STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335323	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Eleanor Nursing Care Center	419 North Quaker Lane Hyde Park, NY 12538

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observation, and interview conducted during the recertification survey from 9/5//2024 to 9/17/24, the facility did not ensure residents' right to a safe, clean, comfortable and homelike environment for 2 of 3 units. Specifically, during environmental observations on Unit 2, room [ROOM NUMBER] D had missing/broken floor molding, room [ROOM NUMBER] had a rusted/ scratched heater, and the walls had damaged sheet rock/ large gouges. The Unit 3 heater (outside the elevator) was rusty and holes were noted in the wall. The Unit 3 floor tiles near the elevator were dirty and dusty with particles. There was a strong odor of urine noted on the Unit 3 hallway on 9/11/24 and Resident #3, #27, #13 had dusty wheelchairs with ripped arm rests and caked on food. Additionally, One of two passenger elevators on the first floor was out of service and not accessible to residents and staff. The findings are: During observation on 9/05/24 at approximately 9:20 AM and through out the duration of the onsite survey, there was only 1 functional elevator in the building. During an observation on 9/5/2024 at 11:40 PM the 3rd Floor hall heating unit (outside the elevator) was rusty and holes were noted in the walls. The floor tiles near the elevator was dirty and dusty with particles. The wheelchairs for Resident #3, #27, and #13 were dusty, and had ripped arm rests and caked on food. The 3rd Floor (outside the elevator) hall heating unit was rusty and holes were noted in the walls. The floor tiles near the elevator was dirty and discolored. During observation on 9/11/2024 at 8:00 AM, the 3rd floor hallway was noted with a strong smell of urine. During an observation on 9/11/24 at 12:00 PM, the heater in room [ROOM NUMBER] (Private Room) was rusted and scratched. The walls had damaged sheet rock with large gouges. During an observation on 09/11/24 at 1:34 PM, the floor molding in room [ROOM NUMBER] D was broken and missing. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An email dated 9/12/24 at 1:57 PM from the Regional Director of Maintenance to the Director of Maintenance was reviewed at the facility on 9/12/24 at 2:00 PM. The email documented the elevator was part of a project which began in the summer of 2022 and would take roughly 24-30 months to complete. At that time Elevator #1 was completed, and work began on Elevator #2. Work was put on a brief hold while renovations were started in the lobby. Work will resume on Elevator #2 once the lobby renovation is completed. During an interview 9/16/24 at 1:49 PM, the Maintenance Director stated, for any maintenance issues, the staff were supposed to note the issue in the maintenance book, which they checked 3 times a day. The Maintenance Director stated they had to prioritize what could be fixed on the units., and they were presently working with contractors on a plan to re-do the units. The Maintenance Director stated the wheel chairs were supposed to be cleaned at night by the nursing staff. They stated there was a machine to clean the wheelchairs, and the machine was inspected by maintenance(daily/monthly/weekly) Despite repeated requests throughout the survey, the facility did not provide a wheelchair cleaning schedule. During an interview on 9/17/2024 at 02:00PM, the Administrator stated the facility was undergoing a renovation. When the 1st floor renovation was complete, the 2nd floor renovation would start. The Administrator stated staff should be updating the maintenance book when needed repairs were noted. 10 NYCRR 415.29 .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review and staff interviews conducted during the recertification and abbreviated surveys (NY00324750) from 9/5/24-9/17/24, the facility did not protect 5 of 6 residents reviewed for abuse from resident-to-resident abuse/mistreatment. Specifically, the facility did not implement interventions for Resident #84 after escalating behaviors were documented starting on 9/16/23 and Resident#84 punched a Staff in the face and punched Resident #73 in the face on 9/22/23. Resident #84 was sent to the hospital for evaluation. Upon return, there were no new interventions to address Resident #84's unprovoked combative behaviors and on 10/7/23 Resident#84 became combative and hit Resident #70 while being transported in a wheelchair from a shower (no injury), hit Resident #49 on the head while they were sleeping, jumped on Resident #65's bed and scratched them on the chest ripping shirt, jumped on Resident #103's bed and repeatedly punched them in the face and arms opening an abscess on Resident # 103's arm. Residents #103 and #84 were sent to the hospital. The findings are: The facility policy for Abuse Mistreatment and neglect dated 2004 documented the purpose is to ensure residents have a safe and secure environment free from abuse, mistreatment, and neglect. Resident #84 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, rectal prolapse and bipolar disorder. The MDS (Minimum Data Set, a resident assessment and screening tool) dated 9/11/23 documented that Resident #84 was moderately cognitively impaired, had physical and verbal behaviors, rejection of care 1 to 3 days (of 7 days) and no wandering behaviors. The resident was independent with eating ad incontinent of bladder and bowel. The care plan titled Restraint Use: Physical Aggression dated 8/16/23 documented the resident was at risk for injury as evidenced by physical aggression manifested by behaviors such as hitting others. Interventions included to maintain daily routine, redirect resident as needed, and provide activities to keep the resident busy. The care plan dated 9/12/23 titled Mood: documented the resident had diagnosis of schizoaffective disorder depressed type as well as dementia. The goal was the resident would maintain a stable mood. Interventions included providing emotional support and recreational programming as a means of coping with their psychiatric symptoms. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for Behavior problem: disruptive/inappropriate/refusals dated 9/13/23 documented the resident presented with a behavior that was or potentially may be disruptive to others, dangerous to self, verbally abusive, socially inappropriate and resisting care. Interventions included medical and psychiatric management as per physician order, psychiatric evaluation and follow up, psychological services, administer psychoactive medications as per physician order, monitor for S/S of adverse reaction to psychoactive medications and report to physician provide emotional support, provide assistance with ADL, provide nutrition and hydration, provide recreational activities, provide rest periods, place in dayroom for supervision, remove resident from public areas when behavior or language is unacceptable, involve family in plan of care. A nurse note dated 08/15/23 documented at approximately 6:45 AM the resident was found in room [ROOM NUMBER] by the window on side of another resident bed when nurse entered. The resident unable to explain what happened when asked they began talking about their daughter, staff assisted the resident back to their room safely. A nurse care plan note dated 9/13/23 documented the resident, at times refused medications and cares. The resident would place self on floor and refuse to get up and sometimes would allow you to help up and then return self-back to floor. The resident would also paint herself and bed with her feces. Redirection and education were provided, and the resident was observed ambulating. A nurse care plan note dated 9/16/23 documented resident was seen being the aggressor in a peer vs peer argument. Redirected and psych evaluation placed. A nurse note on 9/16/2023 at 3:11 PM documented resident refused oxycodone, slapped this staff and grabbed their breast and scratched their arm. The resident yelled vulgar statements to the staff. A nurse note dated 9/16/23 10:49 PM documented resident was noted walking around on the unit, entering other resident's room, not easily redirected. Around 9:30 PM, she went to the day room, throwing things on the floor, hitting staff that was trying to redirect, after a while, they saw another resident in the dayroom, grabbed and hit the other resident in the head, and pushed both of them to the floor. The resident continued to curse at staff, using vulgar language and they (Resident #84) were afraid they were going to kill themselves. The nurse practitioner was made aware and ordered to send resident to the hospital for evaluation. Resident left on a stretcher with 2 attendants and a policeman. A nurse note dated 9/17/2023 at 3:22 PM documented the resident was yelling, screaming, and cursing. She sat herself on the floor and would not allow staff to put her back to bed. Many attempts were made, and the resident continued to hit staff. There was no evidence in the resident record of interventions to address the resident aggressive behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Accident/Incident note dated 9/22/23 documented at 12:00 PM the resident became agitated while the Certified Nurse Aide was performing morning care and while the Aide was standing in the doorway of the resident's room, Resident #84 came over and punched the Certified Nurse Aide in the face. Shortly after that staff went back to the room to check on the resident's roommate, Resident #73, who then reported the Resident #84 punched them in the face causing a cut to the lower lip and blue swelling above left eyebrow. The Resident #84 continued to scratch and claw at another Licensed Practical Nurse who was trying to calm the resident. The Resident was sent to the hospital. Interventions to prevent reoccurrence include separate residents for at least 72 hours, Resident #84 will be moved to another floor in a private room. There was no evidence in the resident record of interventions to address the resident aggressive behaviors to prevent recurrence. A nurse note documented Resident#84 returned to the facility on [DATE] at 11:51 AM. A nurse note on 9/30/23 at 5:47 AM documented the resident throughout shift undressed and attempted to wander the halls. A nurse note dated 10/1/23 at 5:51 AM documented the resident forcefully slapped them in the face while attempting to redirect the resident back to their room. Resident came from room twice during 11-7 shift fully undressed and walked down to nurse's station yelling out that they wanted their dinner. The resident was redirected back to their room. A nurse note dated 10/3/23 at 1:17 PM documented the resident was observed taking her metal spoon and hit herself in the head with it, stated to nursing staff, I'll just hit myself with this spoon or fork, and throw my glass dish on the floor.'' A nurse note dated 10/4/23 at 1:28 PM documented the resident was observed ambulating in hallway on her own, yelling out Feed me, Feed me. The resident was without clothing and without a brief and was hitting the wall. Resident #84 was re-directed to their room and ensured that breakfast was coming. A nurse note dated 10/7/23 at 9:16 AM documented the resident was disruptive, yelling and wandering into peer's rooms, taking clothes off and coming from room undressed into hallways. The resident took large handful of pancakes off a tray on food cart and ate it, when staff intervened the resident threw the ceramic plate which broke onto the floor. It was difficult to redirect the resident from peer's rooms. The resident's room had food on door handle, floors, furniture, bedding and was in disarray. Resident #70 was admitted with diagnoses of Dementia, fracture of part of neck of right femur, cerebral infarction. Resident #49 was admitted with diagnoses of cervical radiculopathy, atrial fibrillation, lesion of radial verve. Resident #65 was admitted with diagnoses of fracture of rib, rheumatoid arthritis, Wegener's granulomatosis. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #103 was admitted with fracture right femur, morbid obesity and Type II Diabetes Mellitus. The Accident/Incident report dated 10/7/23 documented at around 8:40 AM Resident #84 was walking around and grabbed food off the breakfast trays and tried to eat it. Resident #70 was being transported in a wheelchair in the hallway and Resident #84 hit Resident #70. Staff redirected Resident #84 to their room. A few minutes later Resident #84 came out of their room and went into Resident #49's room and hit them on the head. Staff came for Resident #84 and redirected them back to their room. The physician was called and ordered Haldol which was given to the Resident #84. Within minutes staff heard Resident #65 calling from their room and reported that Resident #84 had jumped on their bed, scratched the Resident #65 and ripped their shirt. Staff removed Resident #84 and returned them to their room and left them there. Within minutes Resident #103 was heard calling for help and when staff went to the Resident#103 room, Resident #84 was repeatedly hitting Resident #103 in the face and arms causing bleeding to Resident #103's arm. The facility called the police who arrived, and Resident #84 became aggressive with them. Emergency Medical Technicians arrived and took Resident #84 to the hospital. Resident #103 was sent to the hospital for evaluation for their bleeding arm. During an interview on 9/16/24 at 1:50 PM, Licensed Practical Nurse #100 they stated they remember the incident a little and was at the facility on that day. They stated the resident was having aggressive behaviors and they came to help on the unit because there were not many staff scheduled on the unit. Licensed Practical Nurse #100 remembered redirecting Resident # 84 back to their room as they appeared to be calm, but then Resident #84 got out of their room and went into other resident's rooms. During an interview on 09/17/24 at 10:55 AM with the Corporate Licensed Practical Nurse they stated there was probably more interventions in place, but not documented. They stated there may have been a 1:1 not sure and it was not documented. During an interview with the Director of Nursing on 9/17/24 at 10:58 AM they stated they were not employed by the facility at the time but there should have been increased supervision to prevent another occurrence. During an interview with the Medical Director 09/16/24 04:20 PM about resident #84 they stated they were unaware of Resident #84's psychiatric history until after they were admitted . Resident #84 had a rectal prolapse that was being monitored and impacted the Resident's behaviors. The Medical Director stated they thought about doing 1:1 supervision but the facility did not have enough staff for that, so they sent the resident to the hospital. 415.4(b)(1)(ii)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48847 Based on observation, record review and interview conducted during the Recertification and Abbreviated Surveys (NY 00327092, NY 00324750 and NY 00333010) from 9/5/24-9/17/24, the facility did not ensure for 3 (Residents #104, #45, and #73) of 9 residents reviewed for abuse, that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately, but not later than two hours after the allegation was made, to the State Agency in accordance with State law through established procedures. Specifically, 1) For Resident #104 there was no documented evidence that an injury of unknown origin was reported by the facility to the state agency after the family representative reported bruises to the resident's hands; 2) For Resident #45 the facility did not report a 2/4/24 resident reported allegation of staff to resident abuse to the State Agency until 2/7/2024; and 3) For Resident #73 the facility did not report an allegation of resident to resident abuse to the State Agency within the two hour timeframe for Resident #73 who reported they were hit by their roommate. The findings are: The Facility policy titled Abuse, Mistreatment & Neglect Prevention, Investigation and Reporting last revised on 8/2023 documented that New York State Department of Health requires immediate reporting of abuse, neglect, mistreatment (including injuries of unknown source) to the administrator of the facility and, when required by law or regulation, to the New York State Department of Health. In addition, the attending physician and family member or resident representative will be called immediately following the call to New York State Department of Health. 1. Resident #104 was admitted with diagnoses including but not limited to Anxiety Disorder, Dementia, and Hypokalemia. The 8/22/23 Significant Change Minimum Data Set (an assessment tool) documented Resident #104 had severely impaired cognition, was independent with bed mobility, eating and transfers, and required extensive assist with toileting and had no skin problems. The 10/26/22 at 5:06 PM nursing progress note documented Resident #104's family verbalized they were concerned about Resident #104's hands, that they visited over the weekend and Resident #104's hands were discolored and scratched. Orders placed to have x-rays of the hands done. Review of Resident #104 medical records documented on 10/27/22 x-ray of both hands was performed. The 12/11/22 at 6:58 PM medical progress note documented Resident #104 was seen for a monthly visit and family verbalized noticing bruising to Resident #104's right hand. Review of Resident #104's medical records documented that on 12/11/22 x-ray of both hands was performed. There was no documented evidence the injury of unknown origin was reported by the facility to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/16/24 at 11:28 AM, the Administrator stated they were unable to locate an Accident and Incident report for Resident #104. The Administrator stated if there was an injury of unknown origin, it should/must be reported immediately. During an interview on 09/16/24 at 12:24 PM, the Director of Nursing stated if a resident had an injury of unknown origin, an Accident and Incident Report, and an investigation must be initiated. The Director of Nursing further stated the injury of unknown origin must be reported to the Department of Health immediately. During an interview on 09/17/24 at 10:38 AM, the Medical Director stated Resident #104 was combative and had fragile skin, they bruised easily, and that Resident #104 could have obtained a bruise or a skin tear due to staff holding them tight while getting them dressing. The Medical Director stated staff should notify medical immediately if they see bruises. 2) Resident # 45 with diagnosis of Hepatic Encephalopathy, Type 2 Diabetes, and Chronic Obstructive Pulmonary Disease The 2/17/24 Quarterly Minimum Data Set documented Resident #45 was cognitively intact, was independent or required supervision with all activities of daily living, and had no documented behaviors. The 2/4/2024 Facility Accusation of Abuse Investigation by the former Director of Nursing documented the resident was interviewed the next day with 2 nurses present. The resident stated the person was pulling them and being mean. The resident informed them of pain on the left thigh. There was an ecchymotic area present. The resident stated that it came from when they were being changed. A complete skin check was performed. The investigation was signed but not dated. The 2/4/24 at 8:33 PM Nurse Progress Note by the Director of Nursing documented the nurse called the writer and informed them of the complaint. Regional Team made aware and an investigation was initiated. The resident's son called and expressed concerns, stating they had called the police to report the incident There was no documented evidence the alleged allegation of staff to resident abuse was reported to the state agency prior to 2/7/24. During an interview on 09/12/24 at 09:54 AM Resident # 45 stated they had to go to the bathroom a lot that day and the nurse aide got mad and pulled them by the arm. They did not fall, but had bruises on the leg and the top of their foot hurt. Resident #45 stated they told their son someone beat them. Resident #45 stated their son spoke with the former Director of Nursing who came to the room with security and someone from the kitchen. Resident #45 stated they told the staff, the Aide involved was a female, who worked on the night shift. Resident $45 stated the former Director of Nursing saw the bruises and said they would investigate it. Resident #45 stated they believe the aide now worked on the 3rd floor. Resident #45 stated a little while after the incident they asked the former Director of Nursing for papers about the incident and was told do not worry about it, it was taken care of and had been reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/16/24 at 12:04 PM the current Director of Nursing stated any accusation of abuse must be reported to the Department of Health with in 2 hours of being reported to the facility. A bruise of unknown origin would need to be investigated and staff and/or witness statements obtained. The current Director of Nursing also stated any changes in skin that are found when providing cares should be reported to the nurse. During an interview on 9/17/24 at 12:49 PM, the current Administrator stated accusations of abuse should be reported within 2 hours to Department of Health. This event involving Resident #45 occurred prior to them starting at the facility. 3) Resident #73 was admitted with diagnoses which include Metabolic Encephalopathy, Dementia and Bipolar Disorder. The 9/8/23 Quarterly Minimum Data Set documented Resident #73 had severely impaired cognition, required limited assistance with transfers and toileting and was dependent with eating and bed mobility. The 9/22/23 Nurse Progress note documented Resident #73 reported they were hit by their roommate, and had scant blood on the center middle lower lip and there was blood on their upper teeth). There was a blue raised area above the left eye. The 9/22/23 Accident and Incident Report documented the incident occurred at 12:00 PM. The email face sheet from the facility documented the Accident and Incident Report was sent to the Department of Health and was received on 9/22/23 at 5:21 PM. During an interview with the Director of Nursing on 9/16/24 at 11:28 AM they stated they were not at the facility at the time of the incident and was recently employed by the facility in July 2024. The Director of Nursing stated the incident should have been called in within the two-hour time frame since this was a resident to resident incident with injuries. They further stated they did not know why it had not been called in prior to 5:00 PM. 10 NYCRR 415.4(b)(2) 47626 41666

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review and interviews conducted during the Recertification and Abbreviated Surveys (NY 00327092,), the facility did not ensure for 1 (Residents #104) of 9 residents reviewed for abuse, that all alleged violations involving abuse, mistreatment, or neglect, were thoroughly investigated. Specifically, Resident #104's family member reported to nursing on multiple occasions that they observed bruises to Resident 104's hands which resulted in x rays being done, and the injuries of unknown origin were never investigated by the facility. The findings are: The facility policy titled Resident Accident/Incident Report Policy that was undated documented that if a cause of injury is unknown, the Nursing supervisor is responsible for initiating the investigation into the possible cause. Resident #104 was admitted with diagnoses including but not limited to Anxiety Disorder, Dementia, and Hypokalemia. The 8/2/23 Significant Change Minimum Data Set, dated dated dated [DATE] documented that resident had severely impaired cognition, was independent with bed mobility, eating and transfers, and required extensive assist with toileting and had no skin problems. The 10/6/22 Nursing Admission Assessment documented that the skin was warm, dry, and intact. The 10/19/22 Skin Integrity Care Plan documented that Resident #102 was at risk for skin breakdown related to incontinence and decreased ability to reposition self. Interventions included Certified Nurse Aide evaluation of skin condition daily during care and reporting any skin abnormalities to the nurse. The 10/26/22 at 5:06 PM Nursing Progress Note documented Resident #104's family verbalized that they were concerned about Resident #104's hands, that they visited over the weekend and Resident #104's hands were discolored and scratched. Orders placed to have x-rays of the hands done. There was no documented evidence in the Skin Integrity Care Plan to address the identified bruising on 10/26/22. There was no documented evidence of an Abuse/Victim Care Plan in place. Review of Resident #104 medical records documented that on 10/27/22 and x-ray of both hands was performed. The 12/11/22 at 6:58 PM Nursing Progress Note documented Resident #104 was seen for a monthly visit and the family verbalized they had noticed some bruising to Resident #104's right hand. Review of Resident #104's medical records documented that on 12/11/22 and x-ray of both hands was performed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that Skin Integrity Care Plan was updated for the bruising on 10/26/22 and 12/11/22. The 4/7/23 Physicians Order documented Resident #104 had a bruise to the right hand: apply normal saline and a thin layer of bacitracin and wrap with gauze. There was no documented evidence that the Skin Integrity Care Plan was updated for the bruise and/or skin tear found on 4/7/23. The 8/31/23 and 9/26/23 Physicians Order documented Resident #104 was to have weekly skin checks on bathing days (Mondays, 7 AM-3 PM) and to document the findings in the progress notes. There was no documented evidence in the 12/2022-9/2023 Medication and Treatment Administration Records from 12/2022-09/2023, that skin assessments were being done regularly as per physicians' orders. There was no documented evidence in the 12/2022-9/2023 Certified Nurse Aide documentation that skin checks were being done regularly. During an interview on 09/10/24 at 01:38 PM, the complainant stated that on multiple occasions while visiting Resident #104, they observed skin tears and bruising on the resident, and when they would alert nursing staff, no one would communicate about the complainant's observations, and that they were never called or made aware of the resident's bruising. During an interview on 09/13/24 at 10:21 AM, Certified Nurse Aide #3 stated that if a resident had bruises or skin tears, they would report it the nurse. During an interview on 09/16/24 at 11:28 AM, The Administrator stated they were unable to locate any Accident and Incident reports for Resident #104. The Administrator stated that if there was an injury of an unknown origin, it must be reported immediately. During an interview on 09/16/24 at 12:24 PM, the Director of Nursing stated that if resident had an injury of unknown origin, an Accident and Incident report and an investigation must be initiated and must be reported to the Department of Health. The Director of Nursing stated that even if a resident had Dementia, if staff did not know where the bruises came from, they must report it immediately. During an interview on 09/16/24 at 12:59 PM, the Director of Nursing stated that they looked for Accident and Incident report related to Resident #104 and could not locate any reports. During an interview on 09/17/24 at 10:38 AM, the Medical Director stated that Resident #104 was combative and because of their fragile skin, they bruised easily, and that Resident #104 could have obtained a bruise or a skin tear due to staff holding them tight while getting them dressed. The Medical Director stated that should notify medical immediately if they see bruises. The Medical Director stated that nurses should have been monitoring Resident #104's skin. 10 NYCRR 415.4(b)(3)

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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. 49364 Based on record review and interview conducted during the recertification survey and abbreviated survey (NY 00345570) from 9/5/24-9/17/24, the facility did not ensure that a copy of the Notice of Transfer and Discharge was sent to a representative of the Office of the State Long-Term Care Ombudsman or that a resident's representative was immediately notified when the decision was made to transfer the resident from the facility to the hospital, for 2 of 3 residents (Residents #100 and # 34) reviewed for notification requirement before transfer/discharge. Specifically, 1. Resident #100 was discharged to another facility in July 2024 and there was no documented evidence the Ombudsman had been notified and 2. Resident # 34 was transferred to the hospital on 6/10/24 and there was no documented evidence in the electronic medical record to indicate the resident's Health Care Proxy was notified. The findings are: The facility policy titled Notice of Transfer or Discharge11/2023, revised 3/4/24 documented the facility would adhere to the office of the State Long Term Care Ombudsman practices and would send notices of transfer and discharge of residents from the facility, as to ascertain the State Long Term Care Ombudsman was made aware of the facility practices and activities of residents upon discharge and transfer. The Facility policy titled Notice of Transfer or discharge date d 10/22, revised 3/24 documented that resident/s and their representative would be provided with notification of transfer as soon as practicable when they were transferred on an emergency basis to an acute care facility. 1. Resident # 100 was admitted with diagnoses including Parkinson, Seizure, and Cerebrovascular Accident. The 7/1/24 Minimum Data Set (an assessment tool) documented Resident #100 had moderate cognitive impairment, experienced a decline in activities of daily living status requiring restorative occupational therapy, and currently required extensive assist of 1 staff for self-care and functional mobility. The Nursing Progress Notes dated 7/22/24 at 10:30 AM documented Resident #100's family member was called and informed of the discharge plan for their family member. The receiving facility will send someone to evaluate the resident before discharge is put in place. The 7/23/24 Discharge Summary documented the resident was admitted from another facility following increased confusion. Resident was found to have a non-traumatic subdural hemorrhage and suffering long-term effects from COVID. Resident was doing well today, and they feel ready to leave tomorrow 7/24/24. The 7/24/24 at 12:52 PM Progress Note documented Resident #100 was discharged to another facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence in the electronic medical record that the Office of the State Long-Term Care Ombudsman was sent a copy of the transfer or discharge notice for Resident #100 after the July 2024 discharge from the facility. During an interview on 9/16/24 at 11:34 AM, the Director of Nursing stated the Social Worker was responsible for notifying the Ombudsman on the facility discharges and transfers. During an interview on 9/16/2024 at 4:47 PM, the facility Regional Manager of Operations stated they could not verify that a notification of the facility discharges and transfers letter had been sent to the Ombudsman in July 2024. 2. Resident #34 was readmitted with diagnoses including Epilepsy, Bipolar and Dementia. The 6/24/24 Quarterly Minimum Data Set documented Resident #34 had severely impaired cognition. Nursing progress note dated 6/10/24 at 2:52 PM documented Resident #34 continued to have seizures. The Nurse Practitioner gave orders to send Resident #34 to the emergency room for evaluation. Nursing progress note dated 6/11/24 at 1:52 AM documented Resident #34 was admitted to an acute care facility with diagnosis of seizure. Nursing progress note dated 6/18/24 at 08:42 PM documented the resident returned to the facility. There was no documented evidence in the electronic medical record to indicate the resident's Health Care Proxy was notified on 6/10/24 of the transfer to the hospital. During a telephone interview on 9/10/24 at 8:23 AM Resident # 34's Health Care Proxy stated the resident had 3 seizure episodes in the past year but when the resident was admitted to an acute care facility in June 2024, they did not receive notification from the facility that their family member was hospitalized . During an interview on 09/13/24 at 1:05 PM, Nurse Practitioner #1 stated when residents were transferred to an acute care facility, they notified the Physician, the Director of Nursing, the Administrator, and the Nurses. The Nurses' were responsible for notifying the residents' Health Care Proxy or next of kin. During an interview on 09/13/24 at 1:18 PM, Registered Nurse #17 stated if there was any change in the resident's condition the Physician and the Director of Nursing would be notified and the resident's family member should be notified when a resident is transferred to the hospital. During an interview on 09/16/24 at 12:12 PM, the Consultant Social Worker stated they could not locate any documentation that the resident's next of kin was made aware of the resident's transfer to an acute care facility in June 2024. 10 NYCRR 415.3(h)(1)(iii) (a-c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observations, record reviews and interviews conducted during the Recertification survey from 9/05/24 to 9/17/24, the facility did not ensure resident Comprehensive Care Plan was reviewed and revised upon each assessment. This was evident for 2 of 10 residents reviewed for care planning (Resident #31, Resident #88). Specifically, 1) Resident #31 at risk for falls did not have their comprehensive care plan related to falls updated to reflect current interventions in place to prevent falls. 2) Resident #88 did not have documented evidence of quarterly care plan meetings or updates since 2/27/24. Findings include: The facility policy and procedure Comprehensive Care Plan dated 2/2024 documented the care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate. The Interim Interdisciplinary Care Plan will be located in the care plan section of the Medical Record. It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs. A resident's care should have the appropriate interventions and provide a means of interdisciplinary communication to ensure continuity in resident care. 1. The Resident #31 was admitted with diagnoses including but not limited to Parkinson, Schizophrenia and Muscle Weakness. The 11/24/20 care plan titled Risk for Falls documented the resident assessed at moderate risk for falls. Interventions included but were not limited to place call bell within reach and encourage to use, assess the ability to use call signal. The 6/20/24 Quarterly Minimum Data Set Assessment (a resident assessment tool) documented the Resident #31 had moderately impaired cognition, was independent with self-care abilities, and always continent of bowel and bladder. The 12/13/23 Fall Risk Assessment score was 10 (resident is a moderate risk for falls). The 8/27/24 Fall Risk Assessment score was 18 (resident is a moderate risk for falls) Observation on 9/10/24 at 3:15 PM revealed Resident #31 sitting on the toilet in the resident bathroom. The call bell in the bathroom was tested and neither rang nor light went on over the door, there was no tap bell in the bathroom. The resident bedside call bell was not working and tap bell was present on the bedside table. The resident ambulated independently back to bed. Observation on 9/10/24 at 3:42 PM revealed Resident #31 was noted to be back in the bathroom. The bathroom call bell was pulled with no light over the door and no tap bell within reach, no staff responded. The resident was noted to be back in the bed at 3:48 PM and complained of feeling lightheaded. The surveyor notified nursing staff of resident's complaint and staff went into the room at 3:52 PM. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nurse's Note on 8/27/24 at 7:09 PM documented by Registered Nurse #25, at 6:15 PM the resident was observed sitting on the floor, near their bathroom door, the resident stated that they were coming out of the bathroom, when their left knee gave out and they fell on the floor. No apparent injuries noted, able to move all her extremities, denies any pain at this time. Resident was assisted back up to her bed, reminded to always call for assistance. Call bell and all needed items within reach. During an interview on 9/10/24 at 6:03 PM with the Director of Maintenance, they stated they started on 2/26/24, problems with call bell system started mid-April. The problem was the staff could not hear call bells as there was a problem with the call bell system. Tap bells were provided by their department to all residents. Tried to replace but system was old, and a proposal was offered. Did not receive a proposal until late April early May. Inquired every week with Regional and was told they did not know when the new system would be installed. They said they were advised by (Regional Finance) to use emergency storage tap bells and put the tap bells in all resident rooms on Unit 3. There was no directive to put tap bell in shower or bathroom. When a resident was in the bathroom there would be no way to call for help. During an interview on 09/11/2024 at 03:24 PM, Resident #31 stated that they were aware of the tap bell and knew how to use it and were able to demonstrate how to use it. Resident #31 stated that they used the call bell for when they needed some help, and that when they tapped the bell, staff did not come and that when they did it took too long, they use the wired call bell system that was observed on the bed wrapped around the side rail. Resident #31 stated that the tap bell was just placed in the bathroom and did not know why because staff did not come. Resident #31 stated that they fell coming out of the bathroom because they were trying to pull up their pants and they fell backwards. Resident #31 stated they just found out today that the cord call bell did not work. There was no documented evidence from 4/2024 through 9/10/24 that care plans were updated with interventions to address the resident's ability to contact staff while the call light system was not working. Additionally, there was no documented evidence that the facility increased monitoring for all residents on Unit 3 as per the 4/8/24 Interim Quality Assurance Meeting which documented modification of usual operations that potentially impact routine safety and wellbeing. During an interview on 9/16/2024 at 4:05 PM with Registered Nurse #25 they stated that they were aware about resident fall on 8/27/24. The Registered Nurse #25 stated that any nurse on the unit was able and responsible for updating the care plan. The nurse did not know why the care plan for Resident #31 Risk for Falls was not updated after 8/27/24. 41666 2. Resident #88 was admitted to the facility on [DATE] with diagnoses which included type II Diabetes Mellitus, Pulmonary Embolism, and absence of leg below knee. The Minimum Data Set, an assessment tool dated 8/7/23 documented the resident did not have cognitive impairment and was independent with activities of daily living, chair to bed transfer, toileting and was continent of bladder and bowel. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's discharge care plan dated 12/21/23 documented the goal was the resident would return home after completion of skilled treatment. The last care plan meeting with the resident was dated 2/27/24 in the resident's record. During an interview with the resident on 9/9/24 at 10:18 AM the resident stated they had not been to a care plan meeting in a long time and was anxious because there was no Social Worker to help with her Section 8 housing and depended on them for updates. During an interview with the Corporate Social Worker on 9/10/24 at 10:41 AM they stated the former Social Worker left the facility two weeks ago, but residents who were cognitively intact were invited to the care plan meeting quarterly. Documentation of the meeting would include if the family was invited and a sign in attendance sheet. The Corporate Social Worker stated Resident #88 should have had two additional care plan meetings with attendance and invitation in the record. They stated they did not know why there was no documentation the resident was invited or if their representative was invited to any care plan meeting after 2/27/24. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48847 Based on observation, interview and record review conducted during a recertification and abbreviated surveys (NY 00327092 and NY 00337480) from 9/5/24 to 9/17/24, the facility did not ensure residents received the necessary assistance for bathing to maintain personal hygiene for 2 of 6 residents (Resident #104, and #105), reviewed for activities of daily living. Specifically, 1. Resident #104 did not receive 41 scheduled showers between May 2023 and September 2023 and 2. Resident #105 did not receive 12 scheduled showers between December 2023 and January 2024. Additionally, there was no documented evidence that skin checks were consistently done as per physician order for Resident #105. Findings include: The facility policy for showering dated 2015 and updated 6/23 documented each resident will be offered a shower minimally twice a week, with consideration of personal preferences and facility care routine (i.e. appointment) when scheduling. The purpose of weekly showering is to promote good hygiene, cleanliness, freedom from odor, stimulation of skin and protection of resident dignity with regard to cleanliness. 1. Resident #104 was admitted with diagnoses including but not limited to Anxiety Disorder, Dementia, and Hypokalemia. The 12/14/22 Certified Nurse Aide Instruction documented Resident #104 was to be showered every week on Tuesdays and Fridays (3-11PM) shift. The 2/20/23 Activities of Daily Living Care Plan documented Resident #104 had self-care deficit related to dementia, give physical help in part of bathing activity and if the resident refuses, encourage the resident to wash themselves by the sink or shower with standby supervision as preferred. There was no documented evidence in the May 2023-September 2023 Certified Nurse Aide Documentation of showers being provided as scheduled on 5/2, 5/5, 5/9, 5/12, 5/16, 5/19, 5/23, 5/26, 5/30, 6/2, 6/6, 6/9, 6/13, 6/16, 6/20, 6/23, 6/27, 6/30, 7/4, 7/7, 7/14, 7/18, 7/21, 7/25, 7/28, 8/1, 8/4, 8/8, 8/11, 8/15, 8/18, 8/22, 8/25, 8/29, 9/1, 9/5, 9/8, 9/12, 9/15, 9/19, and 9/22. The 8/22/23 Significant Change Minimum Data Set documented Resident #104 had severely impaired cognition, required extensive assist with bathing/showering and had no behaviors or rejection of care. During an interview on 9/10/24 at 1:38 PM, the Complainant stated when they visited, Resident #104 was visibly filthy and unkempt, and their clothes were not being changed. The Complainant stated the facility was not giving Resident #104 showers, and on multiple occasions they had to provide Resident #104 with shampoo and body wash because the facility told them that they had to provide it. During an interview on 09/12/24 at 12:36 PM, Liaison #21 stated they were a Training Nurses Aide from 4/2022 until 8/1/24, and there were times they were on the unit by themselves and were unable to give resident's a shower. Liaison #21 stated they were aware of how to document showers given or refusals in sigma care, and that if a resident refused, they would document refusals and let the nurse know. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #105 was admitted with the following diagnosis including but not limited to Epileptic Seizures, Overactive Bladder and Spondylolisthesis. The 12/19/23 Admission Assessment Minimum Data Set documented Resident # 105 had intact cognition, was dependent with toileting, shower/bathing, and had no rejection of care. The 12/27/23 Activities of a Daily Living Care Plan documented weekly showers per preference/schedule and as needed. There was no documented evidence in the December 2023-January 2024 Certified Nurse Aide documentation of showers being provided as scheduled on 12/15, 12/19, 12/22, 12/26, 12/29, 1/24, 1/5 1/9, 1/12, 1/16,1/19, and 1/23. The 12/14/23 Physicians orders documented Resident #105 was to have weekly skin checks on bathing days. There was no documented evidence in the 12/2023 Certified Nurse Aide documentation of skin checks being done on 12/29/23 as per nursing instructions to skin checks on Tuesdays and Fridays, 7-3pm shift. There was no documented evidence in the December 2023 -January 2024 Treatment Administration Record of skin checks being done on 12/29, 1/5, 1/12, and 1/19. During an interview on 09/12/24 12:54 PM, Licensed Practical Nurse Manager #4 stated if a resident refused showers, the Certified Nurse Aide did not always let the nurse/s know. Licensed Practical Nurse Manager #4 stated Certified Nurse Aides were supposed to document refusals in the Certified Nurse Aide documentation and stated if there was only one Certified Nurse Aide on the unit, it was hard to give showers, but showers should still be done. Licensed Practical Nurse #4 stated if showers were not documented, then they were not done. During an interview on 09/13/24 at 10:21 AM, Certified Nurse Aide #3 stated there had been times when they could not give a shower because of insufficient staff, and they were aware that they should document when they gave showers. Certified Nurse Aide #3 stated at times they did not document because the unit could be chaotic at times. During an interview on 09/17/24 at 12:25 PM, the Director of Nursing stated the Nurse Managers were responsible for ensuring they check the charts to see if residents were getting their showers and staff should be giving showers. The Director of Nursing stated Nurses should be monitoring the residents' showers, especially since they must check their skin and sign off in the Treatment Administration Record. 10 NYCRR 415.12(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48847 Based on observation, record review, and interview conducted during the Recertification and Abbreviated Surveys (NY 00324324) from 9/05/24 to 9/17/24, the facility did not ensure adequate supervision was provided and that the residents environment remained as free of accidents hazards as possible for 1(Residents #10) of 10 residents reviewed for accidents. Specifically, Resident #102 who had a history of exit seeking behaviors, eloped on 9/18/23 during the night shift, and was found in the early morning hours by the police department at an address away from the facility's property. The findings are: The facility policy titled Elopement/Missing Resident dated 04/2017 and updated on 8/2022 documented that immediately the resident unit is to be searched thoroughly, including bathrooms, closets, behind and under beds, behind privacy curtains, and in any room that is accessible. The facility policy titled Elopement Screening Policy and Procedure dated 04/2017 and updated 8/2022 documented the Individualized Care Plan will include the following interventions at minimum: identification of wandering behavior and possible causative/contributory factors (seeking a person or item), application of wander guard; photo at reception desk, inclusion in Wander Alert Book, assignment to an upper floor in the facility, notification to physician, family, and all staff. 1. Resident #102 was admitted with the following diagnoses including but not limited to dementia, depression, and schizophrenia. The 8/12/23 Risk for Elopement decision tree documented Resident #102 was cognitively impaired, with poor decision-making skills. Resident #102 made statements about leaving the facility. The 8/12/23 Wandering Elopement Care Plan documented Resident #102 was at risk for wandering into unsafe areas, or for elopement out of the building, without supervision, and had a wander guard on their right wrist. Interventions included document the intensity, duration, or frequency of behaviors in the progress notes, ensuring proper placement of ankle alert and check for any malfunction, identifying resident's reason for wandering if possible, and notifying the physician. The 8/12/23 at 3:04 PM Nursing Progress Note documented a wander guard was placed on Resident #102's right wrist. There was no documented evidence in Resident #102 Physician Order of an order for an ankle alert/wander guard. The August 2023 Medication Administration Record documented Resident #102 did not receive Quetiapine 25 mg 8/14/23 at 2 PM. The 8/12/23 Certified Nurse's Aide Instructions documented Resident had #102 had no behaviors, a wander guard was placed on the right wrist and to document on behaviors and wander guard every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence in the August 2023 Certified Nurse's Aide documentation that behavioral symptom and safety (alarms, tasks, protective measures) were documented on multiple days and shifts from 8/13/23-8/31/23. The 8/18/23 at 10:55 AM Nursing Progress Note documented Resident #102 removed the wander guard again, and another wander guard was placed on their left wrist. The 8/18/23 at 9:18 PM Nursing Progress Note documented Resident #102 had increased behaviors and agitation, with attempts to go down the stairs, attempted to get on the elevator stating they were going home, and was argumentative with redirection. The 8/19/23 at 6:51 AM Nursing Progress Note documented Resident #102 had increased behaviors and attempted to elope on the 11PM-7 AM shift. The 8/19/23 at 10:11 PM Nursing Progress Note documented Resident #102 was wandering on the unit, attempting to get on the elevator and go down the stairs all shift. The 8/20/23 at 8:30 PM Nursing Progress Note documented Resident #102 was observed attempting to exit the entrance way, and nursing staff was unable to re-direct due to Resident #102 swinging their cane at staff. Nursing staff always remained with Resident #102 while Resident #102 walked towards and onto road, until 911 was called. The 8/21/23 Admission Minimum Data Set documented Resident #102 had moderate intact cognition, was independent with ambulation and bed mobility, and required setup with transfers. The 8/21/23 at 1:14 PM Nursing Progress Note documented Resident #102 was noted with no wander guard on and refused to have it re applied. The 8/22/23 at 11:58 Nursing Progress Note documented Resident #102 went through the stairwell to the bottom floor, was brought back to the unit, and was still seeking ways to leave the floor. Nursing tried to apply the wander guard multiple times and Resident #102 continued to refuse. The 8/22/23 at 12:20 documented Resident #102 attempted to leave facility again and was visibly angry because they could not leave. The 8/23/23 at 6:52 PM Medical Progress Note by the psychiatrist documented that Resident #102 was depressed and anxious, and to was to start Risperdal for Psychotic disorder with delusions and Escitalopram, and to continue Quetiapine. Resident #102 required care and supervision on a full time basis due to their Dementia, psychiatric, and physical conditions. Resident #102 lacked the capacity to make their own Medical or Healthcare decisions, and nursing was to continue to monitor mood and behaviors. Upon review of Resident #102 progress notes, there was no documented evidence that the Social Worker had interactions with Resident #102, except on 8/22/23. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/23/23 Wandering Elopement Care Plan documented Resident #102 was at risk for wandering into unsafe areas, or for elopement out of the building, without supervision, and had a wander guard on their left wrist. Interventions included to documenting the intensity, duration, or frequency of behaviors in the progress notes, identifying the pattern of behavior, placing Resident #102 on 15 min checks from 7 A-7 PM daily and a 1:1 from 7 PM-7 AM daily, and referring for psychiatric consult as per Physician order. There was no documented evidence in the Physician Order of an order for a wander guard, 15 min checks, or 1:1 supervision. The 8/24/23 at 10:42 PM Nursing Progress Note documented Resident #102 was ambulating on the unit, looking in rooms, and 1:1 was done that shift. The 8/27/23 at 3:02 PM Nursing Progress Note documented Resident #102 was ambulating on the unit most of the shift, near doorways and elevator, and attempted to go through the stairway door. The 9/2/23 at 7:09 PM Nursing Progress Note documented at approximately 4 PM Resident #102 attempted to get on the elevator and open the door to the staircase. The 9/7/23 at 10:14 PM Nursing Progress Note documented Resident #102 attempted to get on the elevator and stairs with a 1:1 in place. The September 2023 Medication Administration Record documented Resident #102 did not receive Quetiapine 25 mg on 9/1/23, and 9/9/23-9/11/23. There was no documented evidence in the September 2023 Certified Nurse's Aide documentation that behavioral symptom and safety (alarms, tasks, protective measures) were documented on multiple days and shifts from 9/1/23-9/18/23 specifically on the 7 AM-3 PM and 3 AM-11 PM shifts The 9/12/23 Wandering/Elopement Care Plan documented resident at risk for wandering into unsafe areas, or for elopement out of the building, without supervision. Interventions included administering medications as ordered by the physician. documenting the intensity, duration, or frequency of behaviors in the progress notes, ensure proper placement of ankle alert and check for any malfunction, identifying pattern of behavior, and referring for psychiatric consult as per Physician order. There was no documented evidence in the Physician Orders of an order for an ankle alert/wander guard. The 9/14/23 at 9:27 PM Nursing Progress Note documented Resident #102 was wandering on the unit and attempted to go on the elevator. The 9/15/23 at 7:17 PM Nursing Progress Note documented at approximately 4 PM Resident attempted to get on the elevator, to try and go downstairs. The 9/16/23 at 6:45 PM Nursing Progress Note documented at 6:40 PM the stair alarm was heard and on investigation Resident #102 was found going downstairs to the first floor. (continued on next page)

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	335323	A. Building B. Wing	09/17/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/17/23 at 9:26 PM Nursing Progress Note documented at 3:45 PM, Resident #102 attempted to go down the stairs. The 9/18/23 at 10:24 PM Nursing Progress Note documented Resident #102 remains on 1 to 1 supervision. An Accident and Incident Report dated 9/18/23 at 4:00 AM documented that the facility received a call from the police department asking to confirm if they had a missing resident. Furthermore, the 9/18/23 Accident and Incident Report documented that there were no safety devices present at the time of the incident, and that usual activity at that time for Resident #102 time was to be sleeping and wandering. An Investigative summary dated 9/18/23 documented Resident #102 was assessed for high risk elopement on admission and was issued a wander guard, that they frequently removed, and prior to their elopement on 9/18/23, they had incidences where they tried to get on the elevator or go down the stairs. The Investigative summary dated 9/18/23 documented at 2:30 AM, the nursing supervisor was doing rounds and observed Resident #102 lying in their bed and left the unit. And at 3:05 AM, Certified Nurse Aide #22 heard the door alarm going off and assumed it was the supervisor still doing their rounds. And at approximately 3:45 AM during their rounds, Staff #22 identified that Resident #102 was not in their room. Furthermore, the Investigative summary dated 9/18/23 documented that Resident #102 was last observed at 3:29 AM in the basement, on camera by the facility. The 9/19/23 at 4:15 PM Registered Nurse #23 documented Late entry: During checks on 9/18/23 at 2:30 AM, Resident #102 observed sleeping in bed. It was later recognized that Resident #102 was no longer in their room. While staff were looking throughout the building for Resident #102, the facility received a call from the police department that they found Resident #102 at an address away from the facility's property. During an interview on 09/11/24 at 05:12 PM, Licensed Practical Nurse #19 stated the wander guards should be order by the physician so that nurses can know to check for placement and functioning. Licensed Practical Nurse #19 stated Resident #102 had history of taking their wander guard off. Licensed Practical Nurse #19 stated Resident #102 always wanted to get on the elevator to go home. Licensed Practical Nurse #19 stated prior to Resident #102's elopement, there were no keypad lock/alarm on stairs to trigger when a resident who has a wander guard tries to open the door. Licensed Practical Nurse #19 stated they would report Resident #102's behaviors to the supervisor and nothing would be done. During an interview on 09/12/24 at 12:02 PM, The Consultant Social Worker stated Resident #102 had a guardian and was unable to leave Against Medical Advice, and that the social workers should have been visiting Resident #102 regularly especially since the resident had the exit seeking behaviors and continued to verbalize going home (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 03:20 PM, Certified Nurse Aide #22 stated on the day Resident #102 eloped, they were the only certified nurse aide on duty that night and there was no nurse on the unit. Certified Nurse Aide #22 stated they were sitting at the nurses' station and heard the alarm going off on the door and when they got up to attend to the alarm, they didn't see anything unusual while walking around the unit. Certified Nurse Aide #22 stated they did not know the resident was not in their room until the supervisor called to inform them that a resident was missing and to check all the rooms. Certified Nurse Aide #22 stated Resident # 102 was always trying to get out of the facility. During an interview on 09/13/24 at 11:02 AM, the Medical Director stated all residents assessed as high risk for elopement must have a wander guard and physicians order for wander guard placement and functioning. The Medical Director stated it was not ideal for a resident assessed to be high risk for elopement to be placed near an exit door if they have exit seeking behaviors. The Medical Director stated Resident #102 was high risk for elopement and was supposed to have a wander guard in place as per telephone order, and the nurse did not input the order into the computer. The Medical Director stated the nurse practitioner reviewed all new admissions and their hospital orders within 48 hrs of admissions to make sure all orders are in place and hospital orders/recommendations are followed and stated the nurses were responsible for ensuring that ancillary services, like wander guards were in place. During a follow up interview on 09/13/24 at 01:14 PM, Certified Nurse Aide #22 stated when the alarm went off, they did not look down the stairs because they were the only staff on the unit and did not want to leave the unit. Certified Nurse Aide #22 stated when the exit door alarm sounds, they are supposed to go up and down the stairs. Certified Nurse Aide #22 stated after the exit door alarm went off, and they did not see anything unusual, they went back to the nurses' station and cut the door alarm off. During an interview on 09/13/24 at 01:36 PM, The Corporate Director of Nursing stated they were told about the resident elopement when they had their weekly call with the administrator. The Corporate Director of Nursing stated once an order was placed, wanderguard placement and function would be documented by nurses in the Administration Record. The Corporate Director of Nursing stated if a resident is exit seeking, they should not be by the exit door. During an interview on 09/16/24 at 11:07 AM, Registered Nurse Supervisor #23 stated they were the supervisor on 9/18/23 when Resident #102 eloped and was also passing meds on another unit. Registered Nurse Supervisor #23 stated during their rounds Resident #102 was in the bed sleeping. Registered Nurse Supervisor #23 stated sometime later, they received a phone call from the police department because they identified the resident from their ID bracelet. Registered Nurse Supervisor #23 stated the alarms did not always sound throughout the building and there was a problem with the alarms. Registered Nurse Supervisor #23 stated the general practice was to make sure stairwells were checked when an alarms sounded. 10 NYCRR 415.12 (h)(1)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, record review, and interviews conducted during the Recertification and Abbreviated Surveys (NY 00324324 and NY 00327092) from 9/05/24 to 9/17/24, the facility did not ensure that the Physician reviewed the resident's total program of care, including medications, and treatments, at each visit for 1 of 10 residents reviewed for Accidents (Residents #102) and 1 of 1 residents reviewed for Change of Condition (Resident #104). Specifically, 1.) Resident #102 who was assessed at high risk for elopement during the 8/12/23 admission, had no physician order in place for placement and checking the function of a wander guard 2.) Resident #104 who was admitted to the facility on [DATE] from the hospital, had no physician order for Oncologist follow up within 1-2 weeks and repeat Computed Tomography Scan within 3-6 months as per Hospital Discharge Instructions. The findings are: The facility policy titled Physicians Visits and Responsibilities dated 10/2023 documented that the intent of these visits is to have the physician take an active role in supervising the care of residents, in order to lead and participate in the development of the resident plan of care. 1. Resident #102 was admitted on [DATE] with diagnoses including but not limited to dementia without behavioral disturbances, depression, and schizophrenia. The 8/21/23 Admission Minimum Data Set documented Resident #102 had moderate intact cognition, was independent with ambulation/bed mobility, required setup with transfers, and wandered into places that put the resident at significant risk of getting to a potentially dangerous place(for example stairs or outside of the facility) and had a Wander/elopement alarm. The 8/12/23 Risk Elopement decision tree done on documented that Resident #102 was making statements about leaving, to have a care plan for high risk for elopement, utilization of wander detection systems per the manufacturer's instructions as warranted, and to reevaluate all interventions at least quarterly and verification of the number on the wander guard detection devices. The 8/12/23 nursing progress note documented that Resident #102 had a wander guard placed on their right wrist. Upon review of the Medication and Treatment Administration Records, there was no documented evidence that there was an order for a wander guard. The 8/12/23 Care Plan titled Wandering and Elopement documented Resident #102 was at risk for wandering into unsafe areas, or for elopement out of the building, without supervision, and a wander guard was on their right wrist. Interventions included to ensure proper placement of the ankle alert and check for any malfunction. The 8/23/23 Medical Progress documented Resident #102 had a wander guard for safety. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/11/24 at 05:12 PM, Licensed Practical Nurse #19 stated all residents that wear wander guards should have a physician's order to check for placement and function. During an interview on 09/13/24 at 11:02 AM, the Medical Director stated residents that wear wander guards must have a physician order and Resident #102 should have had an order for their wander guard. The Medical Director stated Resident 102's admission was done via telehealth and the Physician or Nurse Practitioner who reconciled the orders, should have ensured that there was an order for a wander guard. 2. Resident #104 was admitted with diagnoses including but not limited to anxiety disorder, dementia, and Malignant neoplasm of the supraglottis(cancerous growth in the upper part of the larynx, above the vocal cords). The 8/22/23 Significant Change Minimum Data Set documented Resident #104 had severely impaired cognition and had a malignant neoplasm of the supraglottis. The 10/5/22 Hospital Discharge Summary documented Resident #104 was to follow up with an Oncologist in 1-2 weeks and a repeat Computed Tomography Scan of the chest in 3-6 months due to possible bronchial polyp. There was no follow up evidence in the 10/6/22 to 11/16/23 Physician Orders and Progress Notes that Resident #104 was seen by an Oncologist or had a Computed Tomography Scan done, as indicated in the Hospital Discharge Summary dated 10/5/22 During an interview on 09/13/24 at 12:14 PM, the Medical Director stated Resident #104 did not follow up with an Oncologist within 1-2 weeks of admission and did not have a repeat Computed Tomography Scan of the chest within 3-6 months of admission, as per the hospital discharge summary. The Medical Doctor stated that they were addressing the resident current condition and not focused on the resident seeing the Oncologist. The Medical Doctor stated that Nurse Practitioner and/or Physician should review orders to make sure that everything was followed from the Hospital Discharge Summary and the Patient Review Instrument(PRI). 10 NYCRR 415.15(b)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on interviews and record review conducted during the Recertification and Abbreviated Survey (#NY 00345570) from 9/5/24-9/17/24 the facility did not ensure that sufficient nursing staff was consistently provided to meet the needs of residents on all shifts. Specifically, 1) Several residents reported in a group meeting (Resident Council) that the facility was short staffed especially on various shifts and weekends which resulted in a lack of timely staff response to call bells 2) several nursing staff reported a lack of sufficient staff. 3) resident family members reported staff were not visible during their visits to the facility and 4). an analysis of the actual staffing schedule showed that on multiple occasions from the month of June 2024, and August 5 2024 through September 5 2024, the facility was below their minimum staffing levels. The Facility Assessment documentation for nursing staff was below the minimum requirement to care for a capacity of 120 residents. The findings are: The 8/12/24 Facility Assessment Tool reviewed and approved by the Administrator was documented as the general staffing plan was to ensure the facility have sufficient staff to meet the needs of the residents at any given time. The Nursing Staff Plan documented: 1 Director of Nursing- Registered Nurse full-time day shift. Registered Nurse Supervisor: day, evening and night shift. Licensed Practical Nurse trained to assume supervisory role with an on call registered nurse. Registered Nurse or Licensed Practical Nurse unit manager on each unit and 1 medication nurse per unit. Staffing is based on acuity of units. Direct Care Staff: 3-4 Certified Nurse Aides on the day shift depending on census. 2-3 Certified Nurse Aides on the evening shift and 1-2 Certified Nurse Aides on the night shift. The Facility Assessment revealed the minimum staffing levels of direct care staff were not sufficient to meet the resident's needs. Furthermore, the facility staffing sheets reflected 2 to 3 Certified Nurse Aides were the ideal staff for every shift on each unit daily. In addition, complaints from the Resident Council and staff interviewed further verified the Facility Assessment staffing plan for direct care staff was not adequate. Furthermore, multiple interviews conducted with various staff revealed the staffing ratios were not adequate to meet the needs of the residents. Review of the Nursing Department 24-Hour Staffing Sheet for June 2024 and August 5 2024 through September 5 2024 revealed: -6/2/24, Sunday 7A-3P Unit 100: 2 Certified Nurse Aides, Unit 300: 2 Certified Nurse Aides. (Need 3 Certified Nurse Aides on each unit, excluding the 3-11 shift.) 11PM-7A All Units: 1 Certified Nurse Aide. -6/3/24 Monday 7A-3P All Units: 2 Certified Nurse Aides. (Need 3 Certified Nurse Aides on each unit) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/4/24 Tuesday 11P-7A All Units: 1 Certified Nurse Aide. (Need 2 Certified Nurse Aides on all units) -6/16/24 Sunday 7A-3P All Units: 2 Certified Nurse Aides. (Need 3 Certified Nurse Aides on all units) -6/22/24 Saturday 7A-3P All Units 2 Certified Nurse Aides.(Need 3 Certified Nurse Aides on all units) -6/23/24 Sunday 7A-3P All Units 2 Certified Nurse Aides. (Need 3 Certified Nurse Aides on all unit) -6/27/24 Thursday 11P-7A All Units 1 Certified Nurse Aide.(Need 2 Certified Nurse Aides on all units) -6/30/24 Sunday All Units 7A-3P 2 Certified Nurse Aides. (Need 3 Certified Nurse Aides on all units) -8/5/24 Monday 11P-7A Unit 100 and Unit 300: 1 Certified Nurse Aide (Need 2 Certified Nurse Aides on all unit) -8/6/24 Tuesday All Units 7A-3P 2 Certified Nurse Aides (Need 3 Certified Nurse Aides on all units) -8/7/24 Wednesday 11P-7A Unit 300 1 Certified Nurse Aide. (Need 2 Certified Nurse Aides on all units) -8/9/24 Friday 3P-11P All Units 2 Certified Nurse Aides (Need 3 Certified Nurse Aides on all units) -8/9/42 Friday 7A-3P All Units 2 Certified Nurse Aides (Need 3 Certified Nurse Aides on all units) -8/14/24 Wednesday- Director of Nursing on duty till 5 pm, No other licensed nursing staff in the facility -8/25/24 Sunday 7A-3P All Units 2 Certified Nurse Aides (Need 3 Certified Nurse Aides on all units) -9/1/24 Sunday 7A-3P All Units 2 Certified Nurse Aides (Need 3 Certified Nurse Aides on all units) -9/4/24 Wednesday 7A-3P All Units 2 Certified Nurse Aides (Need 3 Certified Nurse Aides on all units) During the Resident Council Group Meeting on 09/09/24 at 11:32 AM, residents in attendance reported that they had not gotten their bed linens changed, they could not get ice, they were only showered once per week, and they had to wait an extended amount of time for pain medication because the nurse was responsible for giving medications to both sides of the unit. In addition, The Director of Nursing had stated the facility is working on improving the staffing ratios for direct care staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 9/10/24 at 8:23 AM, Resident #34's family member stated the facility was very short staffed, and the current staff did not appear to be as caring. Resident #34's family member stated at times when they visited, they could smell that Resident # 34 had a bowel movement and was not changed in a timely manner. During an interview on 9/12/24 at 10:29 AM, Licensed Practical Nurse #27 stated the facility did not have sufficient nursing staff. Licensed Practical Nurse #27 stated they worked 80- 90 hours a week and daily they were stretched too thin. During an interview on 9/12/24 at 10:35 AM, Certified Nurse Aide #6 stated they worked per diem for the facility but due to staffing ended up working 4 days per week. Certified Nurse Aide #6 stated the facility did not have enough staff and many days, the staff needed more help to take care of the residents. During an interview on 9/12/24 at 11:29 AM,Certified Nurse Aide # 39 stated they worked part- time but did double shifts at times and that they averaged 56 hours/ week. Certified Nurse Aide #39 stated they needed more staff Certified Nurse Aide #39 stated they had worked at the facility for [AGE] years or so, and in the past staffing was better. During an interview on 09/12/24 at 11:43 AM, the Staffing Coordinator stated the facility did not have a contract with outside agencies. An ideal staff of 3-4 Certified Nurse Aides per floor would be ideal. The Staffing Coordinator stated on Mondays there were a lot of call outs and that the facility met the staffing ratio at least 3 days a week. The Staffing Coordinator stated Sundays could be very difficult to staff. The Staffing Coordinator/Director of Human Resources stated although the facility offered bonuses for the nursing staff, because of the location it was a problem to retain staff. The current staff are experiencing burn out from covering extra hours. During an interview on 9/12/24 at 4:29 PM, the Director of Nursing stated the direct care staff of Certified Nurse Aides should be 3-4 Certified Nurse Aides for the day shift, 2-3 Certified Nurse Aides for evening shift and 1-2 Certified Nurse Aides for the nights shift, with a range of 6-9 Certified Nurse Aide staff in 24 hours. During a following-up interview on 9/13/24 at 10:00 AM, the Director of Nursing stated the facility goal was to improve the staffing ratios in the area of sufficient nursing staff through community outreach, referral bonuses for the nursing staff, job fairs and indeed advertising. During an interview on 9/13/24 at 11:23 AM, Licensed Practical Nurse #28 stated they work overtime shifts, 1-2 per week working 12 -16-hour shifts. Stated sometimes they were mandated. Since January 2024, stated they have done multiple overtime shifts and it gradually keeps getting worse with no improvement in the staffing situation. During an interview on 9/17/24 at 11:02 AM, Certified Nurse Aide # 30 stated they work part time, but did double shifts every week more than 32 hours per week of overtime. Stated the facility does not have enough staff to care for the residents. They do cares for residents 1 or 2 times. Stated the facility has only one Hoyer lift for all 3 units in the facility and this contributes to the slow down in providing cares for the residents. Stated on Sunday (9/15/24) they worked alone on the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/17/24 at 11:07 AM, Certified Nurse Aide # 36 stated the facility did not have sufficient staff to provide cares for the residents and stated they worked 80 hours per week. During an interview on 9/17/24 at 11:13 AM, Certified Nurse Aide #29 stated the facility did not have enough staff to provide proper care for the residents. 10 NYCRR 415.13 (a) (7) (i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49364 Based on interview, and record review conducted during the Recertification Survey from 9/5/24-9/17/24, the facility did not ensure each Certified Nurse Aide received twelve hours in-service education per year based on their individual performance review for 8 of 8 Certified Nurse Aides (#6, #11, #22, #31, #32, #33, #34, and #35) randomly selected for review of 12-hour yearly mandatory in-services and yearly performance reviews The findings include: The 8/12/24 Facility Assessment documented education was provided to staff mostly done by the Director of Nursing/Staff Educator. Several sessions were scheduled to allow the staff to attend on all shifts. The sessions were held regularly to include mandatory education per regulation, as well as new topics or topics needing re-education. There was no documented evidence that Certified Nurse Aides #6, #11, #22, #31, #32, #33, #34, and #35 had performance reviews completed at least once every 12 months. During an interview on 9/13/24 at 10:00 AM, the Director of Nursing stated the Certified Nurse Aide education was done by the cooperate team, but going forward the Director of Nursing would be conducting the education for the nursing staff. During an interview on 9/13/24 at 11:11AM, Certified Nurse Aide #22 stated, they had in-service education on charting residents care, and dementia, but stated they could not remember how long the in-service was. Certified Nurse Aide #22 stated they believe they had a performance evaluation done last year 2023, and when they were hired in 2016. There was no documented evidence of these evaluations. During an interview on 9/17/24 at 11:07 AM,Certified Nurse Aide #36 stated they could not recall getting a yearly performance evaluation. In addition, they could not recall receiving 12 hours of yearly in-service training. Certified Nurse Aide #36 stated they had received a piece of paper to sign off on in-services. During an interview on 9/17/24 at 11:13 AM, Certified Nurse Aide #29 stated they could not recall having a performance evaluation and, could not recall receiving 12 hours of yearly in-service training. 10 NYCRR 415.26 (c)(2)(iii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey and Abbreviated Surveys(NY 00337480) from 9/05/24 to 9/17/24, the facility did not ensure residents were free of significant medication errors for 2 of 8 residents reviewed for medications (Residents #105 and #19). Specifically, 1.) Resident #105 had multiple medication omissions on the Medication Administration Record including antihypertensive's, antibiotics, antidepressants, antianxiety, and thyroid hormones and 2.) Resident #19 had multiple missed does of Insulin (medication used to lower blood sugar levels in people with Type 2 diabetes mellitus). The findings are: The facility policy titled Administrations of Medications last reviewed on 10/23 documented that Medications administration must be charted in the Medication Administration Record immediately before going on to the next resident. If a medication is not given for any reason, the nurse must document appropriately; the reason medication was not given must be documented in the appropriate area of the Medication Administration Record's. All problems in medication administration are noted and are reported to the Unit Manager/Charge Nurse or Supervisor prior to the end of the shift. At the end of the medication pass, the medication nurse will review the Medication Administration Record's for omissions to ensure documentation reflecting the medication pass is accurate. 1.) Resident #105 was admitted on [DATE] with diagnoses including but not limited to cognitive communication deficit, fibromyalgia, epileptic seizures, generalized anxiety disorder, heartburn, hypothyroidism, major depressive disorder, overactive bladder, sepsis, and spondylolisthesis. The 12/19/23 Admission Assessment Minimum Data Set documented Resident # 105 had intact cognition. and had no behaviors and no rejection of care. The 12/14/23 Nine or More Medications Care Plan documented Resident #105 was currently taking 9 or more medications, administer medication per Physician Order, monitor Pharmacy Review and reduce medications if possible. The Physician Orders documented 12/15/23 Ozempic subcutaneously every week on Wednesday for weight loss, 12/14/23 Cefuroxime every 8 hours for sepsis, Baclofen every 8 hours for muscle spasm, Amlodipine once a day for hypertension, Hydralazine every 8 hours for hypertension, Vibegron once a day for overactive bladder, and Duloxetine once a day at bedtime for major depressive disorder. 12/29/23 Bupropion once a day and Klonopin(Clonazepam) twice a day for anxiety, 1/06/24 Acetaminophen two times a day for pain, and 1/24/24, antibiotic Rocephin intravenously for 3 days. (continued on next page)

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	335323	A. Building B. Wing	09/17/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2023 Medication Administration Record was left blank and did not identify why the following medications were not administered to Resident #105: Amlodipine 5mg on 12/15/23 (9 am), 12/23/23, and 12/26-12/29 (9 am), Baclofen 10 mg on 12/15/23 (2 pm), 12/19/23 (6 am and 10PM), 12/20/23 (10PM), 12/21/23 (2 pm), 12/25/23 (10PM), 12/26/23-12/29/23 (2 pm), and 12/27/23 (10PM), Bupropion HCL XL 150 mg on 12/23/23, and 12/26-12/29/23, Cefuroxime 500 mg on 12/15/23 (9 am), Clonazepam 1 mg 12/15/23 (11:30am), 12/18/23 (4:30 pm, 9:00 pm), 12/19/23 (6:30am), and 12/20/23 (11:30am), Duloxetine 60 mg on 12/20/23 and 12/25/23 , Hydralazine 25 mg on 12/15/23 (2 pm), 12/19/23 (6 am,10PM), 12/20/23 (10am, 12/21/23 (2 pm), 12/23/23 (2 pm), 12/25/23 (10PM), 12/26/23-12/29/23 (2 pm), and 12/27/23(10PM), Ozempic 2 mg/dose on 12/27/23 and Vibegron 75 mg tab on 12/15/23, 12/23/23, 12/26/23, 12/27/23, and 12/29/23. The January 2024 Medication Administration Record was left blank and did not identify why the following medications were not administered to Resident #105 Acetaminophen 325 mg tablet on 1/16 and 1/20 at 9 pm, Amlodipine on 1/10 (9 am), Baclofen on 1/2 (6 am), 1/4-1/5 (2 pm), 1/9-1/10 (2 pm), 1/16-1/22 (2 pm), 1/12(10PM), 1/16 (10PM), and 1/20 (10PM), Bupropion HCL XL 150 mg on 1/16 and 1/20 at 9 pm, Duloxetine 60 mg not given on 1/16, and 1/20, Hydralazine 2.5mg tab on 1/26 (6 am), 1/2 (6 am), 1/4-1/5 (2 pm), 1/9-1/10 (2 pm), 1/16-1/22 (2 pm), 1/12 (10PM), 1/16 (10PM), and 1/20 (10PM), Klonopin 1 mg tab on 1/16/24 (9 pm), and 1/20 (9 pm, Ozempic on 1/17 and 1/24 and Rocephin 1 gram solution on 1/23 and 1/24 (9 pm). During an observation on 09/11/24 at 7:09 pm, Resident #28 currently residing in building, stated they were waiting for their medications for a long time and wanted to take their medications so they could go to bed. Resident #28 also stated that they did not want to tap the bell because the staff did not respond. During an interview on 09/13/24 at 10:09 am, Licensed Practical Nurse Manager #4 stated there had been plenty of times when they were unable to give medications because if they were the charge nurse, things come up and they don't have time. Licensed Practical Nurse Manager # 4 stated most of the time, they were the only nurse on the unit. Licensed Practical Nurse Manager #4 stated there had been times they were late giving medications, and even if they gave the resident their medications, if it is not documented in the Medication Administration Record, it was not done. Licensed Practical Nurse Manager #4 stated there were times they had to ask for help on the unit if they were unable to give medications. During an interview on 09/13/24 at 10:44 am, Registered Nurse #18 stated they always gave medications late because most of the time it was only one nurse on the unit. Registered Nurse #18 stated it 10:30 am and they were still passing medications for the 9 am medication pass and it was impossible to give medications on time. Registered Nurse #18 stated they have seen that some nurses do not look in the Medication Administration Record when passing medications because they are familiar with the resident's medications and are attempting to get medication administration done. Registered Nurse #18 stated that could be a reason why medications are not being signed for. During an interview on 09/13/24 at 02:06 pm, the Corporate Director of Nursing stated all nurses should document medication administration in the Medication Administration Record and there should be no omissions. They stated if a resident refuses their medications, that should be documented, and the physician should be notified. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/17/24 at 10:30 am, the Medical Director stated if a medication is not given, medical should be notified. If there is an omission report, nursing will put it in the physicians folder for them to review. The Medical Director stated nursing should be reporting to them when medications are not given and stated when they do their reviews, they don't review the Medication Administration Record, they review the orders. The Medical Director stated they rely on nurses to give them reports of residents not getting medications or refusing medications. The Medical Director stated nurses normally call if a resident refuses medications but not for omission of medications because of insufficient staffing or because they simply could not give the medications. During an interview on 09/17/24 at 12:25 pm, the Director of Nursing stated the nurse managers are supposed to check the charts to see if residents are getting their medications. The Director of Nursing stated the nurses should be signing off on medications in the Medication Administration Record and not omitting medications. The Director of Nursing stated they know that there is an issue with medication omissions, and they are trying to fix the problems. 2. Resident # 19 was admitted to the facility with diagnoses which included chronic obstructive pulmonary disease, type II diabetes mellitus and major depressive disorder. The 8/21/24 Minimum Data Set documented the resident had a Brief Interview for Mental Status score of 14 of 15 and the resident received insulin. The 3/19/23 Care Plan titled Diabetes documented administer medications as ordered. The 3/19/24 Physician Orders documented Humalog Kwik pen (U-100) insulin 100 inject 4 units by subcutaneous route 3 times a day before meals and was scheduled at 0730 AM, 11:30 am and 4:30 pm. The September 2024 Medication Administration Record was left blank and did not identify why the following medication was not administered to Resident #19 Humalog Kwik pen insulin 9/1 at 4:30 pm, 9/4 at 4:30 pm, 9/5 at 11:30 am, 9/5 at 4:30 pm, 9/7 at 4:30 pm, 9/9 at 4:30 pm, 9/10 at 7:30 am, 9/10 at 11:30 am, 9/11 at 4:30 pm, 9/12 at 11:30 am, and 9/15 at 430 pm. During an interview on 9/16/24 at 9:35 pm Licensed Practical Nurse #4 stated they thought they gave the medication, but just forgot to sign for them. Licensed Practical Nurse #4 stated they knew if it wasn't signed then it was not given, but when you have so many medications to give, you can forget to sign for them. During an interview on 9/16/24 at 4:06 pm the Medical Director stated the insulin was very important to keep the residents blood sugar in range and should be given as ordered. The Medical Director stated they would normally get a call from the nurse to let them know, but was not aware of the missing insulin doses. 10 NYCRR 415.12(m)(2) 41666

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 49255 Based on observation, interview, and record review during the recertification and abbreviated surveys (NY00345570) from 9/5/2024 through 9/17/2024, the facility failed to adequately equip the facility to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities, or that each resident was consistently provided an alternate method for communicating needs to staff on 1 of 3 units (Unit 3). Specifically, on 9/10/2024 it was revealed there was no functioning centrally located audible call bell system and the current interim system was not functioning throughout the unit. The sound of the tap bells (desk bells with a black base) was not audible at the central nursing station or throughout the hall for 37 residents housed on the Unit 3 Dementia/Long Term Care Unit. Additionally, Resident #31, assessed at moderate risk for falls (fall with no injury on 8/27/2024), was observed on 9/10/2024 at 3:15 PM and 3:42 PM sitting on the toilet in the residents' bathroom. The bathroom call bell was not functioning either audible or visual, a tap bell was noted on the bedside table, and not within resident reach. This resulted in no actual harm with likelihood of serious harm that is Immediate Jeopardy to all Unit 3 residents' health and safety. The findings include: The facility policy, Call Bells, revised 4/2024 documented each resident has a call bell that is within reach to ensure each resident has a means to communicate their needs. The 4/11/2024 Call Bell Contract Proposal for work to be completed on the Unit 3 centrally located call bell light system documented a down payment of 50% was due at signing of the contract. A purchase order was required to process the proposal. By signing the proposal, the price, payment terms and all stipulations mentioned in the proposal have been agreed. The proposal was signed by the facility Assistant Chief Operating Officer on 4/16/2024. (The contractor did not receive the 50% downpayment until 8/29/2024.) Resident #31 was admitted with diagnoses including Parkinson's, Schizophrenia and Muscle Weakness. The 7/2/2024 Minimum Data Set (an assessment tool) documented Resident #31 had intact cognition, was independent with toileting, walking and ambulation, was always continent and received antipsychotic, antidepressant, and antianxiety medications. The 8/27/2024 Fall Risk Assessment documented a score of 18 (moderate risk for falls). The 8/27/2024 Incident and Accident Report documented Resident # 31 sustained a fall outside the bathroom in the resident's room. The 8/27/2024 Care Plan titled Risk for Fall documented the following 9/20/2021 interventions: call bell within reach/encourage use and assess the ability to use the call signal and provide alternate method(s) if necessary. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations on 9/10/2024 at 3:15 PM and 3:42 PM revealed Resident #31 sitting on the toilet in the residents' bathroom. The bathroom call bell was not audible and did not illuminate above the room door. The designated interim system tap bell was observed on the bedside table and not within Resident #31's reach. During an interview and observation on 09/11/2024 at 3:24 PM, Resident #31 stated they fell coming out of the bathroom on 8/27/2024 because they were trying to pull up their pants and fell backwards. Resident #31 stated they found out today that the bathroom call bell did not work. Resident #31 stated a tap bell had not been in the bathroom prior to that day. Resident #31 stated they were aware of the bedside tap bell and knew how to use it. Resident #31 demonstrated how to use the bedside tap bell. Resident #31 stated when they tapped the bell, staff did not come to check on them for a long time because they could not hear it. During an observation on 9/10/2024 between 9:30 AM and 4:30 PM the call bells on Unit 3 were not audible at the central nursing station or throughout the hall for 37 residents. The call bell light did not illuminate above the room door for Residents #5, #11, #15, #31, #59, #75, #78, and #89. The interim communication tap-bells in the room of Residents #59, #78, and #89 were broken. The interim communication tap-bells in the room of Residents #7, #8, #50, and #56 were not audible in the corridor. Resident #23 did not have an interim communication tap-bell. The low side shower room toilet and front shower call bells were not audible. There was no documented evidence from 4/5/2024 through 9/11/2024 that the facility implemented tap bell function and placement logs. There was no documented evidence from 4/5/2024 through 9/11/2024 that care plans were updated, or that interventions were implemented to address the residents' ability to contact staff while Unit 3 had no functioning centrally located audible call bell light system. There was no documented evidence the facility increased monitoring for all residents on Unit 3 as per the 4/8/2024 Interim Quality Assurance Meeting which documented modification of usual operations that potentially impact routine safety and wellbeing. During an interview on 9/5/2024 at 10:41 AM and 9/10/2024 at 4:37 PM three Certified Nurse Assistants (#5, #6, and #7) stated they were not aware the Unit 3 call bell system was not functioning. During an interview on 09/10/2024 at 5:43 PM the Administrator stated they believed the call bell system on Unit 3 had been out since sometime in April 2024, and the Department of Health was notified. The Administrator stated they did not know why it was taking so long for the call bell system to be repaired. The Administrator stated tap bells had been placed in resident rooms on Unit 3 after the call system stopped working and staff were to provide increased monitoring. The Administrator stated they were not sure if there was documented evidence of such increased monitoring. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/10/2024 at 6:03 PM the Director of Maintenance stated the problem with the Unit 3 call bell system started in 4/2024. The problem was identified when the staff could not hear call bells, as there was a problem with the centrally located call bell system. Tap bells were provided by the maintenance department to all residents and the facility tried to replace the old call bell system. The Director of Maintenance stated the tap bells in some resident rooms often went missing. The Maintenance Director stated they did not receive a proposal to address the problem with the Unit 3 call bell system until late April early May. The Maintenance Director stated they inquired every week with the Regional Office and were told they did not know when the new call bell system would be installed. During an interview on 09/11/2024 at 10:57 AM, Licensed Practical Nurse #1 stated they were not sure if call bell logs were previously started because they did not normally work on the unit. Licensed Practical Nurse #1 stated after checking the binder, there was no documentation to indicate monitoring logs were being done. During an interview on 09/11/2024 at 11:00 AM, Registered Nurse #2 stated they worked per diem (works as needed), and they were not aware when or if call bell rounding logs and/or increased monitoring logs were being completed on Unit 3. During an interview on 09/11/2024 at 11:01 AM, the corporate Director of Nursing stated they did not have documented call bell rounding logs and could not confirm that increased monitoring logs were completed prior to 9/11/2024. During an interview on 09/11/2024 at 3:09 PM, Resident #23 stated there was no bedside tap bell yesterday, and they had to yell for help. Resident #23 further stated sometimes they would become upset/cry when no one came to help them. Resident #23 demonstrated use of the tap bell at that time. During an interview on 9/11/2024 at 1:53 PM the Controller at the contractor company that provided a proposal for the work to be done on the facility call bell system stated the 1st contract proposal was dated 4/17/2024. The Controller stated the proposal went out to the facility, but that no work could be started until after they received a deposit for work to be done. The Controller stated there had been a delay and issues with receiving payment from the facility, but they finally did receive the deposit on 8/29/2024. The Controller stated they thought someone was at the facility recently (Monday) to start the work. The facility was notified of the Immediate Jeopardy on 9/11/2024 at 6:27 PM. The Immediate Jeopardy was removed on 9/13/2024 prior to the completion of the survey. The facility implemented the following plan to remove the immediacy: - The facility assigned two to four staff members as monitors to make continuous rounds on Unit 3. Monitoring logs for room rounds dated 9/11/2024 through 9/13/2024 were presented to the survey team by the facility with no negative findings. -Staff education regarding room rounds on Unit 3 was conducted with 90.2% completion as of 9/13/2024. (continued on next page)

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Unit 3 residents were assessed for the ability to use the call bell system. Three residents were assessed by therapy as not being able to use a call bell. - The Policy and Procedure titled Alternate Call Bell System for use during a Partial or Full Call Bell System Downtime was initiated on 9/13/2024. -The Temporary Alternative Call Bell System was installed in Unit 3 rooms on 9/13/2024 with a receiver located at the desk. 10 NYCRR 415.29