on the door. They stated the plan was to move the resident to another hallway but did not do that yet. 10NYCRR 415.19

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41666 Based on record review and interviews during a recertification survey from 5/28/24 to 6/4/24, the facility did not ensure that the Infection Preventionist (IP) completed specialized training in infection prevention and control prior to assuming the role. Specifically, the facility's designated IP was the Assistant Director of Nursing and did not have documented evidence of completed specialized training in infection prevention and control until 05/29/24. The findings are: During the annual survey Entrance Conference on 5/28/24, the Assistant Director of Nursing (DON) was identified as the Infection Preventionist but did not present a certificate of course completion until 5/29/24. Upon review, the Infection Preventionist had 5 outstanding modules to complete in the program including Antibiotic Stewardship and Occupational Health. During an interview with the Infection Preventionist on 6/4/24 at 11:37 AM they stated they had been in the role since the March 2024 but did not finish the Centers for Disease Control training course. They finished the course and presented the certificate after the annual survey started 5/28/24. 10NYCRR 415.19

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41666 Based on interview and record review during the recertification survey conducted 05/28/24-6/04/24, the facility did not ensure each staff was screened, offered the COVID-19 vaccine and provided education regarding the benefits, risks and potential side effects associated with the vaccine for 3 of 10 staff reviewed for COVID-19 vaccines. Specifically, there was no documented evidence of immunization records for Staff #13, #14, and #15. Findings include: During the recertification survey the facility was asked to provide the vaccination status for flu, pneumococcal and COVID-19 vaccines. There was no documented evidence the facility had documentation of screening, education offering or current COVID19 status. During an interview with the Assistant Director of Nursing on 6/4/24 at 11:37 AM they stated they have tried everything to get the staff to be on board with COVID-19 vaccinations, but most employees did not want the vaccine. They stated they got the vaccine records from Human Resources and reviewed them on hire but did not know what happened in this case and was not aware the employee records did not show they were screened, offered or were given an opportunity to decline the COVID-19 vaccine. 10NYCRR 415.19 (a)(1-3)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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)