| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335323 | A. Building<br>B. Wing | 05/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Eleanor Nursing Care Center | 419 North Quaker Lane<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214<br><br>Based on interviews and record review conducted during the recertification and abbreviated surveys (NY00376085 and NY00370712) from 4/29-5/6/2025 , the facility did not ensure the resident representative/emergency contact was notified for 2 of 2 residents (Resident #8 and Resident #201) reviewed for notification of change. Specifically, Residents #8 and #201 were transferred to the hospital and their resident representative was not notified.<br><br>Findings include:<br><br>1) Resident #8 had diagnoses that included end stage renal disease, respiratory failure, and atrial fibrillation.<br><br>Resident #8's family member was listed as the emergency contact on the contact page of the medical record.<br><br>The Five Day Minimum Data Set assessment dated [DATE] documented Resident #8 had intact cognition and required maximum assistance, or dependent on staff, for most activities of daily living except eating and oral hygiene.<br><br>The Facility Policy titled Notice of Transfer or Discharge, last revised October 2024, documented the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The Social Worker and Nurse Supervisors/Unit managers are responsible to ensure residents, and their representatives are notified of any transfers and discharges in a timely manner indicating reason of transfer and discharge.<br><br>A nursing progress note dated 3/16/2025 documented Resident #8 was sent to the hospital to confirm perma- catheter placement.<br><br>A nursing progress note dated 3/17/2025 documented Resident #8 was admitted to the hospital for hypotension and end stage renal disease.<br><br>There was no documented evidence of the any emergency contact/representative notification when Resident #8 was sent to the hospital on 3/16/2025.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nursing progress note dated 3/19/2025 documented Resident #8 returned to the facility from the hospital.<br><br>A nursing progress note dated 3/21/2025 documented an attempt to return a call to Resident #8's family member.<br><br>During an interview on 05/02/25 at 11:24 AM, Resident #8 stated the facility did not always contact their family member when they went out to the hospital. They stated they recalled a time when they went to the hospital, did not have their phone and could not personally make the call. The family member did not until days later.<br><br>During an interview on 5/5/2025 at 9:07 AM, the Director Social Services stated when a resident went out, the floor nurse or social services would notify the family. Resident #8 was admitted to the hospital on 3/17/25 and the nurse documented a call to the family member on 3/21/25 after Resident #8 returned to the facility. This was not a reasonable amount of time to contact the family of a change in the resident's status and transfer.<br><br>During an interview on 05/05/25 at 2:50 PM, the Director of Nursing stated that the floor nurse or Supervisor should notify the representative/emergency contact when a resident was transferred to the hospital.<br><br>51874<br><br>2) Resident #201 had diagnoses that included sepsis, viral encephalitis, and chronic lymphocytic leukemia.<br><br>Resident #201's family member was listed as the emergency contact on the contact page of the medical record.<br><br>The Admissions Minimum Data Set assessment dated [DATE] documented Resident #201 had intact cognition and required maximum assistance, or dependent on staff, for all activities of daily living.<br><br>A medical progress note dated 1/21/2025 documented Resident #201 was admitted to the hospital for other medical issues.<br><br>During an interview on 5/02/2025 at 12:17 PM, Resident #201's family member stated they were not contacted by the facility when the resident was sent to the hospital. The family member stated they were contacted by the hospital that the resident had been brought to the hospital emergency department.<br><br>There was no documented evidence of the any emergency contact/representative notification when Resident #201 was sent to the hospital on 1/21/2025.<br><br>10 NYCRR 415.3(f)(2)(ii)(d) |

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50766<br><br>Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (NY00370712) from 4/29/25 to 5/6/25, the facility did not ensure the resident's right to a safe, clean, comfortable, and homelike environment. This was evident for 3 of 3 (1st, 2nd, and 3rd Floors) resident units during environmental observation. Specifically, 1) Resident #93 had a broken closet bar preventing clothing from being hung on top of closet unit, 2) Resident #35 was not provided with a lock box resulting in the loss of funds, 3) each resident unit contained heat/air conditioning radiators were dusty, rusty, and had exposed conductor fins that were damaged and bent, 4) room [ROOM NUMBER] had missing closet doors, 5) the 3rd Floor dayroom had inadequate lighting, and 6) the 3rd floor was noisy due to a defective beeping call bell system.<br><br>The findings are:<br><br>The facility policy titled Resident Right - Safe/Clean/Comfortable/Homelike Environment, revised 5/2024, documented: It is the policy of the facility to provide a safe, clean, comfortable homelike environment in such a manner to acknowledge and respect resident rights. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>1) During an interview on 05/02/25 at 10:39 AM with Resident #93's family representative, they stated that Resident #93's closet had been missing a bar at top of closet to hang clothing on for over six months. They stated they requested the closet bar be replaced several times with Director of Social Work and had discussed at resident care plan meetings.<br><br>During an interview on 05/06/25 at 2:44 PM, the Director of Social Work stated they had a care plan meeting for Resident #93 on 4/21/25 and the resident representative discussed the closet rod. They also stated they may have received emails from Resident #93's representative in the past regarding the bar. They stated they discussed the missing closet bar on 4/21/25 with the Director of Maintenance. They stated the Director of Maintenance stated they did not have a replacement bar and would look for a suitable replacement and/or order if necessary. They stated they could not remember if a work order request had been completed but they had a verbal conversation with the Director of Maintenance. They stated they informed resident representative at recent care plan meeting that a replacement for the closet bar would be worked on by Director of Maintenance.<br><br>During an interview on 05/06/25 at 2:56 PM, the Director of Maintenance stated they may have been informed of Resident #93's missing closet bar by Director of Social Work and forgot.<br><br>2) During an interview on 04/30/25 at 9:48 AM, Resident #35 stated approximately $45 which they kept in wallet on bedside table was missing. Resident #35 stated they did not have a lock box and were not aware of being offered one or exactly what a lock box was.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/02/25 at 10:00 AM, the Director of Social Work stated stated lock boxes were offered to residents and that lock box availability had been addressed at resident council meetings. They were not aware if Resident #35 was offered a lock box in the past.<br><br>40686<br><br>3) From 4/29/2025 at 2:45 PM to 4/30/2025 at 12:31 PM, the following was observed during environmental observations of residential units on the 1st, 2nd, and 3rd Floors: room [ROOM NUMBER] had a heating/air conditioning radiator unit that was heavily soiled with dust, black stains on the top metal grate, and metal conductor fins located beneath the metal grate that were bent and pinched closed; room [ROOM NUMBER] and the 2nd Floor dayroom were observed with heating/air conditioning radiator units soiled with dust, debris, black stains, and conductor fins that were bent and crushed; and, room [ROOM NUMBER], 324, 316, and the 3rd Floor dayroom contained heating/air conditioning units that were dusty, filled with debris, covered in black stains, and contained bent and crushed rusty conductor fins.<br><br>4) From 4/29/2025 at 12:25 PM through 5/06/2025 at 2:22 PM, room [ROOM NUMBER] contained a closet for the W-bed and D-bed with various clothes hanging from hangers on a long pole. Although the closet had a track around the perimeter to allow for a sliding door on each side of the closet, no closet doors were observed in room [ROOM NUMBER].<br><br>5) From 4/29/2025 at 12:25 PM through 5/06/2025 at 2:22 PM, there were multiple observations of the 3rd Floor dayroom with 4 to 6 out of 9 ceiling fluorescent light fixtures illuminated while residents were present for lunch and activities. This resulted in a dim and poorly lit room.<br><br>6) From 4/29/2025 at 12:25 PM through 5/06/2025 at 2:22 PM, the 3rd Floor unit was observed with a beeping noise that was audible in the hallways, by the nursing station, and from the dayroom. The beeping occurred in 1-second intervals and was observed coming from a call-bell system phone intercom on the wall next to the medication room door behind the nursing station.<br><br>On 5/01/2025 at 1:51 PM, 5/01/2025 at 3:56 PM, and 5/02/2025 at 3:07 PM, the Director of Plant Operations was interviewed and stated they were responsible for overseeing the maintenance and repairs for the facility including resident units. There were logbooks on each unit where staff could communicate repair needs for the unit when the maintenance staff were not available. The Director of Plant Operations stated they made rounds on the units and pointed out areas that needed to be addressed to their 2 maintenance workers. The facility did not have a system to track repairs completed by maintenance staff and/or indicate whether an outside vendor was required to address the issue. The Director of Plant Operations stated heating/air conditioning radiator units were vacuumed by the housekeeping staff quarterly to ensure they remain clean. The Director of Plant Operations stated the beeping heard on the 3rd Floor was nonstop, 24-hours daily, and stemmed from a call bell telecom system at the nursing station. The facility changed their call bell system and vendor within the last 1-2 years and, when the Director of Plant Operations inquired about the noise coming from the unit, the call bell vendor responded that the system was functioning properly and did not explain any further how to address the issue. An activated call bell produced a separate beeping noise and corresponded to a blinking hallway light indicating call bell activation location. The Director of Plant Operations stated the call bell system was the same on each unit; however, the 3rd Floor was the only unit with the beeping noise.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10 NYCRR 415.5(h)(2) |

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|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214<br><br>Based on interviews and record review during the recertification and abbreviated surveys (NY00376085 and NY00370712) from 4/29-5/6/2025, the facility did not ensure that the resident, resident's representative(s), or ombudsman was notified of the transfer or discharge, and the reasons for the move, in writing and in a language and manner they understand for 2 of 4 residents (Resident #8 and Resident #201) reviewed for hospitalization . Specifically, 1) the facility did not complete a discharge notice or notification of bed hold for Resident #8 when they were hospitalized on [DATE], 3/3/2025, and 3/17/2025. The ombudsman was not notified of Resident #8's 2/2/2025 hospitalization . 2) The facility did not complete a discharge notice or notification of bed hold for Resident #201 when they were discharged to the hospital on 1/21/2025.<br><br>Findings include:<br><br>Resident #8 had diagnoses that included end stage renal disease, respiratory failure, and atrial fibrillation.<br><br>The Five Day Minimum Data Set assessment dated [DATE] documented Resident #8 had intact cognition, required maximum assistance or was dependent on staff for most activities of daily living except eating and oral hygiene.<br><br>The Facility Policy titled Notice of Transfer or Discharge, last revised October 2024, documented the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The Social Worker and Nurse Supervisors/Unit managers are responsible to ensure residents, and their representatives are notified of any transfers and discharges in a timely manner indicating reason of transfer and discharge. Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the transfer notice to the ombudsman only needed to occur as soon as practicable.<br><br>The nursing progress notes dated 2/2/25 and 2/3/25 documented Resident #8 was discharged to the hospital and admitted with hyperkalemia.<br><br>There was no documented evidence of the 2/2/25 discharge notice or notification of bed hold in the medical record for Resident #8.<br><br>There was no documented evidence of notifying the ombudsman of Resident #8's 2/2/25 hospitalization .<br><br>The nursing progress notes dated 3/3/25 documented Resident #8 was discharged to the hospital and admitted with shortness of breath and end stage renal disease.<br><br>There was no documented evidence of the 3/3/25 discharge notice or notification of bed hold in the medical record for Resident #8.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The nursing progress notes dated 3/16/25 and 3/17/2025 documented Resident #8 was discharged to the hospital and admitted with hypotension and end stage renal disease.<br><br>There was no documented evidence of the 3/16/25 discharge notice or notification of bed hold in the medical record for Resident #8.<br><br>During an interview with the Director Social Services on 05/05/25 at 9:07 AM, they stated that discharge notices were completed by nursing or social services and were uploaded into the medical record. They stated they were unable to find evidence of the discharge notices or notification of bed hold for Resident #8 on 2/2/25, 3/3/2025, and 3/16/2025. They stated the ombudsman was notified by social services via email. They were unable to find evidence of the ombudsman being notified of Resident #8's 2/2/2025 hospitalization .<br><br>51874<br><br>2) Resident #201 had diagnoses that included, but not limited to sepsis, viral encephalitis, and chronic lymphocytic leukemia.<br><br>Resident #201's family member was listed as the emergency contact on the contact page of the medical record.<br><br>The Admissions Minimum Data Set assessment dated [DATE] documented Resident #201 had intact cognition and was maximum assist or dependent on staff for all activities of daily living.<br><br>A medical progress note dated 1/21/2025 documented that Resident #201 was admitted to the hospital for other medical issues.<br><br>During an interview on 5/02/2025, resident #201's family member stated they were not contacted by the facility when the resident was sent to the hospital. The family representative stated they were contacted by the hospital that their family member had been brought to the emergency department.<br><br>There was no documented evidence of the 1/21/2025 discharge notice or notification of bed hold in the medical record when Resident #201 was sent to the hospital on 1/21/2025.<br><br>10NYCRR 415.3(i)(1)(iii)(a-c) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214<br><br>Based on observations, interviews, and record reviews conducted during the recertification and abbreviated surveys (NY00376085) conducted from 4/29-5/6/2025, the facility did not ensure that the Comprehensive Care Plan was revised to reflect the resident's current condition for 3 of 8 residents reviewed for accidents (Resident #8, Resident #9, and Resident #38). Specifically, Resident #8, Resident #9, and Resident #38's Comprehensive Care Plan was not updated to reflect falls that occurred, and the effectiveness of interventions or new interventions implemented after the falls.<br><br>Findings include:<br><br>The facility policy, Comprehensive Resident Centered Care Plans, reviewed 1/2025 documented it is the policy of the facility to promote interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals. The Care Plan will be updated and/or revised for the following reasons: significant change in the resident's condition, a change in planned interventions, goals are achieved and new goals established to meet current resident needs and/or goals, or new diagnosis, new medications, or abnormal labs.<br><br>The facility policy, Falls and Fall Risk Managing, revised 9/2022 documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The policy further documented if falling reoccurs despite initial interventions, staff will implement addition or different interventions or indicate why the current approach remains relevant while keeping the resident safe and preventing re-occurrence.<br><br>1) Resident #8 had diagnoses that included, but not limited to, end stage renal disease, atrial fibrillation, and peripheral vascular disease.<br><br>The five-day Minimum Data Set, dated dated dated [DATE] documented intact cognition, maximum assist to dependent for most ADLs, no falls since last assessment.<br><br>The nursing progress note dated 3/3/25 documented that Resident #8 had a fall while on stretcher when being transported to hemodialysis, the Nurse Practitioner was notified and assessed.<br><br>The medical progress note dated 3/3/25 documented Resident #8 sustained a fall and was sent to the hospital for evaluation.<br><br>The Accident and Incident report dated 3/3/25 documented the resident was secured in stretcher, wheel seemed to get caught between black top and bricks during transfer out of building. The Nurse Practitioner assessment was completed; the resident was sent to the hospital for evaluation. Statement from driver. Education provided to staff upon resident return for transferring resident.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Risk for Falls care plan dated 3/19/25 documented fall risk of 15, impaired mobility, mechanical lift status. Interventions included call bell in reach, mechanical lift 2 person assist for transfers, frequently used items within reach. There was no documented evidence of the fall on 3/3/25, or new interventions.<br><br>2) Resident #38 had diagnoses that included, but not limited to, peripheral vascular disease, anxiety disorder, and cerebrovascular accident.<br><br>The Quarterly Minimum Data Set, dated dated dated [DATE] documented moderately impaired cognition, independent to maximal assistance for activities of daily living, and no falls since last assessment.<br><br>The nursing progress notes dated 3/27/25 documented that resident sustained unwitnessed fall, denied hitting head, neuro status check completed.<br><br>The nursing fall event documentation dated 3/27/25 documented that resident found sitting on floor next to bed. Resident reported that he rolled from bed to floor. Denies hitting head. Blister right foot open and draining. Neuro status evaluated at time of incident. Resident referred to skilled occupational therapy services by nursing status post fall, 3-5 times per week, neuro checks for 24 hours, continue to monitor for 72 hours.<br><br>The Risk for Falls Care Plan last reviewed 12/4/24 documented goal of maintaining safety. Interventions included assessing resident ability to use call bell, promote appropriate lighting, ensure adequate footwear, call bell in reach. There was no documented evidence of the fall on 3/27/25, or new interventions.<br><br>3) Resident #9 had diagnoses that included, but not limited to, chronic obstructive pulmonary disease, iron deficiency anemia, and an aneurysm of iliac artery.<br><br>The admissions Minimum Data Set, dated dated dated [DATE] documented intact cognition, maximum assist or dependent on staff for most activities of daily living with no falls in the last six months.<br><br>The nursing progress note dated 4/08/25 documented Resident #9 had an unwitnessed fall out of bed. Resident #9 was placed on a 72-hour neurological watch.<br><br>The Risk for Falls care plan dated 2/13/25 documented a fall risk of 13 with interventions for low bed, frequent items within reach, call bell within reach, ensure a clutter free environment and others.<br><br>The Risk for Falls care plan was updated on 4/09/25 to document a fall risk of 16.<br><br>There was no documented evidence of new interventions or a new care plan for Falls created after the actual fall on 4/08/25.<br><br>(continued on next page) |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 05/05/25 at 1:45 PM the acting Director of Nursing stated when a fall occurs, the care plan should be updated with the fall and any interventions implemented after the fall occurred. They were unable to provide any evidence of any updates on the care plans for Resident #8 after their fall on 3/3/2025 or for Resident #38 after their fall on 3/27/2025 and Resident #9's fall on 4/8/2025.<br><br>During an interview on 05/05/25 at 1:56 PM the Regional Director of Operations assisted with the search and review of care plan for the falls sustained by Resident #8 and Resident #38. They stated they were unable to find any updates to the care plans that would reflect the falls or new interventions after the fall. However, they stated they were uncertain how Resident #8's care plan would have been updated after the fall on 3/3/2025. The fall involved an outside agency so uncertain what other interventions would have been added.<br><br>During a telephone interview on 5/5/2025 at 2:13 PM, the Regional Nursing Coordinator stated that they were unable to provide any documented evidence of updates to the care plans for Resident #8 after their fall on 3/3/2025 or for Resident #38 after their fall on 3/27/2025.<br><br>10 NYCRR 415.11(c)(2)(i-iii)<br><br>51874 |

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|---|---|---|---|
| | 335323 | A. Building<br>B. Wing | 05/06/2025 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>50766<br><br>Based on record review and interviews conducted during the Recertification and Abbreviated survey (NY00360576) from 04/29/25 to 05/06/25, the facility did not ensure that there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, 1. Upon review of the nursing staffing schedule from 3/29/25-5/29/25, for multiple days, on all three shifts of staffing for each unit, the facility did not provide adequate staffing to meet the needs of the residents and as per their Facility Assessment and, 2. Resident Council meeting attendees expressed concerns the facility did not staff enough nurse aides to provide them with necessary activity of daily living care.<br><br>The findings included:<br><br>The facility Staffing Policy reviewed 9/2024 documented the facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility shall further assure that staffing levels enable each resident to receive treatments, medications, diets and other health services in accordance with individual care plans.<br><br>The Facility Assessment last updated 2/25/25 documented the following minimum status requirements for direct care staff: licensed nurses 1-2 per unit per day days; 1-2 per unit evenings, and 1 at night. Certified nurse aides were documented 3-4 per unit day shift dependent on census, 2-3 per unit evenings, and 1-2 per unit nights.<br><br>A review of unit resident acuity provided by facility Administrator documented the following unit resident care needs: Unit 1: four mechanical lift transfer residents, three residents required assistance with eating (not including set up assistance), seventeen residents required total or extensive assistance with toileting, eight residents required limited assistance with toileting. One resident required two-person assistance with cares. Unit 2: six mechanical lift transfer residents, four residents required assistance with eating (not including set up assistance), twenty-one residents required total or extensive assistance with toileting, twelve residents required limited assistance with toileting. Unit 3: thirteen mechanical lift transfer residents, eleven residents required assistance with eating (not including set up assistance), twenty-six residents required total or extensive assistance with toileting, eight residents required limited assistance with toileting, two residents required two-person assistance with cares.<br><br>During an interview on 05/01/25 at 3:49 PM, the Interim Director of Nursing stated staffing had been difficult for the facility. They stated the facility pool of nursing was sufficient but the problems with staffing were related to callouts. Staffing coordinator or supervisor will call staff pool and offer incentives or bonuses to cover callouts. They stated the facility did not currently use staffing agencies. They had used agencies in the past and stopped using them preferring to have an internal staffing pool who were familiar with residents. They stated recruitment was on-going. They stated when facility did not meet minimum staffing numbers, ancillary staff, therapy department would assist getting residents out of bed and activities staff would assist handing out meal trays. They stated they had no concerns with having enough staff for resident acuity.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During interviews and observation on 05/02/25 at 02:48 PM and 05/06/25 at 10:52 AM, the Staffing Coordinator confirmed the following dates/shifts did not meet the facility minimum staffing requirements for certified nurse aides for the dates 3/29/25-5/5/25: on 3/30/25 unit 100 had 2.5 certified nurse aides evening shift, 4/1/25 Unit 200 had two certified nurse aides day shift, 4/5/25 units 100 and 300 had two certified nurse aides evening shift, 4/6/25 unit 200 had two certified nurse aides day shift, 4/9/25 units 100 and 200 had two certified nurse aides day shift, 4/10/25 units 100 and 200 had two certified nurse aides day shift, 4/11/25 and 4/12/25 unit 100 had two certified nurse aides day shift, 4/13/25 units 100 and 200 had two certified nurse aides day shift, 4/18/25 unit 200 had two certified nurse aides on day shift, unit 100 had two certified nurse aides evening shift and unit 300 and one certified nurse aide night shift, 4/23/25 unit 100 had three certified nurse aides for one hour only day shift, two certified nurse aides for remainder of shift, 4/27/25 unit 100 had two certified nurse aides day and evening shifts and one certified nurse aide night shift, 4/28/25 units 100, 200 and 300 had two certified nurse aides day shift, and 5/4/25 units 100 and 200 had two certified nurse aides day shift. The Staffing Coordinator stated facility unit staffing is planned daily as follows: three certified nurse aides for all units day and evening shift and two certified nurse aides for night shift. One, and occasionally two, nurses for Unit 100 depending on census, and one nurse for units 200 and 300. They stated that facility corporate staff provided the above staffing guidelines after a meeting in late 2024. They stated that they can staff four certified nurse aides on units for days and evenings only if resident census reaches 120 residents. They stated that nurses and certified nurse aides have expressed concerns with low staffing and heavy workload of units including many residents who require total assistance and two-person assist cares/transfers. They stated they have discussed staff complaints regarding staffing levels with Directors of Nursing and Administrator. They stated that Unit 300 certified nurse aide and nurse staff frequently complain of short staffing and acuity. They stated staff callouts have been excessive on all units with nursing staff. They attempt to restaff with staff already in the building and if not successful they text/call other staff members and offer a bonus. They stated weekends can be difficult, especially Sundays, to meet minimum staffing requirements.<br><br>During an interview on 05/05/25 at 9:37 AM, Certified Nurse Aide #21 stated they were presently working a double shift due to a callout. They stated this occurs frequently. They stated they usually work the night shift on unit 200 and there have been occasions where there has only been one certified nurse aide on night shift, or they are requested to report to another unit to assist with cares due to low staffing. They stated that they frequently must work into the next shift to complete tasks. They stated that the day shift can be challenging due to two meals with only two to three certified nurse aides. They stated that during day shift on unit 200, they care for approximately eighteen residents and approximately 25 during the night shift. They stated the facility used to have four certified nurse aides on units during day and evening shifts and it was reduced to three resulting in difficulty completing resident cares.<br><br>During an interview on 05/05/25 at 10:04 AM, Certified Nurse Aide #24 stated unit 200 staffing routinely is three certified nurse aides and one nurse. They stated they have discussed the need for another certified nurse aide with Staffing Coordinator who stated they were only allowed to staff unit with three certified nurse aides. They stated when unit had three or less certified nurse aides, they have difficulty completing resident cares and frequently must work into the next shift to complete. They stated there have been numerous occasions when unit 200 has had two certified nurse aides instead of three due to callouts. They stated due to low staffing, tasks are rushed and stressful.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 05/05/25 at 10:34 AM, Certified Nurse Aide #23 stated they routinely work on unit 300. They stated the facility was short staffed and there were frequently 2 certified nurse aides on unit due to callouts. They stated they often missed taking a lunch break and worked into the next shift to complete tasks. They stated the facility used to staff the unit with four certified nurse aides and lowered to three certified nurse aides. They stated unit 300 was a heavy workload unit due to most residents requiring monitoring due to dementia diagnosis and dependence for activities of daily living cares. They stated due to low staffing, resident cares were rushed. They stated day shift had two meals which was time consuming because unit had many residents who required assistance with eating. They stated during night shift, there were times when there was only one certified nurse aide on unit and cares were not completed. They stated that frequent staff lateness/leaving early also affected cares completion and resident breakfast service. They stated that on 5/4/25, the unit nurse was also the facility supervisor and had to leave the unit at times to attend to other units. They stated they had addressed staffing concerns to Staffing Coordinator in writing in the past.<br><br>During an interview on 05/05/25 at 10:58 AM, Registered Nurse Supervisor #32 stated they frequently worked as nurse on unit 300 and worked as facility supervisor. They stated unit 300 was appropriately staffed with three aides due to the Activities Department staff being present and engaging residents. They stated they had one-two activities members on the unit from 7 AM-3 PM. They stated there were occasions when certified nurse aide staff must work into the next shift to complete assigned tasks. They stated Unit 300 had one nurse assigned to unit and that a second nurse was needed to assist with cares, documentation monitoring, de-escalation and treatments. They stated there were times when there were less than the minimum three certified nurse aides on unit 300 and the pull certified nurse aides from other units to assist or call for all hands-on deck assistance to meet resident needs, usually for meals. When this occurred, the activity, therapy, and administrative staff would assist with resident monitoring and food tray distribution. They stated evening and weekends had the most certified nurse aide callouts, leading to less than three certified nurse aides on units. When call outs occur, Staffing Coordinator and Administrator were notified, and staff re-assigned. They stated unit 300 relied on Activity Department staff to keep residents occupied and monitored while nursing staff completed tasks and cares.<br><br>During a follow-up interview and observation on 05/05/25 at 4:18 PM with the Interim Director of Nursing, facility acuity was reviewed. They stated that it would be difficult to ensure certified nurse aide task would be completed when three or less certified nurse aides were assigned to units. They stated low staffing levels could negatively affect resident cares.<br><br>During an interview and observation on 05/05/25 at 4:34 PM, the Regional Human Resource/Payroll Director, stated that the current minimum staffing for all units was three certified nurse aides for day shift, three certified nurse aides for evening shift and two certified nurse aides for night shift. They stated that the Staffing Coordinator was allowed to staff 4 or more certified nurse aides per unit for day or evening shift. During the interview, a review of the unit acuity was observed with Regional Human Resources Director. They stated it would be difficult for the minimum staffing guideline of three certified nurse aides on each unit to complete all tasks. They stated that certified nurse aides sometimes must work into next shift to complete assigned tasks. They stated that staff frequently were requested to cover additional shifts or stay later into shifts to cover callouts.<br><br>40686<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 2.) The Resident Council Meeting Minutes dated 2/27/2025 documented attendees reported that nurse aides refused to take them out of bed in the morning saying they were short of staff. There was no documented evidence these concerns or requests were addressed by the facility.<br><br>The Resident Council Meeting Minutes dated 3/31/2025 documented attendees expressed concerns regarding their call bell being answered timely and weekend staff sleeping or using their phones while working. There was no documented response to the groups nurse staffing concerns.<br><br>The Resident Council Meeting Minutes dated 4/24/2025 documented attendees expressed concerns that weekend nursing staff were on their phones, were wearing ear buds, and/or were not addressing resident needs. There was no documented evidence these concerns were addressed.<br><br>On 4/30/2025 at 11:07 AM, Resident Council Meeting was held with Residents #103, 48, 46, 90, 86, 66, 29, 31, 10, and 28 in attendance. All those in attendance stated they expressed nurse staffing concerns during previous resident council meetings because residents had to wait a long time for call bells to be answered, food to be delivered, and to receive activities of daily living care from nursing staff due.<br><br>On 5/06/2025 at 2:22 PM, the Administrator was interviewed and stated they regularly attended Resident Council meetings. The Administrator stated meeting attendees expressed their concerns with the facility's nursing staffing. The Administrator stated the facility offered bonuses and incentives to attract and keep staff.<br><br>10 NYCRR 415.13 |