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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on observation, interview, and record review during a recertification survey from 9/5/24 to 9/17/24, the facility did not ensure residents had the right to a dignified experience for 3 of 6 residents. (Residents #80, #401 and # 97) reviewed for dignity. Specifically, 1.) A Registered Nurse was observed standing over Resident #80 and Resident #97 while assisting the residents with their meals. 2.) Resident #401 was observed in the dining room with other residents while wearing a hospital gown and/or sweatshirt with no pants. and 3.) On 9/12/24 on the first floor hallway outside room [ROOM NUMBER] (a resident's room on unit one) Certified Nurse Aide #11 verbally labelled the residents who needed to be fed as Feeders. The findings include: The Facility policy titled Residents' Rights dated 8/22 documented protect the dignity and well-being of the residents by providing a dignified, respectable and a comfortable living environment. 1. Resident # 80 was admitted to the facility with diagnoses including Parkinson, Diabetes, and Alzheimer's disease. The 8/27/24 Annual Minimum Data Set (an assessment tool) documented Resident #80 had severely impaired cognition and required partial to moderate assistance from staff with eating. The 9/1/24 Comprehensive Care Plan titled Activities of Daily Living documented Resident #80 required partial to moderate staff assistance with all cares. During observation on 09/05/24 at 12:49 PM, Registered Nurse #26 was standing over Resident #80 while feeding them their meal. Resident # 97 was admitted to the facility with diagnoses including Congestive Heart Failure, Diabetes, and Dementia. The 8/7/24 Annual Minimum Date Set documented Resident #97 had moderately impaired cognition and required partial to moderate assistance with eating. The 8/8/2024 Comprehensive Care Plan titled Activities of Daily Living documented Resident #97 required moderate staff assistance with all cares. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 09/05/24 at 1:00 PM, Registered Nurse #26 was standing over Resident #97 in the dining room, while feeding them their meal. During an interview on 09/12/24 at 10:25 AM, Licensed Practical Nurse #27 stated when assisting residents' with their meals, staff should be seated and facing the resident/s. The residents mealtime should be a personal experience. During an interview on 9/17/2024 at 12:10 PM, Certified Nurse Aide #29 stated when feeding the residents they should be seated at eye level, and facing the resident. During an interview on 9/17/2024 at 12:05 PM, Licensed Practical Nurse #28 stated staff should be seated and facing the resident when assisting the residents with their meal. 2. Resident #401 was admitted to the facility with diagnoses including but not limited to Unspecified Dementia. The 9/1/24 Admission Minimum Data Set Assessment documented Resident #401 had mildly impaired cognition, and was dependent on staff for dressing the upper/lower extremities. During an interview and observation on 9/05/24 at 11:30 AM, Resident #401 was observed sitting in the unit day room watching television,wearing a hospital gown. Resident #401 stated they sit like this everyday. Resident #401 stated they would like to wear their own clothes, but they did not have clothes to wear. During observation on 9/06/24 at 11:46 AM and 1:35 PM, Resident #401 was sitting in the unit day room/dining room, wearing a sweat shirt over a hospital gown. During observation on 9/06/24 at 1:38 PM Resident # 401's closet and drawers contained no resident clothing. During an interview on 9/13/24 at 11:50 AM Certified Nurse Aide #6 stated Resident #401 wore a hospital gown after admission to the facility because they had no clothing. Certified Nurse Aide #6 stated if a resident does not have clothing, staff would check the laundry or at times staff would bring clothing in for the residents. During observation on 9/16/24 at 1:00 PM Resident #401 was observed in the dayroom wearing a sweatshirt and without pants. During an interview on 9/16/24 at 12:53 PM the Corporate Social Worker stated the facility had a donation box of clothing and if a resident did not have clothing they would obtain their size and try to locate, label, inventory and provide clothing to the resident. The Corporate Social Worker stated this was supposed to be done within the first 24 hours post admission, as long as it was not a weekend. If it was a weekend the staff could grab items from the donation box and provide them to the resident. After checking the electronic medical record, the Corporate Social Worker stated thy could not locate a note to indicate that Resident #401 had been offered clothing or that the family had been contacted to request clothing prior to 9/6/24.The Corporate Social Worker stated Resident #401 should have been offered clothing from the donation box. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/16/24 at 1:25 PM Licensed Practical Nurse #4 stated in the past they would reach out to the social worker to find out if they could work on getting clothes or donated clothes, whenever a resident did not have any of their own clothes. Licensed Practical Nurse #4 stated they knew Resident # 401 didnot have clothes, so they ended up bringing in clothes from home for the resident. Licensed Practical Nurse #4 stated they were not aware Resident #401 did not have pants to wear on this day. 3. During an interview and observation on 9/12/24 at 12:09 PM on the first-floor hallway outside room [ROOM NUMBER] with residents in wheelchairs close by, Certified Nurse Aide #11 was asked about staffing on the unit and feeding residents. Certified Nursing Aide #11 stated there were two feeders on the unit and pointed to a room at the end of the hallway. Certified Nurse Aide #11 stated they would get to the feeders next. During an interview on 9/12/24 at 12:09 PM Certified Nurses Aide #11 was asked why they used the term feeders when speaking of residents, and they stated they did not know they could not do that. During an interview on 9/16/24 at 1:41 PM the Director of Nursing stated staff were not allowed to call residents by nicknames and certainly not use the word feeders. 10 NYCRR 415.3 (d)(i)(i) 41666 50729

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47626 Based on interview, and record review conducted during the recertification survey from 9/05/2024 to 9/17/2024, the facility did not ensure residents had a right to organize and participate in resident groups in the facility. Specifically, during a Resident Council meeting on 9/9/2024 at 11:32 AM, Residents #96, #66, #88, #70, #30, #4, #33 and #10 stated it had been a couple of months since they last attended a resident council meeting, because they did not know who should be assisting them. There were no documented resident council minutes for April-July 2024. The findings are: Policy and Procedure dated 10/2020 documented per the regulation found at S483.10(f)(5), residents of a skilled nursing/long term care facility have a right to organize and participate in resident groups in the facility. The Facility promotes the residents' participation in the Resident Council meeting. During a survey scheduled Resident Counsel meeting on 09/09/24 at 11:32 AM attending residents stated it had been a couple of months since the last Resident Council meeting. The residents stated the activities department had previously assisted them, but they did not know who should be assisting them at this time. The Resident Council minutes dated 3/6/24, and 8/15/24 revealed there were no Resident Council minutes for April 2024, May 2024, June 2024, and July 2024. During the survey the Director of Recreation and/or Director of Social Work were not available for interview. During an interview on 9/17/24 at 12:00 PM the Administrator and the Director of Nursing stated they became aware when they started working at the facility that Resident Council meetings were not being held on a regular basis. The Administrator and Director of Nursing stated they were aware meetings should be held on a regular basis and there should have been a staff liaison assigned. The Administrator and Director of Nursing stated they scheduled a meeting on 8/15/24 to introduce themselves to the members of the Resident Council. The meeting was hosted by the activities director. The Administrator and Director of Nursing stated the facility did not have a President of Resident Council, prior to the Resident Council meeting scheduled during the onsite survey. NY CRR 415.5(c)(1-5)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 50729 Based on observation, interview, and record review during the Recertification Survey from 9/5/2024 to 9/17/2024, the facility did not ensure that each resident received an accurate assessment, reflective of the residents status for 1 of 6 residents reviewed for Activities of Daily Living and 1 of 1 resident reviewed for Respiratory Care (Resident #22). Specifically, the 8/8/24 Quarterly Minimum Data Set Assessment for Resident #22 did not accurately code/capture the residents impaired vision and use of oxygen. The Findings Are: Resident # 22 was admitted with diagnoses including but not limited to chronic obstructive pulmonary disease, neuromuscular dysfunction of bladder, and adult failure to thrive. The 3/12/24 Admission Minimum Data Set documented Resident #22 was cognitively intact and had highly impaired vision. The 5/27/24 Physician Order documented continuous oxygen 2 liters continuous. The 8/24 Administration Record documented continuous oxygen 2 liters via nasal cannula was administered. The 8/8/24 Quarterly Minimum Data Set documented Resident #22 was cognitively intact, was able to see fine detail and did not use oxygen. During observation on 9/06/24 at 9:22 AM Resident #22 was in bed, oxygen at 3 liters was being administered via nasal cannula. The food tray was set up in front of Resident #22, who was calling out for help. Resident #22 was observed with a fork in their hand and was unable to locate the food on the tray, Resident #22 was asking for help to eat and stated they could not see the food. During an interview on 09/16/24 at 11:12 AM when asked about coding Resident #22's 8/8/24 assessment as being able to see fine details such as regular print in newspapers, the Minimum Data Set Coordinator stated it looked like in the past Resident #22 could only see large print. The Minimum Data Set Coordinator stated in all honesty they wanted to reassess Resident #22's vision and correct the most recent Minimum Data Set Assessment. When asked about the coding in the last Minimum Data Set the Coordinator stated if the oxygen was not signed in the administration record they would not code it in the assessment. The Coordinator pulled up the 8/8 quarterly as well as the 8/24 Administration Record and stated that the oxygen was there and signed for, but not consistently. The Coordinator stated they did not know how they missed it. NYCRR 415.11

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47626 Based on observation, record review, and interview during the recertification survey conducted 9/05/2024 through 9/17/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 of 7 residents (Residents # 40) reviewed for pressure ulcers, and 1 of 5 residents (Resident #19) reviewed for unnecessary medications. Specifically, 1.) Resident #40 was not care planned for an actual Pressure Ulcer and 2.) Resident #19 did not have a plan of care in place to address the residents needs for Psychotropic drug use. Findings Include: Policy and Procedure: dated 2/2024 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 intervention and provide a means of interdisciplinary communication to ensure continuity in resident care. The findings are: 1) Resident #40 was admitted with diagnoses including but not limited to Parkinson's Disease, Peripheral Vascular Disease, and an amputation of lower leg. The 5/22/23 Care Plan titled At Risk for Skin Breakdown documented, encourage frequent changes in position, incontinent care, pressure relieving mattress, turning and positioning schedule. The 7/3/24 Quarterly Minimum Data Set (an assessment tool) documented Resident #40 was cognitively intact, required substantial to maximal assistance for activities of daily living, and had no unhealed pressure ulcers. The 7/9/24 Wound Note documented Sacrum Moisture Associated Skin Damage, unmeasurable. The 8/2/24 Hospital Patient Review Instrument documented Decubitus Stage II., Coccyx wound. The 8/3/24 Wound Care Consultant Note documented the resident was readmitted with a change in wound status of the sacrum. Resident left the facility with Moisture Associated Skin Damage and returned with an Unstageable wound. Patient will be reevaluated, and treatments as ordered. The 8/9/24 Wound Note documented Unstageable Pressure Ulcer to the Sacrum with measurements of 2.9 centimeters x 1.5 centimeters x 0.1 centimeters and 90% eschar (dead tissue). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/19/24 Wound Note documented a Stage IV Pressure Ulcer with measurements of 2.8 centimeters x 1. 3 centimeters x 0.1 centimeters. There was no documented evidence in the electronic medical record to address the actual Pressure Ulcer Unstageable or Stage IV was developed after the residents return from the hospital on 8/2/24. Observation on 9/05/24 at 3:36 PM Resident #40 was in bed sleeping positioned on their back, on an air mattress. During an interview on 9/09/24 at 9:47 AM Resident #40, stated they have a sore on their bottom and staff do change my dressing but not often enough. During an observation and interview on 9/12/24 at 11:46 AM of the sacral dressing change, Licensed Practical Nurse #28 stated we do the residents dressing, it has been improving since the return from the hospital. During an observation and interview on 9/16/24 at 09:43 AM, Resident #40 was in bed on an air mattress positioned on their back. Resident #40 stated the staff do help me turn but I do not think it is often enough. I am not sure how often they help me. During an interview on 9/16/24 at 1:56 PM the Wound Physician Assistant stated the resident had moisture associated skin damage, the resident went out to the hospital and upon return the sacral wound was noted to be an Unstageable pressure ulcer. The Wound Physician Assistant stated the wound was being treated and the resident was seen weekly during wound rounds. The pressure ulcer was restaged as a stage IV and the wound has shown ongoing improvement. The resident was on an air mattress, and should be turned and positioned, checked and changed as needed. This should be included in a care plan for actual pressure ulcer. During an interview on 9/17/24 at 3:02 PM Licensed Practical Nurse #28 stated the care plan should have been intiated by the Registered Nurse who completed the skin assessment upon the residents return from the hospital. 41666 2) Resident #19 had diagnoses of Type II Diabetes Mellitus, Major Depressive Disorder and Atrial Fibrillation. The Minimum Data Set, an assessment tool, dated 8/21/24, documented the resident was cognitively intact, and did not have mood or behavior problems. The physician orders documented the resident was prescribed Cymbalta 30 mg delayed release, 2 capsules one time a day, Rexulti 0.25 mg one tablet one time a day and Xanax 0.25 mg one tablet one time a day. The nursing care plan for Psychiatric Drug Use dated 9/4/24 has a goal that the resident will be maintained at the highest practicable level of psychosocial well-being as evidenced by reduction of depressive signs and symptoms while on lowest therapeutic dose of medication. There were no interventions for this goal in the resident's record. Other archived care plans for Psychotropic Drug Use were reviewed and none had interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Minimum Data Set Coordinator on 9/16/24 at 11:08 AM, they stated the resident had been in and out to the hospital and they will make sure the resident has a current plan of care. The Minimum Data Set Coordinator stated they do not know why there were no interventions but thinks maybe they got called away and the plan was not completed. 10 NYCRR 415.11(c)(1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50729 Based on observation, record review and interview conducted during the recertification survey from 9/5/2024 to 9/17/2024, the facility did not ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 1 of 7 residents (Resident #401) reviewed for pressure ulcers. Specifically, For Resident #401 with a left foot wound, treatments and weekly skin checks were not consistently documented as per physician order and/or care plan, a physician order was not obtained as per wound round recommendations for the implementation of heel booties and an air mattress, and Resident #401 was observed wearing a left air heel boot with velcro straps without a physician order. The Findings Are: Resident #401 was admitted on [DATE] with diagnoses including but not limited to Repeated Falls, Unspecified Dementia, and Pressure Ulcer of Left Heel. The 8/21/24 Care Plan titled Skin Integrity related to presence of wounds documented off load extremities, Certified Nurse Assistant evaluation of skin condition daily during care and report any skin abnormalities to nurse. The 8/21/24 Baseline Care Plan titled Presence of Pressure Ulcers/Blister located interior left heel, documented apply local treatments as ordered. The 8/23/24 Physician Order documented Santyl 250 unit/gram apply to left foot wound after cleanse with wound cleanser then apply abdominal pad and wrap with Kling daily. There was no documented evidence in the August-September 2024 Treatment Administration Record for the administration of Santyl to the left foot wound on 8/27, 8/28, 9/5, 9/6, 9/7, 9/10 and 9/11. The 9/1/24 Admission Minimum Data Set Assessment documented moderate cognitive impairment, had functional limitation of 1 upper extremity, was dependent for roll left to right, resident was at risk for pressure ulcers, had 1 stage 3 pressure ulcer and 3 unstageable pressure ulcers and 1 Suspected Deep Tissue Injury present on admission, had a pressure device for chair/bed/nutrition hydration to address skin conditions and application of ointments other than to feet and dressing to feet with/without topical medication, and received 5 days of occupational therapy and 7 days of physical therapy. The 9/3/24 Wound Physician Assistant Note for the 8/22/24 visit documented recommend reposition, heel booties and an air mattress. There was no follow up evidence in the 9/3/24-9/16/24 Physician Order for heel booties/air mattress as per Wound Physician Assistant recommendation (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 9/5/24 at 10:50 AM Resident #401 was observed in the dayroom resting in there wheelchair. The left heel was covered with a bandage. Both heels were resting on the wheelchair footrests. There were no heel booties in place/no heel offloading. During observation and interview on 9/06/24 at 11:50 AM Resident #410 was observed in the dayroom with the left foot on the floor. The left foot had an air heel lift boot in place. The velcro straps on the air heel lift boot were open. Resident #401 was attempting to reposition their left leg/foot and stated they would be fine if they could keep this up here, referring to left leg/foot. During observation on 09/12/24 at 9:30AM Resident #401 was in bed laying on their left side,There was an air heel lift boot with velcro straps resting on the mattress at the foot of the bed. There were no heel booties in place/no offloading. Resident #410 did not have an air mattress. During observation on 9/13/24 at 9:24 AM Resident #401 was sitting on the side of the bed, There was an air heel lift boot with open velcro straps on Resident #401's left foot. There were no heel booties in place/no offloading. Resident #410 did not have an air mattress. During an interview on 9/13/24 at 11:26 AM Physical Therapist #15 stated Resident #401 had a heel sore and was admitted to the facility with an air heel lift boot, which should be worn as much as possible. Physical Therapist #15 stated Resident #401 was supposed to have it on in bed, but the resident stated it was not comfortable. Physical Therapist # 15 stated Resident #401 will wear the air heel lift boot if they put them back to bed with it on, then in the morning it is not there. Physical Therapist #15 stated the air heel lift boot only had a velcro strap, so it can come off easily. Physical Therapist # 15 stated the air heel lift boot should be removed for skin checks. During an interview on 9/16/24 at 2:03 PM Licensed Practical Nurse #4 stated Resident #401 had a wound to their left heel, and treatments were supposed to be signed in the administration Record. Licensed Practical Nurse #4 stated there were no orders for the use of the air heel lift boot, but Resident #401 does wear it. Licensed Practical Nurse #4 stated Resident #401 was supposed to wear the air heel lift boot while they were in bed. Licensed Practical Nurse #4 stated there was a note in the electronic medical record indicating Resident #401 was seen by the wound care team on 9/3/24 and it was recommended that reposition, heel booties and an air mattress be put in place. Licensed Practical Nurse # 4 checked the electronic medical record and stated Resident #401 was actually seen on 8/22/24 and the note was not entered in the electronic medical record until 9/3. Licensed Practical Nurse #4 stated none of the wound recommendations were captured. Licensed Practical Nurse #4 was asked what was implemented in regard to the wound recommendations from 8/22/24 to 9/4/24 and they did not provide an answer. During an interview on 9/16/24 at 4:41 PM Registered Nurse #2 stated after checking the electronic medical record that the Wound Physician Assistant had notes in the electronic medical record dated 9/3/24 for 2 earlier visits. Registered Nurse #2 stated they were not aware the Wound Physician Assistant entered the offloading/air mattress recommendations as the notes were put in after the date the resident had actually been seen. During interview on 9/16/24 at 4:56 PM Certified Nurse Assistant #11 stated Resident #401 usually had a left leg brace on, and that they slept in it and unless they were being transferred, they wore the left leg brace all day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During follow up interview on 9/16/24 at 6:03 PM Registered Nurse #2 stated they knew Resident #401 should have their heels off loaded. Reviewed documentation in the chart with Registered Nurse #2 and they confirmed that the Wound Physician Assistant wrote air mattress, booties, and off-loading. Registered Nurse # 2 stated they make rounds with the Wound Physician Assistant and write down what the Wound Physician Assistant says as they are giving a description of the wound/s. Registered Nurse #2 stated they were responsible for reviewing the Wound Physician Assistant notes, changing orders, putting orders in place, and updating the care plan. Registered Nurse #2 stated Resident #401 did not use heel booties and did not have an air mattress as per the Wound Physician Assistant recommendation. NY CRR 415.12

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47626 Based on observation, record review, and interview during a recertification survey conducted (9/5/2024-9/17/2024), the facility did not ensure the provision of nutrition and hydration care and services for 1 of 5 residents reviewed for Nutrition (Residents # 22). Specifically, the facility did not ensure that For Resident #22 with a 9.79 % weight loss over 6 months, that meal intake was consistently monitored as per care plan. Additionally, Resident #22 with impaired vision was not reassessed to determine the level of assistance needed during meal intake. This is evidenced by: Resident # 22 was admitted with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Neuromuscular Dysfunction of Bladder, and Adult Failure to Thrive. The 3/5/24 Activities of Daily Living Care Plan documented eating supervision set up. The 3/6/24 Dietary Nutrition Risk Care Plan documented at risk for altered nutrition related to advanced age, variable by intake 25-75% and Body Mass Index of 17.2 indicative of underweight status interventions continue ensure plus three times daily, provide tray set up at meals, initiate super cereal at breakfast to help increase calorie intake. Monitor weights, labs, and intake. The weight record documented Resident #22 weighed 104.2 pounds on 03/06/2024. The 3/12/24 Admission Minimum Data Set Documented Resident #22 was cognitively intact, received supervision for eating, weighed 104 pounds, had no weight loss. The 5/31/2024 Mini Diet Assessment documented Body Mass Index 19.5 No weight loss. Moderate decrease in food intake. At risk for malnutrition. The June 2024 Certified Nurse Assistant Documentation Record documented no food consumption on 6/3, 6/6, 6/7, 6/8, 6/9, 6/10, 6/13, 6/14, 6/23, 6/26, and 6/28. The weight record documented Resident #22 weighed 97 pounds on 7/11/24, The July 2024 Certified Nurse Assistant Documentation Record documented no food consumption on 7/5, 7/6, 7/7, 10, 7/11, 7/13, 7/14. 7/19, 7/20, 7/21, 7/26, 7/27, 7/30 and 7/31/24. The weight record documented Resident #22 weighed 94 pounds on 08/07/2024. The 8/21/24 Minimum Data Set (an assessment tool) quarterly review documented supervision or touching assistance helper provides verbal cues and or touching/steadying and or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently During observation on 9/06/24 at 9:22 AM Resident #22 was in bed calling out for help, as they stated I am hungry. Resident #22 was observed holding a fork in their hand, but was unable to find food on the tray, The meal tray was set up in front of them on the overbed table. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 09/09/24 at 9:15 AM Resident #22 was in bed and stated they were upset because Certified Nurse Assistant #11 left them in the middle of feeding them. Resident #22 asked if there was an ensure on the tray. At 9:29 AM Resident stated I can't believe Certified Nurse Assistant #11 came to feed me and left I am not being taken care of properly I can't see, During interview on Licensed Practical Nurse #4 stated Resident #22 required set up for meals, everything needed to be opened and depending on the day sometime more assistance was needed. During an interview on 9/13/24 at 9:13 AM Registered Dietician #10 stated Resident #22 fed themselves and only needed tray set up. Registered Dietician #10 stated they did not know Resident #22 had a reduction in eyesight. Registered Dietician #10 stated that had they known Resident #1 had a visual deficit they might use a clock method, and would open food for the resident. During an interview on 9/13/24 at 10:34 AM Occupational Therapist #9 stated Resident #4 could feed themselves somethings, Resident #22 stated sometimes I can sometimes I can't. Occupational Therapist #9 stated they did not document meal intake percentages anywhere and stated they did not always communicate percent of food eaten to nursing. During an interview on 9/13/24 at 11:40 AM Certified Nurse Assistant #6 stated Resident #22 required meal set up. Certified Nurse Assistant #6 stated they were not sure if Resident #22 ate or not today. Certified Nurse Assistant #6 stated there were days the resident did not do so well, and at times when the Occupational Therapist was done assisting the resident, they did not always tell staff about the outcome of the meal. Certified Nurse Assistant #6 stated today the Occupational Therapist did not report to them how much the resident consumed. During a follow up interview on 9/13/24 at 10:58 AM Occupational Therapist #14 stated they were aware Resident #22 had vision problems, and the resident might benefit from a clock method or divided plate, Occupational Therapist #14 stated they did not document such recommendations in the electronic medical record but were sure they verbalized to nursing staff. Resident #22 can usually feed themselves, you just have to tell them what is on the tray. Occupational Therapist #14 stated they can feed themselves if they know what it is and if they can reach it, it would be ideal if someone stayed with them to ensure they take in adequate nutrition, but they are usually running short, and can not sit with Resident # 22 for 45 minutes or so, as this is time consuming and Resident # 22 gets frustrated if they feel rushed. Staff only have a limited amount of time. NY CRR 415.12(i)(1) 50729

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50729 Based on record review, observation and interview during the Recertification Survey the facility did not ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice for 1 of 1 resident reviewed for Respiratory Care (Resident #22). Specifically, Resident #22 with a physician order to receive continuous oxygen 2 liters/min was administered oxygen 3 liters/min via nasal cannula. The findings are: Resident #22 was admitted with diagnoses including Coronary Artery Disease, Congestive Heart Failure and Asthma. The 3/5/24 Care Plan titled Cardiovascular Disease documented provide oxygen as ordered, encourage resident to elevate head as needed. The 5/27/24 Physician Order documented continuous oxygen 2 liters/min The 8/08/24 Quarterly Minimum Data Set documented Resident #22 was cognitively intact, and did not receive oxygen therapy. The September 2024 Medication Administration Record documented continuous oxygen 2 liters/min was administered every shift. There was no documented evidence in the Medication Administration Record that oxygen 2 liters was administered on 9/6/24. During observation on 9/6/24 at 12:59 PM, 9/11/24 at 7:45 PM, 9/13/24 at 9:50 AM and 9/16/24 at 3:00 PM Resident # 22 was resting in bed with oxygen 3 liters/min being administered via nasal cannula. During an interview on 9/16/24 at 5:28 PM Registered Nurse #2 stated during report they were told Resident #22 was receiving 2 Liters of oxygen. At that time Registered Nurse #2 checked Resident #22's oxygen concentrator and stated it was not being administered at 2 liter/min as per physician order, but instead was being administered at 2.5 - 3 liters/min. Registered Nurse #2 stated when they did rounds they only checked to see if the residents were okay. Registered Nurse #2 stated at that time they did not check the oxygen concentrator settings. Registered Nurse #2 stated they normally checked the oxygen concentrator settings when they administered medications. NY CRR 415.12(k)(6)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47626 Based on interview and record review conducted during the Recertification Survey completed on 9/5/24-9/17/24, the facility did not ensure that the pharmacist reported irregularities to the attending physician, the facility's Medical Director and the Director of Nursing or that the attending physician documented in the medical record that the identified irregularities had been reviewed and what action should be taken for 3 of 5 residents reviewed for unnecessary medications (# 89, #83, and #19). Specifically, 1) Resident # 89 had no documented follow up for drug regimen reviews from 3/24-8/24. 2) Resident # 83 had no documented follow up for drug regimen reviews from 3/24-8/24 and 3)Resident #19 had no documented follow up for drug regimen reviews dated 3/21/24 and 4/15/24. The findings are: 1)Resident # 89 had diagnoses including but not limited to Metabolic Encephalopathy, Type 2 Diabetes, and Dysphagia The 1/29/24 Care Plan titled Psychiatric Drug Use documented assess behavior daily, and psychiatric management. The 7/16/24 Quarterly Minimum Data Set (an assessment tool) documented Resident #89 had severely impaired cognition. The 8/24 Physician Orders documented Rexulti 25 mg daily at bedtime for depression, Buspirone 7. 5mg 2 times a day for Anxiety and Mirtazapine 15 mg at bedtime for depression. The 3/19/24, 4/15/24, 5/19/24, 6/19/24, 7/25/24 and 8/26/24 Medication Regimen Reviews documented irregularities, see report. The 3/24 to 8/24 Drug Regimen Review Reports were requested for resident #89, and were not provided. There was no documented evidence in the 3/24-8/24 Electronic Medical Record of progress notes,and/or interventions to address the drug regimen reviews. There was no documented evidence in the Drug Regimen Review binder that the facility medical provider received, reviewed, or acted upon the pharmacy drug regimen review. 2) Resident #83 with Diagnosis of Dysphagia following unspecified Cerebral Vascular Disease, Depression, and Dementia. The 8/26/24 Quarterly Minimum Data Set documented the Resident #83 had severely impaired cognition and received antipsychotic, antianxiety, and antidepressant medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/24 Physician Orders documented, Cephalexin 500 mg 2 times a day for 10 days, Clonazepam 0. 5mg 3 times a day, Depakote Sprinkles 125 mg (500) 3 times a day. Trazadone 250mg bedtime, and Zyprexa 5 mg 1 time a day at bedtime. The 6/8/23 Care Plan titled Psychotropic Drug Use documented administer medications, and monitor the need for medication. The 3/24, 4/24, 5/24, 6/24, 7/24 and 8/24 Medication Regimen Reviews documented irregularities, see report. The 3/24 to 8/24 Drug Regimen Review Reports were requested for resident #83, and were not provided. There was no documented evidence in the 3/24-8/24 Electronic Medical Record of progress notes,and/or interventions to address the drug regimen reviews. 3) Resident #19 was admitted with diagnoses that include Chronic Obstructive Pulmonary Disease, Type II Diabetes Mellitus, and Atrial Fibrillation. The 8/21/24 Minimum Data Set documented Resident #19 was cognitively intact. The 3/19/24 Physician Orders documented Apixaban 5mg, Farxiga 10 mg and Bumex 2 mg, 3/29/24 Xanax . 25 mg, 4/19/24 Brillinta 90 mg , 4/22/24 Lantus Solostar U-100 and Moprolol Succinate ER 250mg 1/2 tab, 5/14/24 Cymbalta 30 mg, 5/17/24 Prednisone 250mg and 8/18/24 Rexulti .2.5mg. The 3/24-8/24 Pharmacy Drug Regimen Review documented the pharmacy reviewed the residents drug regimen. There was no documented evidence of follow up for which the pharmacy documented irregularities in 3/24 and 4/24. During an interview on 9/13/24 at 8:58 the Director of Nursing stated they get Pharmacon reports in an email. In addition, the physician gets reports in their email. The physician is supposed to print, sign and return a signed copy to the Director of Nursing. The Director of Nursing stated they did not go back and see if it if this had been done and stated they were working on a better system. They stated they started working at the facility in July 2024 and would only be responsible from that time period. During an interview on 09/16/24 at 11:27 AM the Director of Nursing stated the only Drug Regimen Reviews they had were available in the binder. The Director of Nursing stated when they started working at the facility in July 2024 they noted that the facility had not been receiving the Drug Regimen Reviews, and they emailed the pharmacy to request them. The Director of Nursing stated they were now receiving the reviews; but did not know about past reviews. The Director of Nursing stated the Pharmacist should send the Drug Regimen Reviews to them via email and they should be handed to the medical provider/s for a response, and any ordered interventions should be put in place. 10 NYCRR 415.18 (c)(2 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41666

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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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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41666 Based on observation, record review and interview during the recertification survey conducted from 09/5/24-09/17/24, the facility did not ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards. Specifically, 1) a cupful of morning medications was left for Resident #45 on their bedside table while the resident was in the bathroom and 2) Dakins' solution and a tube of Silver Sulfadiazine were left on Resident # 90s bedside table. The findings are: 1. Resident #45 had diagnoses of hepatic encephalopathy, hypothyroid and neoplasm of breast. The 9/5/24 Physician Order documented Resident #45 received Aldactone 25 mg, Vitamin E 268 mg, Ursodiol 300mg capsule, Tramadol 250mg, Propranolol 10 mg, Amlodipine 5mg, Gabapentin 100 mg and Acidophilus at 09:00 AM. During an observation on 9/05/24 at 10:35 AM Resident #45 was in the bathroom and a cup with approximately ten pills were observed on the resident's bedside table. The nurse was not in the resident room. During an interview on 9/5/24 at 10:40 AM Resident #45 poured the pills onto the table and a total of 13 pills were noted. Resident #45 stated the pills in the cup were their morning medications and consisted of cancer, thyroid, and heart medications but could not remember what the remaining pills were for. During an interview on 9/16/24 at 9:23 AM Licensed Practical Nurse #4 stated they knew they should not leave the residents medications at the bedside but had a lot of medications to give out. Licensed Practical Nurse #4 stated it would have been better to put the medications in the medication cart and return when the Resident was out of the bathroom. 2. Resident #90 had diagnoses which included chronic obstructive pulmonary disease, hypertension, and pressure ulcer on the sacrum and heels. The 8/16/24 Physician Order documented Resident #90 received Dakins' Solution .125% apply 60 milliliters by topical route to cleanse the sacral wound, pack with Dakins' solution soaked gauze and cover with Opti foam dressing and Silvadene 1% topical cream, apply to the right hip and left heel areas following Normal Saline cleanse and cover with a dry dressing. During an observation on 09/06/24 at 10:27 AM a bottle of Dakins' solution and a tube of Silver Sulfadiazine were observed on Resident #90 bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/24 at 9:30 AM Licensed Practical Nurse #4 stated cream and treatments should be locked up in the treatment cart and had no explanation for the treatments that had been left in Resident #4's room. NY CRR 415.18 (e) [1-4]

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review and interview conducted during a recertification survey 09/05/24-09/17/24, the facility did not ensure that the necessary dental services were provided in a timely manner for 1 of 1 resident (Resident #70) reviewed for dental services. The findings are: Resident #70 was admitted to the facility on [DATE] with diagnoses and conditions including Dementia, Major Depressive Disorder, and Cerebrovascular Accident. The 6/22/24 Annual Minimum Data Set (a resident assessment tool) of 6/22/24 documented Resident #70 had intact cognition, performed oral care independently and had no natural teeth. During interview on 9/6/24 in the late morning Resident #70 stated that they did not have teeth and had not seen a dentist. During an interview on 09/17/24 at 10:30 AM Licensed Practical Nurse #27 stated when a resident is admitted to the unit they will be seen by the dentist on their next routine visit. When the in-house dentist arrives, they will ask the nurses for a list of new residents. Licensed Practical Nurse #27 stated they did not know why the Resident had not been seen but stated they should have been evaluated by now. During an interview on 9/17/24 at 10:43 AM the Director of Nursing stated every resident would see the dentist on admission and as needed. When a resident becomes long term, they qualify for a dental evaluation. This resident transitioned to long term on 5/20/24 and the Social Worker should have made the team aware. The Director of Nursing stated they did not know why this didn't happen. During an interview on 9/17/24 at 10:50 AM the Corporate Licensed Practical Nurse stated it was the facility's responsibility to make sure dental services were provided. NY CRR 415.17(a-d)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observations and interviews conducted during the recertification survey from [DATE] to [DATE], the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, there was open and undated food located in the walk-in refrigerator, there were two metal trays with chicken and tuna salad that passed length of storage and expired half pint boxes of low-fat milk. There were two opened and expired orange juice boxes. In the walk-in freezer there were two boxes of frozen chicken thighs without expiration dates. One of these two boxes was opened to air without the date of opening. In the dry food storage there were Mac orzo and egg noodle pastas' loose in plastic bags without expiration dates. Finding include: The facility policy Food Receiving and Storage which was last revised on ,d+[DATE] documented expired items will be discarded, refrigerator storage of potentially hazardous foods or time/temperature control for safety foods, required time/temperature control for safety to limit the growth of pathogens or toxin formation. All opened items would be labeled and dated and discarded after three days once opened. All non potentially hazardous foods/time/temperature control food items would be labeled and dated and discarded after five days once opened. Freezer Storage: all opened items will be labeled and dated and discarded after five days once opened. The facility policy Trayline Refrigerated Leftover Storage undated documented the following guidelines are to be used for length of storage in refrigerators once food has been on the trayline not to be saved: eggs-cooked, egg-based salads, mayonnaise-based salads. During an initial tour of the kitchen on [DATE] at 09:47 AM conducted with the Food Services Director the following were observed in the walk-in refrigerator, there was a metal container with chicken salad dated [DATE] and a metal container with tuna salad dated [DATE]. During an observation on [DATE] at 09:57 AM of the milk/juice refrigerator, there was a plastic crate containing 6 boxes of half pint low fat milk with an expiration date of [DATE]. There were two opened orange juice boxes without date of opening and with an expiration date of [DATE]. During an observation on [DATE] at 10:06 AM of the walk-in freezer, there were two boxes of frozen chicken thighs without an expiration date. One of these two boxes was opened to air without the date of opening. During an observation on [DATE] at 10:14 AM of a dry food storage room, there were Mac Orzo and egg noodle pastas' loose in plastic bags, and without expiration dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:21 AM the Food Services Director stated that chicken and tuna salads passed the appropriate length of storage and must be discarded right away. They stated they did not know why the staff did not throw out the expired juices and milk. The Food Service Director stated all boxes needed to be kept closed with inner plastic wrap between use of the product and dated with a date of opening. They stated the cook used the frozen chicken thighs and must have forgotten to close them. They stated that they always reminded staff to keep all boxes closed once an item was taken out. The Food Service Director stated that they did not know what the expiration date of frozen chicken thighs was and stated that they received these boxes without expiration dates, and had sent the vendor notification but had not heard back from them yet. The Food Service Director stated that they did not know the expiration dates of the Mac orzo and egg noodle pastas' loose in the plastic bags because they were stored without the original boxes. They stated they did not know why the staff kept them stored that way. During an interview on [DATE] at 10:21 AM the Food Services Director introduced the description of the code system for manufacturing and expiration dates, which they stated were left for them by the previous Food Services Director. They stated they had to use it to identify the expiration dates, but they forgot about it. 10 NYCRR 415.14 (h)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 41666 Based on observation, record review, and interviews conducted during the recertification survey on 9/5/2024 - 9/17/2024, it was determined that the facility did not have a process and frequency by which the administrator reported to the governing body, the method of communication was not recorded, and the governing body did not establish and implement procedures for a clear line of communication regarding the management and operation of the facility. Furthermore, due to this lack of communication to the governing body, they did not ensure that the call bells on unit 300 (3rd floor) were in working order and in regulatory compliance. Specifically, it was revealed during the survey that the call bell system had been non-functional since April of 2024 and there were no plans in place to correct the issue, as well as no documentation to show that this issue was brought up or addressed in any Quality Assurance Performance Improvement meetings. The facility did not provide documented evidence of a Quality Assurance Performance Improvement plan/action to address identified issues related to the call bell system being out of service. The facility also did not have proper and or through documentation, or evidence of Quality Assurance Performance Improvement meetings regarding the fact that the facility only had one working elevator for more than a year. Findings include: The facility was cited at F919 at an Immediate Jeopardy. The facility was also cited for having only one working elevator and not notifying the Department of Health that this situation had been on-going for more than a year. The facility provided Quality Assurance/Performance Improvement meeting agendas from March and July of 2024. Neither agendum had any mention of the non-working elevator, or non-working call bells. During a brief interview with the Administrator on 9/05/24 at 9:30 AM they stated they did not know exactly how long the elevator had been out as they had only been working at the facility for about a month. The Administrator stated they did not know if the problem regarding the non-working elevator had been called in to the Department of Health. During an interview on 9/10/2024 at 6:03 PM the Director of Maintenance they stated that the problems 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 or early May 2024. 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. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/10/2024 at 6:10 PM with the Corporate Director of Nursing and the Corporate Licensed Practical Nurse, they stated that in April they were aware of the call bells not working. The previous Administrator reported this to the Department of Health. At that time an audit was completed, and the residents' families were notified of the call bell system failure. They put tap bells in the rooms, an ad hoc meeting was held to discuss the plan to ensure resident safety in the absence of a call bell system. The supervisors were made aware to increase rounding. They were unsure if this was documented. The plan included education of residents and staff, they were unsure if the education was ongoing. They were unsure if an assessment of the residents' ability to use the call bells was done. Maintenance was responsible to ensure tap bells were in the rooms and functioning. The bathrooms would be covered with increased rounding. They stated that they had a call with the operator/owner every week but there was no documentation of these calls. They admitted that there were no documented audits being conducted to ensure tap bells were appropriately placed or that staff could hear them. During an interview on 9/17/24 at 2:50 PM, the Corporate Administrator stated they had weekly calls with the facility operator/owner and went over any issues that were happening at the facility. Once an issue was discussed they moved on to the next topic. The Corporate Administer stated there were no logs of call content discussed with the facility owner. The call was not formal, it was a casual discussion about what was going on at the facility. They stated that the call bell issue would not have waited for the weekly call because they would call the owner sooner. However, they were unable to provide documentation that the owner/operator was aware of the ongoing issues with the call bell system and interim plan. During an interview with the Regional Director of Maintenance on 09/17/24 at 9:20 AM, they stated the elevator did not qualify as a loss of service because there was always one working elevator. They stated they kept in touch with the facility owner and made them aware of facility issues but was not aware the issue needed to go to the Quality Assurance/Performance Improvement committee. Several attempts were made to talk to the facility owner, but they were not available. During an interview on 9/17/24 at 12:41 PM the Assistant Chief Operating Officer stated they worked closely with the facility operator. They stated that they were the person to reach if the operator was not available. They stated they did not know when the call bell system stopped working but thought it was July or August 2024. The Assistant Chief Operating Officer stated the facility owner received notes from QAPI meetings and made visits to the facility on ce a week. When requested, they were unable to provide notes. 10NYCRR 415.26(b)(3)(1)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on record review, observation and interviews conducted during the recertification survey from 9/5/24 to 9/17/24, the facility did not ensure the Quality Assurance Performance Improvement committee developed and implemented an appropriate plan of action to address identified issues that impacted resident safety or ensured corrective actions addressed gaps in systems, and were evaluated for effectiveness; and that clear expectations were set around safety, quality, rights, choice, and respect. Specifically, the centralized call bell system had not been working since April of 2024. The facility did not ensure the Quality Assurance Performance Improvement committee developed and implemented an appropriate plan of action to address identified issues related to the central call bell system being out of service. On the 3rd Floor Unit residents were unable to call for assistance when necessary while in their rooms or when using their bathrooms. Family that were visiting were unable to call for staff assistance if help was needed with their family member when necessary. Staff in a shower room, working with a resident, were unable to call for assistance if necessary. The facility did not provide documentation for any meetings held to address the ongoing problem with the call bell system not functioning, and up until 9/10/2024 there was no plan in place to ensure that residents had ways to have their needs met while in their rooms or bathrooms. Findings include: The facility was cited at F919 at a Immediate Jeopardy. The facility was also cited for having only one working elevator and not notifying the Department of Health that this situation had been on-going for more than a year. The facility provided Quality Assurance/Performance Improvement meeting agendas from March and July of 2024. Neither agenda had any mention of the non-working elevator. There was no documented evidence from 4/5/2024 through 9/11/2024 that the facility documented their interim plan to use tap bells while the call bell system was being fixed. There was no evidence that the Quality Assurance Performance Improvement Committee monitored the interim plan for effectiveness and safety. There was no documented evidence that this issue was brought up in any Quality Assurance Performance Improvement committee meetings. There was no documented evidence that the facility sought input from residents, representatives, or direct care staff. There was no documented evidence that the Governing Body or facility operator was made aware of the ongoing issues with the malfunctioning call bell system. Per the facilities Quality Assurance Policy/Performance Improvement policy The [NAME] failed to follow its purpose specifically number 4. To establish and provide a system whereby a specific process and documentation related to it is maintained to support evidence of an ongoing quality assessment program. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/10/2024 at 6:10 PM, the Corporate Director of Nursing and the Corporate Licensed Practical Nurse stated that in April they were aware of the call bells not working. They stated the previous administrator reported this to the Department of Health and at that time an audit was completed, and the residents' families were notified of the call bell system failure. They stated put tap bells were put in the rooms, and an ad hoc meeting was held to discuss the plan to ensure resident safety in the absence of a call bell system. They stated supervisors were made aware to increase rounding but they were unsure if this was documented. The plan included education of residents and staff but they were unsure if the education was ongoing. They were unsure if assessments of the residents' ability to use the call bells were done. They stated the call bell contractor was onsite yesterday, 9/9/2024, to begin the installation of the system. Maintenance was responsible to ensure tap bells were in the rooms and functioning. The bathrooms would be covered with increased rounding. They were unaware if the care plans were updated. Maintenance checked if the tap bells were audible. They stated they had a call every week regarding falls, and had not noted an increase in falls on Unit 3 since the call bell system went down in April. On 9/11/24 at 1:53 PM in an interview with the Controller for the call bell contractor, they stated the first contact from the facility was on 4/17/24 and they believed that there was a person at the facility on Monday 9/9/2024 to start the install. They described the process of how a job order and work got arranged. They stated a proposal was sent but no work was started until a deposit was received. They recalled there being a delay and issues with getting the money for the deposit, they finally received the deposit on 8/29/24. During an interview on 9/17/24 at 2:50 PM, the Corporate Administrator stated they had weekly calls with the owner and went over any issues that were happening at the facility. They stated once an issue was discussed, they moved on to the next topic. The Corporate Administer stated there were no logs of call content discussed with the facility owner it was a casual talk about what was going on at the facility. The call bell issue would not have waited for the weekly call because they would have called the owner sooner. The Director of Maintenance would talk about the bigger projects. Several attempts were made to talk to the facility owner, but they were not available. During an interview on 9/17/24 at 12:41 PM, the Assistant Chief Operating Officer stated they could be reached if the facility could not reach the facility owner and they worked closely with the facility owner. They stated they did not know when the call bells became an issue but thought it was July or August 2024. The Assistant Chief Operating Officer stated the facility owner received notes from Quality Assurance Performance Improvement meetings and made visits to the facility on ce a week. 10NYCCR415.26

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47626 Based on observation, record review, and interview during the recertification survey conducted 9/05/2024-9/17/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 7 residents (Resident #3 and # 63) reviewed for pressure ulcers. Specifically, 1) Signs identifying resident needs for enhanced barrier precautions or any personal protective equipment were not placed outside the room of Resident #3 with a pressure ulcer and 2) staff were observed not wearing the required personal protective equipment while completing a dressing change for Resident #63 with a stage 4 pressure ulcer. Findings include: A Policy and Procedure titled Enhanced Barrier Precautions date 4/2024 documented; it is the policy of this facility to implement enhanced barrier precautions. Enhanced Barrier Precautions require the use of gowns and gloves for certain residents for high contact resident care activities. Signage will be posted on the door or wall outside the resident's room indicating the need for enhanced barrier precautions. Carts with appropriate Personal protective equipment will be placed outside the resident's room. All staff will receive training on enhanced barrier precautions. Review of the 4/22/24 education topic for enhanced barrier precautions documented 12/50 employees signed off as being educated. 1. Resident #3 was admitted with diagnoses including but not limited to quadriplegia, personal history of traumatic brain injury, and a community acquired pressure ulcer. The 8/5/24 Annual Minimum Date Set (an assessment tool) documented Resident #3 had severely Impaired cognition, and had a community acquired pressure ulcer. During an observation on 09/05/24 at 9:27 AM and 9/6/2024 at 10:42 AM Resident #3 was receiving morning care and staff were not wearing personal protective equipment. There were no enhanced barrier precaution signs on the door and no personal protective equipment bin outside the room door. During an interview on 09/12/24 at 1:46 PM Certified Nurse Aide #17 stated they were in serviced on enhanced barrier precautions yesterday, before that, staff had no idea what that meant. Certified Nurse Aide #17 stated the enhanced barrier precaution signs were only put-up last week. During an interview on 09/12/24 at 2:50 PM Licensed Practical Nurse #28 stated they were not doing enhanced barrier precautions prior to the state survey beginning. During an interview on 9/13/24 at 12:42 PM the Infection Control Practitioner stated they did education on enhanced barrier precautions in the past and was not clear as to why staff stated they had not received the in-service. The Infection Control Practitioner stated they did not know why the enhanced barrier precaution signs were not up or why the personal protective equipment was not placed outside the resident room doors. The facility has enough personal protective equipment on the units and in central supply which is available 24 hours a day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident # 63 was admitted with diagnoses including but not limited to Pressure ulcer of sacral region, stage 4; Acute embolism; and Anemia unspecified. The 7/15/24 Annual Minimum Data Set Assessment documented Resident # 63 was cognitively intact. The 9/5/24 Physician Order documented sacrum ulcer, pack with silver alginate, except for left upper corner, apply Santyl, and cover with abdominal pad, xeroform to cover scar tissue. Cleanse areas with wound spray or normal saline prior. During wound observation on 9/17/24 at 1:23 PM Resident # 63 was positioned on their stomach. and the old dressing was removed, treatment provided as per physician order and a new dressing applied. Licensed Practical Nurses #27 and #1, performing the wound treatment were not wearing personal protective equipment. During interview on 9/17/24 at 1:23 PM Licensed Practical Nurse #27 stated they recently received an in-service on enhanced barrier precaution and did know that anyone performing wound care treatment/s should wear a gown when providing the cares. Licensed Practical Nurse #27 stated they did not know an enhanced barrier precaution sign was hanging on the door of Resident #63's room. During interview on 9/17/24 at 1:23 PM Licensed Practical Nurse #1 stated they did not see the enhanced barrier precaution sign outside Resident #63's room door, and there was no personal protective equipment cart outside the room. Licensed Practical Nurse #1 stated they had been in-serviced regarding enhanced barrier precaution after beginning employment. 10NYCRR 415.19(a) 50729

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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