| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335311 | A. Building<br>B. Wing | 09/02/2025 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review during the recertification and extended survey from 08/21/2025 - 09/02/2025, the facility failed to establish consistent mechanisms for documenting and communicating a resident's choice regarding advance directives to the staff responsible for the resident's care, resulting in staff not being able to appropriately identify Do Not Resuscitate orders for (6) six of 26 residents with Advance Directives. Specifically, Residents #64 and #67 were admitted to the facility with Do Not Resuscitate directives signed at the hospital that were not transcribed to the physician orders in the electronic medical record at the time of admission. Additionally, there was not a consistent process for identifying or communicating the resident's wishes regarding Do Not Resuscitate orders for Residents #9, #16, #28 and #36. Subsequently, the facility's failure to have a system to ensure code status was properly identified and implemented, had the likelihood to cause serious adverse outcome to all 64 residents in the facility. This resulted in Immediate Jeopardy to resident health and safety. The findings include:The facility policy titled ?Advance Directives Advance Care Planning' last reviewed 07/25/2024, documented clinical team members are responsible for reviewing advance directives and incorporating the resident's wishes into treatment and care provision, as well as continuing or modifying approaches as appropriate as well communicating the resident's wishes to involved staff.1. Resident #64 was admitted on [DATE] with diagnoses including COVID-19, dementia, and repeated falls. The physician admitting orders dated 08/20/2025, did not document Resident #64's code status. A review of Resident #64's electronic medical record on 08/22/2025 at 10:37 AM revealed no documented orders regarding code status, and there were no advance directives on the banner in the electronic medical record. A Physician order dated 08/22/2025 at 4:50 PM documented Do Not Resuscitate, Do Not Intubate. A Do Not Resuscitate order dated 08/19/2025 had been scanned into the resident's electronic medical record.During an observation on 08/25/2025 at 9:18 AM, Resident # 64 was in bed with no identification wristband, and the resident's name on the door was typed in black font.During an interview on 08/25/2025 at 9:22 AM, Certified Nurse Aide #2 stated if the resident had a Do Not Resuscitate order, there was an envelope on the back of the door. If they came to a room and the resident was unresponsive, they would ring the bell and go into the hall and yell for help. During an interview on 08/25/2025 at 9:24 AM, Registered Nurse #3 stated the resident's code status was assessed on admission by the admission nurse. In an emergency, the nurse would look in the electronic medical record for the code status. Registered Nurse #3 stated if the resident had a Do Not Resuscitate order, their name on the door was in red font and their identification wristband was in red. In an emergency, the nurse would look in the Electronic Medical Record for the code status. The code status was on the banner under special instructions. During an interview on 08/26/2025 at 11:47 AM, the Assistant Director of Nursing stated Resident #64 had a Do Not Resuscitate order that was included in the admission paperwork packet from the hospital. They stated it was the responsibility of the admission nurse to review the paperwork and discuss advance directives with the resident or responsible party and obtain an order for code status. They stated directives for Do Not Resuscitate were on the banner in<br>(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 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | the resident's electronic medical record under special instructions. There was no identifier that they were aware of on either the resident's door or on the identification wristband. If staff found a resident unresponsive, they should ring the bell, call out for help and the nurse should check the banner. During an interview on 08/26/2025 at 1:45 PM, Registered Nurse Supervisor #7 stated they completed the admission for Resident #64. They looked at the referral information from the hospital and did not see the code information. Since there was no information, they did not put an order in the electronic medical record related to the code status. They stated if there was not an order for Do Not Resuscitate the resident would be considered a full code. They stated they did not attempt to reach out to the responsible party or discuss Advance Directives with the resident.2. Resident #67 was admitted on [DATE] from the hospital with diagnoses including toxic metabolic encephalopathy (brain dysfunction), congestive heart failure (heart condition) and dementia.The admission orders dated 08/22/2025 did not document a code status for Resident #67. Nursing admission notes by Registered Nurse Supervisor #7, dated 08/22/2025, had no documented evidence of code status or any discussion regarding code status.A physician order dated 08/23/2025 documented Do Not Resuscitate. A Medical Order for Life Sustaining Treatment (MOLST) form was completed on 08/25/2025 with instructions including Do Not Resuscitate, comfort measures only, do not intubate, no feeding tube, a trial period of intravenous fluids, and determine use or limitations of antibiotics when infection occurs. During an observation on 08/26/2025 at 10:15 AM, Resident #67 was in bed and had their name typed in black font on the door and their identification wristband was also in black font.During an interview on 08/26/2025 at 1:45 PM, Registered Nurse Supervisor #7 stated Resident #67 was admitted to the facility with their designated representative present at the bedside. They discussed the advance directives with their designated representative who stated they had a Medical Order for Life Sustaining Treatment (MOLST) and would bring it in. They further stated the family had questions about the Do Not Resuscitate and wanted to discuss it with the physician. Registered Nurse Supervisor #7 also stated if the resident had a cardio-pulmonary arrest before a Do Not Resuscitate order was entered in the electronic medical record, they would perform Cardiopulmonary Resuscitation.During an interview on 08/26/2025 at 2:16 PM, Resident # 67's designated representative stated the resident had no quality of life and they did not want them to be resuscitated. They stated Resident #67 had a Do Not Resuscitate order at the hospital and they understood it was to be continued at the nursing facility when the resident was admitted .3. During an observation and record review audit on 08/25/2025 from 9:43 AM to 10:04 AM, Residents #9, #16, #28, and #36 had their door labels typed in black font, identification wristbands were in black font, and Do Not Resuscitation orders were in their electronic medical records.During an interview on 08/25/2025 at 11:30 AM, the Director of Nursing stated if residents had wishes not to be resuscitated, a Medical Order for Life Sustaining Treatment (MOLST) form was obtained and a Do Not Resuscitate order would be placed in the Physician Orders in the electronic medical record upon admission by the admission nurse. Directions regarding the Do Not Resuscitate would then be then noted on the banner under special instructions in the electronic medical record. A care plan would also be created for residents with Advanced Directives; the Social Workers would be responsible for initiating the care plan. They stated they only had a Social Worker on the weekend and not during the week.During an interview on 08/25/2025 at 12:29 PM, the Director of Admissions stated if the resident was known to have a Do Not Resuscitate order on admission, they would print both the wrist band label and door label in red. If they had Full Code status, they printed a label with black font. If the resident's code status changed after admission and the unit manager let them know, they would reprint the door and wrist band label. During an interview on 08/26/2025 at 11:28 AM, Licensed Practical Nurse #1 stated if the resident had a Do Not Resuscitate order, their identification wristband and door label would have their name in red font and if they were full code status the name would be in black font. Licensed Practical Nurse #1 pointed to Resident #16's door and stated the resident name was in black meaning the resident was a full code. Review of Resident #16's electronic medical record documented<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Do Not Resuscitate.During an interview on 08/26/2025 at 11:37 AM, Certified Nurse Aide #13 stated that when they found an unresponsive resident they called the nurse as soon as possible. They stated they did not know how to distinguish who had a Do Not Resuscitate order or who was a Full Code. Certified Nurse Aide #13 stated some residents did not wear identification bands. Certified Nurse Aide #13 stated nobody told them what the color of the wristband meant.During an interview on 08/26/2025 at 1:32 PM, the Social Worker stated the resident's Do Not Resuscitate status needed to be addressed within 48 hours of admission. The Social Worker stated there was a possibility that a Do Not Resuscitate would not be addressed if the resident was admitted on a Monday when the Social Worker was not working. The Social Worker stated it would be addressed on Saturday when they were at the facility. The Social Worker stated they spoke to administration about the Medical Order for Life Sustaining Treatment (MOLST) forms and how the physicians were not updating them regularly. They further stated they had not spoken to anyone in the facility about a plan to address who would cover the Medical Order for Life Sustaining Treatment forms and updating the Do Not Resuscitate list due to their part time schedule. The Social Worker stated when a resident had a cardiopulmonary arrest, one (1) nurse went to the Medical Order for Life Sustaining Treatment (MOLST) book, and one nurse went to the resident's room to identify the resident's code status on the resident's wristband.During an interview on 08/26/2025 at 2:58 PM, the Administrator stated they had an Advance Directives Policy. They stated if a resident was not breathing, the staff would check the electronic medical record to view the resident's wishes related to Advanced Directives. They stated they thought there was a sign behind the bed for residents with Do Not Resuscitate orders.During an interview on 08/26/2025 at 3:40 PM, Physician #2 stated the Medical Director was on leave, and they were covering. They stated they were not aware of the Do Not Resuscitate Policy and initially could not elaborate on how quickly a Do Not Resuscitate order should be entered into the electronic medical record.During a follow-up interview on 08/28/2025 at 9:38 AM, the Social Worker stated they had not reviewed the Do Not Resuscitate policy at the facility. The Social Worker stated they had not received orientation or been in-serviced on Do Not Resuscitate since the start of their employment at the facility. The Social Worker stated they only worked on weekends. They stated they were not sure if the Social Work Consultant Supervisor was providing supervision or coverage for them, and they had not had any in-person meetings with the Social Work Consultant Supervisor.During an interview on 08/28/2025 at 9:56 AM, Social Work Consultant Supervisor stated when new administration started at the facility, they assisted Human Resources with trying to find a social worker and interviewed the social worker for the position. The Social Work Consultant Supervisor stated the social worker they hired had a full-time job, was only available to work on weekends, and was hired to fill in until they found a permanent person. Social Work Consultant Supervisor stated they provide supervision by having meetings with the Social Worker via telephone. The Social Work Consultant Supervisor stated the advance directives and code status should be discussed on admission or within 24 hours. Social Work Consultant Supervisor stated when the Social Worker was not at facility the Do Not Resuscitate would be addressed by a designee and physician. The Social Work Consultant Supervisor stated the designee was the nurse doing the admission. The Social Work Consultant Supervisor stated the Assistant Director of Nursing and Director of Nursing were responsible for getting Do Not Resuscitate orders in place, completing the Medical Order for Life Sustaining Treatment (MOLST) form and updating the record when the social worker was not at the facility. 10NYCRR 400.21(7)(iii) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the recertification survey, the facility failed to ensure that properly trained personnel (and certified in CPR for Healthcare Providers) were available immediately (24 hours per day) to provide basic life support, including cardiopulmonary resuscitation (CPR), to residents requiring emergency care prior to the arrival of emergency medical personnel, and subject to accepted professional guidelines, the resident's advance directives, and physician orders between [DATE] and [DATE]. Specifically, eight (8) out of 14 licensed nurses reviewed did not have current or acceptable completed standardized training and certification. This included six (6) Licensed Practical Nurses (Licensed Practical Nurse #1, #12, #11, #5, #17, #27), and one (1) Registered Nurse (Registered Nurse #3). Additionally, the facility did not have a reliable system to track the cardiopulmonary resuscitation certification status of its staff. This resulted in Immediate Jeopardy and Substandard Quality of Care, putting the health and safety of all 64 residents at risk. The findings include:The facility's policy and procedure titled ?Cardiopulmonary Resuscitation' dated [DATE], documented cardiopulmonary resuscitation is performed by individuals certified in cardiopulmonary resuscitation, all licensed nursing personnel are required to be cardiopulmonary resuscitation certified and must possess a current certification to perform cardiopulmonary resuscitation.When requested on [DATE], the Director of Nursing provided a list titled CPR/BLS (Cardio-pulmonary Resuscitation/Basic Life Support) with 14 staff listed. When the list was received, the Director of Nursing was asked to provide the CPR certifications. Review of the certifications revealed Licensed Practical Nurse #27 had an expired certification card. The certifications for Licensed Practical Nurse #1, #12 and Registered Nurse #3 were dated [DATE] and were not from an accepted standardized cardiopulmonary resuscitation certification course (training that included hands on practice and in person assessment). Licensed Practical Nurses #5, #11, and #17 were on the list and had no documented evidence of certification. Review of staffing lists and staff schedules from [DATE] through [DATE] revealed that on multiple shifts, there was a lack of staff certified and trained in cardiopulmonary resuscitation. In total there were no certified staff available on five (5) days during the 7:00 AM to 3:00 PM shift ([DATE], [DATE], [DATE], [DATE], and [DATE]); on five (5) days during the 3:00 PM to 11:00 PM shift ([DATE], [DATE], [DATE], [DATE], and [DATE]). During an interview on [DATE] at 3:31 PM, Licensed Practical Nurse #1 stated that on [DATE] they took a course offered by the National Cardiopulmonary Resuscitation Foundation at the direction of the Director of Nursing. They stated this course was comprised of online learning. They stated the course did not include a practical portion it was only a video with question-and-answer format.During an interview on [DATE] at 11:44 AM, the Director of Nursing stated the Human Resource Director was responsible to make sure the staff obtained and maintained cardiopulmonary resuscitation certification. They stated the Human Resource Director resigned on [DATE]. They stated Human Resources was being covered by the management company's Human Resource specialist in the interim while they were seeking to fill the position. They further stated there was no recommended organization for the staff to receive cardiopulmonary resuscitation certification. They stated there was no procedure regarding timing of certification renewal. During an interview on [DATE] at 12:01 PM, the management company Human Resource Director stated currently there was no policy or procedure that guided the facility on reviewing the Cardiopulmonary Resuscitation certification and training for staff. They were unaware of current Cardiopulmonary Resuscitation trainings that were aligned with nationally approved standards.During an interview on [DATE] at 12:32 PM, Registered Nurse Supervisor #3 stated the supervisor of each shift was responsible for submitting a schedule to the Director of Nursing who was responsible for overseeing and approving the schedule. They stated Human Resources was responsible for obtaining cardiopulmonary resuscitation cards and ensuring<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | they were up to date. They stated if there was not a cardiopulmonary resuscitation certified person available, they would call 911. They did not know which staff had active Cardiopulmonary Resuscitation certifications. They stated they were not aware of a plan to ensure cardiopulmonary resuscitation certified staff were in the building.During an interview on [DATE] at 3:40 PM, Physician #2 stated the Medical Director was on leave, and they were covering for the Medical Director. They stated they were not aware of the Do Not Resuscitate or Cardiopulmonary Resuscitation Policies.During an interview on [DATE] at 3:58 PM, the Administrator stated they had only been at the facility a few months and were unaware the building did not have cardiopulmonary resuscitation certified staff present during all shifts. 10 NYCRR 415.11(c)(3)(i) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews conducted during the recertification and extended survey from 08/21/2025 to 09/02/2025, the facility did not ensure sufficient staff was consistently provided to meet the needs of residents on all shifts. Specifically, residents and family members reported during confidential interviews and group meetings that there were frequent delays in responses to call bells. An analysis of the facility assessment and the daily staffing levels documented on multiple occasions between 07/21/2025 and 08/21/2025 the facility did not meet their staffing requirements set forth in their Facility assessment dated [DATE].Findings include: The Facility assessment dated [DATE], documents that each day the facility will have, in total, nine licensed nurses, 20 certified nurse aides, one social worker and two activity therapy staff members available to meet the resident's needs. The Facility Assessment did not include a break down by shift for nursing staff. The Facility Assessment also documented 75 percent of their residents were of high acuity. A document titled Par Levels, dated 8/2025, and provided by the Director of Nursing on 8/25/2025 at 10:00 AM, documented one registered nurse, two licensed practical nurses and eight certified nurse aides for the day shift (7AM-3PM); one registered nurse, two licensed practical nurses and eight certified nurse aides for the evening shift (3PM-11PM); one registered nurse, two licensed practical nurses and four certified nurse aides for the night shift (11 PM-7AM).A record review of the staffing sheets provided by the Director of Nursing documented the following shifts where the required staffing (par level) was not met:- on 07/24/2025, evening shift had one registered nurse, three licensed practical nurses and four certified nurse aides.- on 07/26/2025, evening shift had one registered nurse, two licensed practical nurses and five certified nurse aides.- on 07/29/2025, evening shift had one registered nurse, three licensed practical nurses and three certified nurse aides.- on 08/03/2025, day shift had one registered nurse, two licensed practical nurses and six certified nurse aides.- on 08/04/2025, evening shift had one registered nurse, two licensed practical nurses, and five certified nurse aides.- on 08/07/2025, evening shift had one registered nurse, two license practical nurses and five certified nurse aides.- on 08/08/2025, evening shift had one registered nurse, two licensed practical nurses and five certified nurse aides.- on 08/09/2025, evening shift had one registered nurse, two licensed practical nurses and four certified nurse aides.- on 08/14/2025, evening shift had 1 registered nurse, one licensed practical nurse and six certified nurse aides.- on 08/15/2025 The night shift had One registered nurse, Two licensed practical nurses and two certified nurse aids- on 08/21/2025 The evening shift had one registered nurse two licensed practical nurses and four certified nurse aidesDuring a Resident Council meeting on 8/22/2025 at 10:30 AM, several residents stated the call bells were not answered in a timely manner, and they felt as if insufficient staffing was to blame. They stated that there was only one activities person and there were frequently no activities on the weekend.During an interview on 08/25/2025 at 4:15 PM, Resident #46's family member stated that the call bells were never answered, they ring and ring and no one comes. They stated that the staff seemed overwhelmed and when they tried to call the front desk phone, no one answered the phone.During an interview on 08/26/2025 at 3:54 PM, the Director of Nursing stated they were aware there were shifts where the staffing levels were not met and that sick calls were a problem. They stated that they were usually able to fill vacancies by asking staff to do overtime and adjusting employee's schedules to ensure coverage. They also stated that they did not offer incentives or use agency staff to fill vacancies. They additionally stated that they had ads posted for recruitment and that their managing company's staffing agency was currently trying to recruit for them. During an observation 08/27/2025 at 4:42 PM of the lower-level nursing station, multiple call bells were ringing and not being answered and there was a noticeable urine odor in the hall. During an interview on 08/27/2025 4:51 PM, Licensed Practical Nurse #12 stated that their staffing for today was good.<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | They had two licensed practical nurses and four certified nurse aides for 37 residents. They additionally stated the staffing sometimes dropped to one nurse which happened once or twice a week. They stated that they had the training necessary to care for the residents. 10 NYCRR 415.13(a)(1)(i-iii) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during the recertification and extended survey on [DATE] - [DATE] the facility administration did not use its resources effectively and efficiently to attain, or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, 1) the facility administration failed to ensure policies and procedures for residents' advance directives were properly identified, communicated, and consistently implemented (See F578). 2) The facility failed to ensure a the policy for cardiopulmonary resuscitation (CPR) was implemented and there were certified staff on every shift (See F678). Findings include:The facility policy titled Advance Directives Advance Care Planning last reviewed [DATE], documented clinical team members are responsible for reviewing any advance directives and incorporating the resident's wishes into treatment and care provision, as well as continuing or modifying approaches as appropriate as well communicating the resident's wishes to involved staff.The facility Cardiopulmonary resuscitation (CPR) policy, dated [DATE], documented all licensed nursing personnel were required to be certified in CPR and must possess a current certificate to perform CPR.During an interview on [DATE] at 1:32 PM, Social Worker stated they were at facility on the weekends and would meet with the new admissions and at that time they review advance directives, including Do Not Resuscitate orders. The Social Worker stated the Do Not Resuscitate needed to be addressed in 48 hours and they only worked weekends. The Social Worker stated they spoke to administration about the Medical Orders for Life Sustaining Treatment (MOLST) and the physicians not updating them regularly but never spoke to facility about a plan to address the Do Not Resuscitate orders while they were not working. During an interview on [DATE] at 2:58 PM Administrator stated that the facility had an Advanced Directives policy and a Do Not Resuscitate (DNR) policy. The Administrator stated they believed there was a sign behind the bed for residents with do not resuscitate orders. They stated that they knew everything needed to be changed, and that the Medical Order for Life sustaining treatment (MOLST), Advanced Directives, and Do Not Resuscitate were a priority. The Administrator stated that they were unaware of what the identifier was for Advance Directive/Do Not Resuscitate. The Administrator stated that the Director of Nursing needed to make the determination how staff would identify residents' code status. During another interview on [DATE] at 3:58 PM, the Administrator stated they had only been at the facility a few months and were unaware the building did not have cardiopulmonary resuscitation certified staff present during all shifts. 10NYCRR 415.26(a) |

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| F 0837<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.<br><br>Based on interview conducted during the recertification and extended survey on 08/21/2025 - 09/02/2025 the facility did not have a process and frequency by which the administrator reported to the governing body, the method of communication was not recorded, and the governing body did not establish and implement procedures for a clear line of communication regarding the management and operation of the facility. Specifically, the governing body did not receive minutes of the facility Quality Assurance Performance Improvement. The facility did not provide documented evidence that minutes of Quality Assurance Performance Improvement were provided to the governing body. During an interview on 8/28/2025 at 10:38 AM, the Chairman of the Board of Directors stated that the Board of Directors was the governing body of the facility. The management was led by the Interim Administrator. The Chairman stated that they had hired an Administrator who would be starting soon. The management was responsible for administrative duties such as payroll, human resources, purchasing and union dealings. The Chairman was unable to state their involvement with QAPI (Quality Assurance Performance Improvement). They stated that they had quarterly meetings with the facility but was unable to state if they had seen the minutes of the QAPI meetings. The Chairman further stated that they did not review the result of the recertification survey in 2024, and they were not involved with the plan of corrections. They stated that management company was responsible for oversight of the entirety of the nursing home. During an interview on 8/29/25 at 3:05PM, the Administrator stated they did not recall sending the QAPI (Quality Assurance Performance Improvement) minutes to the Board of Directors. During an interview on 9/2/25 at 10:58AM, Chief Executive Officer at the management company stated that about three months ago they signed agreement to help the facility. They stated the board hired them effective June 1, 2025. The problems they identified were financial problems such as the staffing, the building roof was leaking, there was a gap in the doors that causes the doors to not fully close, and the call bell system needed to be replaced. They stated every Thursday they had a board meeting, the secretary of the board was on the calls and they were not sure if they took minutes. They stated they were not involved in the QAPI (Quality Assurance Performance Improvement) meetings, and they did not review the minutes. Stated that the problem at the facility was that nobody was properly managing the process. 10 NY CRR 415.26 (3) (1) |

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| Tolstoy Foundation Rehabilitation and Nrsg Center | 100 Lake Road<br>Valley Cottage, NY 10989 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on observation, record review and interview during a recertification survey it was determined the facility did not make information on how to file a grievance or complaint available to residents. Specifically, during an 08/22/2025 resident council meeting Residents # 8, 11, 32, 34, 35, 36, 40, 41, 50, 53, 54, 59 and 65 stated they were unaware of the process of filing a formal grievance with the facility and were unaware of who the facility grievance official was.The findings include:A review of the policy titled Social Services/ Complaints and Grievances dated 07/25/2024, documented the Administrator will inform the Abuse Coordinator (Director of Social Services) that a complaint has been made, and an investigation has begun.The facilities grievance log revealed three grievances from: 02/01/24 (initiated by a resident), 03/18/24 (initiated by family) and 03/25/24 (initiated by family). No other grievances were noted for the past 15 months. During an observation on 08/22/2025 at 10:00 AM of the front entrance lobby, and resident units, there were no postings identifying the facilities grievance officer or providing information on the grievance process.On 08/22/2025 at 10:30 AM, a resident council meeting was held with Residents # 8, 11, 32, 34, 35, 36, 40, 41, 50, 53, 54, 59 and 65. All attendees stated they were unaware of the process of filing a formal grievance with the facility and were unaware of who the facility grievance official was.During an interview on 08/25/2025 at 1:31 PM, the Administrator stated they advised residents of the grievance process during admission and that a complaint and grievance form was given to the residents in the admission packet. The Administrator stated there was no Abuse Coordinator (Director of Social Services), and they were trying to hire a full-time social worker. The Administrator also stated they did not know if the process of filing a formal grievance was ever reviewed at the resident council meetings.During an interview on 8/25/25 at 2:56 PM Resident #20 stated they were unaware of the grievance process. They had no knowledge who the grievance officer was.During an interview on 8/27/2025 at 3:21 PM, Resident #1's family member stated they were not familiar with the process of filing a formal grievance with the facility. During an interview on 08/29/2025 at 4:02 PM the Social Worker stated no one asked them to handle grievances upon hire, they just assumed they would handle them. The Social Worker stated they were unaware of the grievance policy. 10 NYCRR 415.3 (D) (1) (ii) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during the recertification and extended survey from 8/27/2025-9/3/2025, the facility did not ensure that the resident, resident's representative(s), or ombudsman was notified of the transfer or discharge, and the reasons for the move, in writing and in a language and manner they understand for three (3) of 3 residents (Resident #61, #63 and Resident #66) reviewed for hospitalization or discharge home. Specifically, 1) the facility did not complete a discharge notice or notification of bed hold or notify the ombudsman for Residents #61 and #66 when they were hospitalized . 2) The facility did not notify the ombudsman for Resident #63 when they were discharged to the home. Findings include:<br><br>Policy and Procedure titled “Written Notification of Bed Hold” dated December 1995 documents written notice of Bed hold must be provided to all residents or representatives upon transfer or discharge.<br><br>Policy and Procedure undated titled “Ombudsman Notification Discharge” documents the facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br><br>1) Resident # 61 had diagnoses including Chronic Obstructive Pulmonary Disease, and Adult Failure to Thrive,<br><br>The admission Minimum Data Set (an assessment tool) dated 6/23/25, documented the resident's cognition was severely impaired and they required substantial to maximal assistance with activities of daily living.<br><br>A progress note dated 7/6/2025 documented the resident went to the hospital with acute respiratory distress.<br><br>A review of the medical record revealed no documented evidence that a notice of Bed Hold, or notification of the ombudsman was completed.<br><br>2) Resident #63 had diagnoses including pneumonia, diabetes, and an intellectual disability.<br><br>The admission Minimum Data Set (an assessment tool) dated 6/6/2025 documented the resident's cognition was severely impaired, and they required partial assistants with all activities of daily living,<br><br>The progress note dated 6/20/25 documented the staff picked up the patient after lunch. All medication and clothing were given to group home staff and the resident was discharged .<br><br>The facility was unable to provide documented evidence that the ombudsman was notified of the discharge.<br><br>3) Resident #66 was admitted to facility on 8/7/25 with diagnoses including Sepsis, Spastic Quadriplegic Cerebral Palsy, and [NAME] Syndrome.<br><br>Resident #66 was discharged [DATE], there was no documented evidence of a transfer discharge<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | notice or bed hold policy notice provided to the resident/designated representative and Ombudsman.<br><br>During an interview on 08/22/2025 at 11:14 AM, the Assistant Director of Nursing stated the notice of bed hold and the notification to the ombudsman should be sent by the social worker. They reviewed the social worker's email and the medical record and could not locate any proof of notice of bed hold, or notification of the ombudsman.<br><br>During an interview on 8/28/25 at 9:30 AM, the social worker stated they were only at the facility on weekends. They received no orientation and were unclear what their responsibilities were. They had only worked in the facility (7) seven days since they started. They were not hired to be the Director of Social Services.<br><br>During an interview on 08/29/2025 at 11:18 AM, the ombudsman they stated they had not been receiving notices of discharge consistently; they had not received any notice of discharge from the facility since 7/9/25 and had no notices for Resident #61, #63, or #66.<br><br>NYCRR 415.3 |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observation, record review and interviews conducted during the recertification and extended survey from 8/21/2025 through 9/2/2025, the facility did not ensure residents were adequately equipped to call for assistance through a communication system that relays the call directly to a staff member or to a centralized staff work area. Specifically, 1) the light above the residents' doors on the second floor were not functioning in five (5) of the 26 rooms (Rooms #202 A, 202B, 205B, 207B, 212B, and 217B). The call lights lit up above the residents' rooms but had no audible sound. Additionally, tap bells were not provided or readily available for three bathrooms (Rooms #202, 207, and 212). 2) The centralized call monitor console at the second-floor nurse station produced an audible sound when room call lights were activated, but it did not accurately display the corresponding room numbers. 3) The facility could not provide the documentation related to staff rounds when the call light system was malfunctioning.The findings include:The facility's policy on the resident call system, revised on 04/2025, states that the call system must be properly equipped to enable residents to request staff assistance. This communication system should relay calls directly to a staff member or to a centralized staff work area from each resident's bedside, toilet, and bathing facilities. Staff members are required to check all call lights daily and report any that are not functional to the charge nurse. Additionally, staff must conduct rounds every two hours.During an observation and interview on 08/21/2025 at 11:12 AM, Certified Nurse Aide #23 stated sometimes the call bells lit up but did not ring in all the residents' rooms. They stated that someone from outside came to repair the call bells, and they thought there might be a problem with the wiring.During an observation on 08/21/2025 at 11:40 AM, surveyors conducted tests on the call bell system located on the second floor, specifically in rooms 201P to 226P. During the observation, several resident rooms had visible lights above their doors indicating an active call. However, the console at the nursing station did not accurately display which resident's room had activated the call signal, nor did it produce any sound.During a Resident Council Group meeting held on 08/22/2025 at 10:30 AM, residents stated the call bells did not consistently work and were not answered in a timely manner. Additionally, residents stated they sometimes received tap bells but were not given instructions on how to use them. They stated the call bells had not been functioning properly for at least eight months.During an interview on 08/22/2025 at 3:19 PM, Licensed Practical Nurse Manager #21 stated sometimes the console lit up, but the room lights did not. They stated the call bells had been malfunctioning and needed to be replaced. They stated the staff conducted frequent rounds and was always present around the unit.During an interview on 08/25/2025 at 7:33 AM, Registered Nurse Night Supervisor #22 stated some call bells were not functioning properly. Residents had stated they pressed the call bells, and no one responded to them in a timely manner. Registered Nurse Supervisor #22 stated they observed the centralized call monitor console did not accurately light up to indicate the resident's room. They stated the night shift staff typically conducted rounds every two hours, which was standard practice. Registered Nurse Night Supervisor #22 stated all staff received annual in-service training, which included information about the call bells not functioning properly, but it was not specifically focused on the call bell issues. They were unaware of the actions taken for residents whose call bells were not operational, and they were not aware exactly which call bells malfunctioned. Registered Nurse Night Supervisor #22 stated they observed tap bells in use but was unsure why they were provided and did not inquire further. Additionally, they did not know if the situation had been communicated to the residents' families, nor were they certain whether families should be notified when the call bell system was not working properly.During an interview on 08/27/2025 at 12:07 PM, the Maintenance Director stated they were made aware of the malfunctioning call bell system in several rooms. They stated the first report of the issue occurred in June 2025. They stated they consulted a vendor to install a new call bell system, and they received a proposal for this in July 2025 and the proposal had not been signed. The Maintenance Director stated they spoke with the Chief Executive Officer, who<br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was responsible for signing the proposal for the new call bell system. The Maintenance Director stated they were responsible for call bell system functioning. They stated in the meantime; staff members were making rounds and tap bells were distributed to residents whose call bells were not working.During an interview on 8/27/2025, at 12:52 PM, the Director of Nursing stated that since starting at the facility in March 2025, the call bell system had not functioned properly. They stated that the system did not work in certain rooms and the Maintenance Department was working on the issue. The Director of Nursing explained the protocol regarding a no pass zone, which required staff to respond immediately when a call light was activated. They stated staff had education on the call bell system beginning in May 2025, and temporary tap bells were placed in residents' rooms where the call bells were broken. The Director of Nursing stated they instructed the Charge Nurse for the second floor to relocate residents to a room where the call bell was functioning. However, feedback indicated that the residents did not want to move. The Director of Nursing stated there was no documentation to confirm that rounds had been conducted, but they expected the staff to maintain professionalism in caring for the residents. Additionally, they stated that the social worker was in communication with the families regarding the issues with the call bell system. The Director of Nursing stated that they were in the process of creating a flow sheet to monitor hourly rounds by the staff and will ensure follow-up on this matter.During an interview on 09/02/2025, at 10:58 AM, the Chief Executive Officers stated that the call bell system would be replaced. They were currently seeking a second quote. They stated that tap bells were in use and the nursing staff was actively rounding. They stated they became aware of the call bell malfunctions in July 2025 but were unaware about any issues that began in February 2025. They stated they had met with the Director of Nursing, the Administrator, and Maintenance Department regarding the plan to address the call bell system.10 NYCRR 415.29 |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on record review and interview during the recertification survey the facility did not ensure residents and/or their designated representative were fully informed of their right to an expedited review of a service termination for one (1) of three (3) residents (Resident #71) reviewed for Beneficiary Protection Notification. Specifically, Resident #71 who received Medicare Part A services did not receive two (2) day notification of the termination of services with the Notice to Medicare Provider Non-coverage (NOMNC), form CMS-10123. The findings are:Resident #71 was admitted to facility with diagnoses including Anemia, Arthritis and Cataracts.The 02/26/2025 admission Minimum Data Set (an assessment tool) documented Resident #71 was cognitively intact and received 60 minutes of physical therapy and 40 minutes of occupational therapy.There was no documented evidence of a signed Notice of Non-Coverage for Medicare that was issued 2 days prior to the last Medicare covered day of 04/23/2025. The 08/27/2025 late entry Therapy Note documented on 04/21/2025 Resident #71 was provided a Notice of Non-Coverage the resident refused to sign it and would speak to their designated representative.During an interview on 08/29/2025 at 12:02 PM, Occupational Therapy Assistant #25 stated they called Resident #71's designated representative to find out if they signed the Notice of Non-Coverage since they gave it to the resident but were not sure if it was signed. They further stated they called the former therapist and were told Resident #71 was cut from therapy. Occupational Therapy Assistant #25 stated when there was a planned discharge the therapy department was supposed to get the Notice of Non-Coverage for Medicare signed by the resident and/or designated representative and the nursing department was responsible for insurance cuts from therapy. Occupational Therapy Assistant #25 stated Resident #71 did not want to appeal and was discharged home. They further stated they needed a better system for getting the Notice of Non-Coverage for Medicare signed and there should have only been one department involved in the process. 10 NYCRR 415.3 (g) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the recertification and extended survey from 08/21/2025 through 09/02/2025, the facility did not ensure that residents who had pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote wound healing for one (1) of three (3) residents (Resident #1) reviewed for pressure ulcers. Specifically, Resident #1 was readmitted to the facility on [DATE] with a hospital acquired sacral pressure ulcer and there was no documented evidence of treatment or assessment from 08/01/2025 to 08/13/2025. Findings include:The facility policy and procedure titled Prevention and Treatment of Pressure Ulcers, revised 01/04/2024, documented it is the policy of the facility to prevent, care for, and provide treatment of pressure ulcer. The policy included to document weekly the status of the ulcer in the nursing notes. Resident #1 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus, depression, and unstageable sacral pressure ulcer. The admission Minimum Data Set (an assessment tool) dated 07/31/2025 documented the resident had intact cognition and required assistance from staff to complete their activities of daily living and had one Stage 3 pressure ulcer and one unstageable pressure ulcer present on admission. A wound consult dated 7/30/2025, from the hospital, documented the resident was seen for an unstageable sacral pressure injury. The recommendation was to cleanse the sacrum with normal saline, pat dry. Apply a nickel thick layer of Santyl (Collagenase) to wound bed daily and cover with a silicone bordered foam dressing daily and as needed if soiled/dislodged. The 07/30/2025 at 9:25 PM, nursing admission summary documented Resident #1 arrived from hospital at 5:00 PM via ambulette. The resident presented with a Stage 4 sacral pressure ulcer from the hospital which was not present at the facility prior to hospitalization. Orders were sent from the hospital to treat the pressure ulcer. These orders were followed, and the treatment was completed immediately after assessment. The 07/30/2025 at 9:34 PM, nursing skin check notes documented a new skin issue on the sacrum, identified a Stage 4 pressure ulcer present upon admission with full thickness skin and tissue loss. The duration of the wound was unknown and had signs and symptoms of infection, including a red and bleeding with granulation tissue and painful. Measurements as followed: length 8.0 centimeters, width 7.0 centimeters, and depth 0.1 centimeters. A nursing progress note dated 07/31/2025 at 2:14 PM, documented the resident had an unstageable sacral pressure ulcer that was cleansed with normal saline, Santyl and a protective dressing were applied. A physician's progress note/ physiatry consult note dated 8/1/2025 at 4:15 PM, documented Resident #1 had returned from the hospital and had a sacral Stage 4 ulcer and would be followed by wound care. Review of nursing and physician progress notes from 08/01/2025 to 08/13/2025, revealed no documented evidence the resident's sacral pressure ulcer was assessed. The 08/13/2025 wound care rounds summary documented Resident #1 had a sacral Stage 3 pressure ulcer that measured 9.0 centimeters x 10 centimeters x 0.2 centimeters (length x width x depth). The wound bed was 90 percent slough (moist dead tissue), 10 percent granulation (healing tissue), and moderate amount of serosanguineous (blood-tinged fluid) drainage. The recommended treatment was to cleanse with normal saline, apply Santyl and cover with dry protective dressing every day. The 08/14/2025 Physician's order documented to cleanse sacrum with normal saline and apply Santyl and cover with dry protective dressing daily. The August 2025 Treatment Administration Record documented Collagenase Ointment (Santyl) 250 unit/gram, apply to sacrum topically in the morning for pressure ulcer. Cleanse with normal saline, apply Santyl and cover with dry protective dressing daily. The start date was 08/15/2025, there was no documented treatment for the sacral ulcer prior to 8/15/2025. The 08/21/2025 wound care rounds documented sacral Stage 3 pressure ulcer measured in length 10.5 centimeters, width 11 centimeters, and depth 0.2 centimeters. Had 90 percent slough, 10 percent granulation, and moderate amount of serosanguineous drainage. Wound treatment cleanse with normal saline, apply Santyl and cover with<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dry protective dressing every day and as needed. During an observation and interview on 8/22/2025 at 8:38AM, the resident was lying on their back, in bed with an air mattress in place. Resident #1 stated they came from the hospital two weeks ago and had a wound on their back that had been problematic. During an interview on 8/27/2025 at 8:20 AM, the Director of Nursing stated the resident developed a severe pressure ulcer on their sacrum during the recent hospital stay. They stated the wound rounds were done weekly on Wednesdays by a wound care provider. They stated the wound rounds were not done on 8/6/2025 as the wound care provider was unavailable that day. During an observation and interview on 8/27/2025 at 11:32 AM, the Wound Nurse Practitioner stated wound rounds were conducted for all residents with wounds every Wednesday, unless unavailable. They stated the Resident #1 had a Stage 3 pressure ulcer to the sacrum. During the observation the old dressings was removed with large amount of sanguineous drainage the wound was cleansed with normal saline, the wound measured 11.0 length x 8.5 width and 2.5 depth, the wound bed had 60 % brown/black tissue, and 40% granulation tissue with no odor present. During a follow-up interview on 8/27/2025 at 12:43 PM, the Wound Nurse Practitioner stated they sent the wound care notes to the registered nurses, Director of Nursing, and the physicians through email. They stated in their absence the facility was made aware and had the option of conducting the wound rounds themselves or requesting for another wound care provider to do the wound rounds. In addition, they stated any of the registered nurses could measure the wounds in their absence as the facility was responsible for weekly wound measurements. During an interview on 8/28/2025 at 3:42 PM, Licensed Practical Nurse Unit Manager #21 stated the Wound Nurse Practitioner was not available on 8/6/2025 and the wound measurements were typically done by registered nurses and would be in the progress notes. When requested, they stated they could not find information regarding weekly wound measurements for 8/6/2025 in the resident's electronic medical record. During a follow-up interview on 8/29/2025 at 4:22 PM, the Director of Nursing stated when residents were admitted with a pressure ulcer, the nursing staff would contact the physician to obtain treatment orders for the wounds. A wound consult would be ordered, and the resident would be discussed in the morning meeting with all the clinical disciplines present. 10 NYCRR 415.12(c)(2) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a recertification and extended survey from [DATE] to [DATE], the facility did not ensure that pharmaceutical services including procedures that assure the accurate acquiring of medications, met the needs of each resident for (1) one of three (3) residents (Resident #47) reviewed during the medication administration task; and the facility did not ensure a system of disposition and reconciliation for all controlled drugs. Specifically, 1) Resident #47's oral hypoglycemic medication was not available for administration as ordered; and 2) Resident #68 was discharged [DATE] and two boxes of Lorazepam concentration, prescribed for the resident, were not counted by two licensed staff members. Findings include:<br><br>The Policy & Procedure dated [DATE], titled Ordering and Receiving Drugs, Discontinued Drugs and Label Changes documented to reorder medications, peel off the duplicate label on the container and affix it to the order form.<br><br>1) Resident # 47 had diagnoses including diabetes, post cerebral infarction, and hemiplegia.<br><br>The Quarterly Minimum Date Set (an assessment tool) dated [DATE], documented the resident had intact cognition, and required partial to moderate assistance for activities of daily living.<br><br>The physician order dated [DATE] documented to administer Metformin1000 milligrams two times a day at 9:00 AM and 6:00 PM.<br><br>During a medication administration observation on [DATE] at 9:44 AM, Licensed Practical Nurse #1 took Resident #47's medications from the blister packs and placed them in the medication cup. They stated Resident #47 Metformin was unavailable in the medication cart and that they would have to request it from pharmacy.<br><br>The nurse progress note dated [DATE] at 2:42 PM documented the facility was waiting for pharmacy to deliver Metformin.<br><br>During an interview on [DATE] at 12:41 PM, the Director of Nursing stated that nurses were responsible for stocking medication cart. Prescribed medications were delivered by the pharmacy every night and as needed. When delivered, a Registered Nurse would verify the contents of the delivery then the Registered Nurse would restock medication carts. If there was a medication missing/unavailable, the pharmacy would be notified by the nurse. They stated that they were unsure of how long it took for medication to be delivered. Additionally, they stated Metformin was not available in the back-up box.<br><br>During an interview on [DATE] at 2:37 PM, Licensed Practical Nurse #1 stated that medication was still not available.<br><br>During an interview with the pharmacy on [DATE] at 2:24 PM, the pharmacy representative stated the facility could reorder medication from the pharmacy in the electronic medical record, call it in or fax it over. The facility should have re-ordered the medication 4-5 days before they ran out. The blister pack had a change in color to cue the nurse to reorder. When they order the medication, it will come the next afternoon. The pharmacy could send a medication over STAT (immediately) and they (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | had an agreement to deliver within 2 hours if a medication was needed.<br><br>During an interview on [DATE] at 2:59 PM interview with Physician #2, (covering for the Medical Director), they stated they did not remember being called about the omission of Metformin for Resident #47. They stated if they were called, they would have advised to give the next dose as ordered and monitor the blood glucose.<br><br>2)The Nursing Medication Storage policy and procedure, dated [DATE], documented that expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of according to facility policy.<br><br>The Nursing Access to Narcotic Storage and Locked Drug Areas policy and procedure, dated [DATE], documented that at the beginning and end of each shift all narcotics and controlled substances will be accounted for by having two nurses count narcotics and sign the appropriate accountability records.<br><br>Resident # 68 was admitted on [DATE] with a diagnosis of subdural hemorrhage, altered mental status and acute post procedural respiratory failure.<br><br>The Minimum Data Set (an assessment tool) dated [DATE] documented a discharge date of [DATE] due to death in facility.<br><br>A physician order dated [DATE] documented Lorazepam Intensol Oral Concentrate two milligrams/milliliter; give one milliliter by mouth every eight hours for agitation.<br><br>During an observation of the upper-level west medication room on [DATE] at 2:53 PM with Nursing Supervisor #7, two boxes of Lorazepam oral concentration were found in the lock box in the refrigerator. One of the boxes was sealed and unopened, the other box was open, with an open date of [DATE]. The box was labeled for Resident #68.<br><br>During an interview on [DATE] at 2:57 PM, Nursing Supervisor #7 stated the Lorazepam was for a resident who passed away and a count sheet for that medication could not be located.<br><br>During an interview on [DATE] at 12:51 PM, the pharmacy consultant stated they found the Lorazepam in the refrigerator on their last inspection and the Director of Nursing was notified. They stated that if the nurses had access to the Lorazepam, it should have been counted. They stated that if the Lorazepam was scheduled to be destroyed, it should have been pulled from the refrigerator.<br><br>During an interview on [DATE] at 3:45 PM the Director of Nursing stated they were aware that if nurses had access to narcotics, it should be counted every shift. They stated they did not know why the medication remained in the refrigerator and stated they asked for all narcotics when they started in [DATE]. They additionally stated they tried to complete narcotic destruction every quarter and the next destruction was scheduled for [DATE]. They stated the narcotics to be destroyed were kept in a lock box in their office.<br><br>10NYCRR 415.18(a) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on record review and staff interviews during the Recertification and Extended surveys from 08/21/2025-09/02/2025, the facility did not ensure residents were free of significant medication errors for (1) one of (5) five residents (Resident # 3) reviewed for Unnecessary Medications. Specifically, Resident #3 had blood pressure parameters for Metoprolol (decreases blood pressure and heart rate) and Midodrine (increases blood pressure), and on 25 occasions the medications were given outside of the blood pressure parameters specified in the physician orders. Findings include:The undated Medication Error policy documented a nurse manager is responsible for completing a medication incident report and forwarding to Director of Nursing. Director of Nursing completes a monthly summation of medication errors /omissions, and the information is reported to the Pharmacy, and Nursing Quality Assurance Council for facility QAPI Committee review. Resident #3 was admitted to the facility with diagnoses including Hypertension, Hypotension, and End Stage Renal Disease. The 11/9/2024 physician's order documented to administer Metoprolol (lowers blood pressure) 100 milligrams one time a day for hypertension, and to hold for blood pressure below 110.The 11/9/2024 physician's order documented to administer Midodrine 5 milligrams, give 3 tablets by mouth 3 times a day for hypotension on dialysis days, and to hold for blood pressure greater than 130. Order renewed 4/30/25.The March 2025 Medication Administration Record (MAR) documented 3 medication errors; Midodrine was given on 3/13/25 and the blood pressure was 149/67. Metoprolol was given on 3/18/25 the blood pressure was 104/70, and on 3/27/25 when the blood pressure was 109/60.The April 2025 Medication Administration Record (MAR) documented 4 medication errors; Midodrine was given on 4/11/25 when the blood pressure was 132/72, and on 4/13/25 the blood pressure was 149/76. Metoprolol was given on 4/18/25 when the blood pressure was 104/70, and on 4/19/25 when the blood pressure was 105/68.The 4/24/25 Pharmacy Consultation documented on 4/14/25 midodrine was administered despite blood pressure being over 130. On 4/15/25, 4/18/25 and 4/19/25 Metoprolol was given despite blood pressure being lower than 110. It further documented to inquire, address and initiate a medication error report per the facility policy. The May 2025 Medication Administration Record MAR documented 5 medication errors; Metoprolol was given on 5/2/25 the blood pressure was 101/62, on 5/11/25 when the blood pressure was 103/64, on 5/16/25 when the blood pressure was 102/59, on 5/20/25 the blood pressure was 107/71, and on 5/24/25 when the blood pressure was 107/65.The 5/19/25 Pharmacy Consultation documented resident has order for metoprolol with a hold parameter of blood pressure less than 110. It further documented that doses were given when blood pressure was below the parameter on 5/2/25 and 5/16/25. The 5/27/25 Medication Error Inservice was given by the Pharmacy Consultant to one registered nurse and four licensed practical nurses to provide education for medications administered outside the physician ordered parameters for the medication. The June 2025 Medication Administration Record MAR documented 5 medication errors when Metoprolol was given on 6/5/25, 6/21/25, and on 6/27/25 when the blood pressure was less than 110. Midodrine was given on 6/7/25 and 6/23/25 when the blood pressure was greater than 130 The 6/22/25 Pharmacy Consultation documented to please note resident has order for metoprolol with a hold parameter of blood pressure less than 110. It further documented that doses were given when blood pressure was below the parameter on 6/5/25 and 6/21/25.The July 2025 Medication Administration Record MAR documented 4 errors, Metoprolol was given on 7/2/25 and 7/27/25 when the blood pressure was less than 110. Midodrine was given on 7/7/25 and 7/14/25 when the blood pressure was greater than 130.The August 2025 Medication Administration Record MAR documented 3 medication errors; Midodrine was given on 8/4/25 the blood pressure was 133/67, Midodrine was given on 8/13/25 the blood pressure was 132/74, Metoprolol was given on 8/14/25 the blood pressure was 109/65. The 8/18/25 Pharmacy Consultation documented metoprolol given outside parameters on 8/14/25. Midodrine was given outside parameters 8/4/25 and 8/9/25. There was no documented evidence of medication error<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reports for the 24 times the blood pressure medications were administered outside the blood pressure parameters for each medication.There was no documented evidence of disciplinary actions for the medication errors for Resident # 3.During an interview on 08/26/2025 at 11:34 AM, the Pharmacy Consultant stated it was a work in progress, the staff were new and they felt there had been progress. The Pharmacy Consultant stated they had been involved in a medication pass audits to assist and provide education to the nursing staff. During an interview on 08/26/2025 at 12:28 PM, The Pharmacist and the Pharmacy Consultant stated they checked for medication errors when they did their reviews and informed the Assistant Director of Nursing. They stated the Assistant Director of Nursing would check for medication errors and would identify the nurses involved and would send documentation the nurses were educated. They further stated the Assistant Director of Nursing provided an in-service on medication parameters. They stated the administration error report was sent to Assistant Director of Nursing and provided an overview and education a few weeks ago. They stated they came to the facility and did a medication pass assist and provided education to the nursing staff about parameters errors. They stated they did attend the QAPI meetings and had informed facility of medication errors. During an interview on 8/26/25 at 12:38 PM, the Assistant Director of Nursing stated they did not use the Medication Incident Report form and instead would just document the medication error on the disciplinary action form and was unable to provide copies of any reports or disciplinary actions for Resident #3 medication errors. During an interview on 08/26/2025 at 2:45 PM, Physician #3 stated they signed off on the pharmacy recommendations but was unable to give specific dates. Physician #3 stated Resident #3 had end stage renal disease and had issues with blood pressure. They further stated they were not made aware of the 25 medication errors. Physician #3 stated the resident had been hospitalized for hypotension in the past while receiving dialysis and had to be transferred to the hospital. The resident had been hospitalized many times for hypotension in the past. In order to control heart rate, the resident needed a medication that limits the heart rate. Physician #3 stated while the resident was taking the medication and going to dialysis the resident would become hypotensive. Physician #3 stated they had to add the Midodrine to bring the blood pressure up. Physician #3 stated if the blood pressure medications were given outside of the blood pressure parameters for the Midodrine and Metoprolol, the harm caused would be either the resident could become hypertensive or hypotensive. During an interview on 08/29/2025 at 10:38 AM, Licensed Practical Nurse #17 stated the medication sometimes both blood pressure medications for Resident #3 contradicted each other. Licensed Practical Nurse #17 stated they use their judgement at times and sometimes the systolic blood pressure was off, and the heart rate was too high. Licensed Practical Nurse #17 stated they had tried to call Physician #3 so many times to talk about the patient and they were unable to reach them. Licensed Practical Nurse #17 stated they tried to use their best judgement. Licensed Practical Nurse #17 stated they had been disciplined by the Assistant Director of Nursing on administering medications outside the parameters and was educated about it in May 2025. During an interview on 08/29/2025 at 10:48 AM, the Director of Nursing stated they were not aware the nurse was attempting to call Physician #3 about concerns with the blood pressure medications given to Resident #3. The Director of Nursing stated the resident went to dialysis and when they returned the blood pressure was low and the nurses were not reading the parameters properly. The Director of Nursing stated when there was a medication error, the process was the Assistant Director of Nursing would collect the list of medication errors, call the physician, and inform the Director of Nursing. The Assistant Director of Nursing was supposed to audit the medical record and do a Medication Incident Report form. The Director of Nursing stated they did have the Medication Incident Report Form, and they should have been using it. They did not know why the Assistant Director of Nursing was not using the form. The Director of Nursing stated they spoke to Physician #3 about Resident #3 medications and Physician #3 stated they could not change any of the blood pressure medication. 415.12(m)(2) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observations, record review and interviews conducted during the recertification and extended survey from 08/21/2025 to 09/02/2025, the facility did not ensure the labeling of medications in accordance with currently accepted principles and the facility did not ensure all drugs and biologicals were stored in a locked compartment. Specifically, 1) an open Insulin pen was found in a medication cart without an open date. The manufacturer recommendation is to date the insulin pen when opened. After opening the medication is considered viable for 28 days. 2) a medication cart was observed unattended and un-locked. Findings include:The Nursing/medication storage policy dated 01/24/ 2025, documented all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel.The Nursing/medication administration policy dated 10/2024, documented that it is the responsibility of the licensed professional nurse to be aware of the drugs classification, action, correct dosage, side effects, and any specific manufacturer recommendations.1) Resident #5 was admitted with a diagnosis of type two diabetes mellitus, metabolic encephalopathy and brief psychotic disorder. The Quarterly Minimum Data Set (an assessment tool) dated 08/04/2025, documented the resident received insulin injections daily.Physician order dated 07/21/2025, documented Lantus Solo-Star Subcutaneous Pen-Injector 100U/milliliter. Administer 26 units every day at bedtime.During an observation on 08/21/2025 at 4:00 PM of the upper-level east medication cart with Nursing Supervisor #7, an insulin pen for Resident #5 was found with no open date.During an interview on 08/21/2025 4:05 PM, Nursing Supervisor #7 stated that insulin was viable for 60 or 30 days after opening. They stated that someone clearly opened the insulin pen and did not date it.During an interview on 8/26/25 at 3:45 PM, the Director of Nursing stated they did not know why an insulin pen would be in the medication cart without an opening date. They additionally stated that it was the responsibility of the pharmacy consultant as well as nursing leadership to educate the staff on proper labeling and insulin storage. 2) During an observation on 8/22/2025 at 3:30 PM, the medication cart on the upper-level east unit was unsupervised and unlocked in the hallway.During an interview on 8/22/2025 at 3:35 PM, Nursing Supervisor #7 stated that the day nurse must not have locked the cart when they left for the day. They stated that they had the keys and would lock the cart.During an interview on 8/22/2025 at 3:40PM, the Director of Nursing stated the medication carts should be locked when left unsupervised. 10 NYCRR 415.18(d) (e) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review during a recertification survey the facility did not ensure they maintained an infection prevention and control program designed to provide a sanitary environment and to help prevent development and transmission of infection for two (2) of seven (7) residents reviewed for infection control. Specifically, (1) Certified Nurse Aide #26 was observed touching dresser drawers in Resident #65's room who was on contact precautions. Additionally, there was no contact precaution sign posted outside Resident #65's room and no personal protective equipment bin outside the room/garbage bin for discarding personal protective equipment by or inside the room (2) Certified Nurse Aide # 8 and Certified Nurse Aide # 4 did not wear a gown when providing incontinence care for Resident #23 who was on enhanced barrier precautions and (3) the facility did not ensure a complete infection surveillance plan was implemented for the identification, containment, and prevention of infection.The findings are:<br><br>The undated policy and procedure titled “Infection Control” documented hand hygiene as well as other forms of personal protective equipment are to be utilized when caring for all residents. When providing High-Contact Care to residents on enhanced barrier precautions, staff will use a gown and gloves. It further defined “High-Contact Care” as dressing, bathing/ showering, providing hygiene, changing briefs, or assisting with toileting.<br><br>The policy titled “Infection Control Program” revised November 2024 documented maintain records of incidents and corrective actions related to infections.<br><br>The policy titled “Infection Control Policy” documented the Director of Nursing will maintain updated precautions list and communicate when there are changes.<br><br>(1) Resident #65 was admitted with diagnoses including Gram Negative Sepsis, Parkinsons Disease with Dyskinesia, and Extended Spectrum Beta Lactamase.<br><br>The 8/14/2025 physician order documented contact precaution for Extended Spectrum Beta Lactamase in urine or blood<br><br>During observation and interview on 08/21/2025 at 10:31 AM, Resident #65 was in their room. There was no personal protective equipment bin outside the room/garbage bin for discarding personal protective equipment by or inside the room and no contact precaution sign on the door.<br><br>During observation and interview on 8/22/25 at 11:30AM Certified Nurse Aide #26 was inside Resident #65's room wearing a mask. Certified Nurse Aide #26 without the use of gloves/gown opened the residents' dresser drawer and closed them. Certified Nurse Aide #26 stated when they provided care for a resident on contact precaution they needed to put on a gown, gloves, and mask. They further stated they were not providing cares therefore they did not need to wear a gown or use gloves.<br><br>During an interview on 08/29/2025 at 11:06 AM, Registered Nurse #3 stated it was their responsibility to place personal protection equipment carts/red bins to dispose of the personal protective equipment and educate staff, residents and visitors about precautions. Registered Nurse #3 stated they did not know why Resident #65 had no personal protective equipment cart or red bin to dispose of items. Registered Nurse #3 further stated Resident #65 was on contact precaution, and needed an isolation cart with a mask, gloves, and gown inside it.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (2) During an observation on 08/21/2025 at 1:20 PM, Certified Nursing Aide #8 and Certified Nursing Aide #4 wore gloves and masks and did not wear gowns when they provided incontinence care for Resident #23 on enhanced barrier precautions.<br><br>During an interview at 08/21/2025 at 1:30 PM Certified Nursing Aide #8 stated a gown was required when they entered the room to provide care for a resident on enhanced barrier precautions.<br><br>During an interview 08/21/2025 at 2:19 PM, the Director of Nursing/Infection Preventionist stated infection tracking sheet/s were utilized as infection surveillance. They stated they were not able to provide complete documentation of infection surveillance to include onset of symptoms, antibiotic start date/s, and which isolation precautions were ordered.<br><br>During a phone interview on 08/22/2025 at 3:18 PM, the covering Medical Director stated before starting antibiotics for Urinary Tract Infection, residents would be assessed for signs/symptoms of infection, urine would be collected for culture and antibiotics would be prescribed if needed.<br><br>10 NYCRR 415.19 |