

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Eger Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 140 Meisner Avenue Staten Island, NY 10306	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interviews conducted during an abbreviated survey (NY00369908/728066), the facility failed to protect a resident's right to be free from the misappropriation of resident property and/or exploitation. This was evident for one out of nine residents (Resident #9) reviewed for personal property. Specifically, on 01/23/2025 at 7:10 AM, when counting narcotics (pain relieving) medications, Registered Nurse #1 reported a blister pack containing thirty Oxycodone 2.5 mg tablets that belonged to Resident #9 was missing from the medication cart drawer. During the facility-wide search, the empty medication blister pack had been torn into pieces in the shredder, and 30 Oxycodone tablets were missing. Additionally, Registered Nurse Supervisor #1 was seen on the facility surveillance counted the narcotics medications alone and then removed the medications from the medication cart drawer. The findings are: The facility policy and procedure entitled Abuse Prohibition Protocol, dated 01/2025, documented that residents must not be subject to abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property by anyone including, but not limited to facility's staff, other residents, consultants or volunteers, or staff of another agency serving the individual. The facility policy and procedure entitled Medication Ordering/Administration and Electronic Recordation, with an approved date of 01/2025, documented that all controlled drugs will be counted jointly at the end of each tour of duty by licensed nurses. Controlled medications needed for each med pass are to be placed in a separate locked drawer of the med cart and returned to the locked drug cabinet in the medication room after the med pass is completed. Resident #9 was admitted to the facility with a diagnosis including Humerus Fracture, Anxiety, and Depression. The Minimum Data Set (a resident assessment tool) dated 12/27/2024, documented that Resident #9 had intact cognition. A Physician Order dated 01/02/2025 documented an order for Oxycodone 5 milligrams, give 2.5 mg (1/2 tablet) by mouth every six hours as needed for pain. An image with the torn top part of the blister pack labeled one of two of Resident #9's Oxycodone 5 mg 1/2 tablets=2.5 milligrams revealed holes in all 30 blisters. A review of the facility's investigation dated 01/29/2025 documented that during count narcotics medication on 01/23/2025 at 7:10 AM, the day Registered Nurse #1 reported a blister pack of thirty Oxycodone 2.5 mg tablets and a blue narcotic count sheet was missing from the third-floor medication cart drawer. Registered Nurse #1 had worked the day prior and identified that two blister packs were present on 01/22/2025 at 03:00 PM. Registered Nurse #1 immediately contacted the Assistant Director of Nursing. Registered Nurse #2, who worked on 01/22/2025 3-11 shift, recalled last seeing both blister packs at 10:30 PM, prior to being counted by Registered Nurse Supervisor #1. The Assistant Director of Nursing attempted to call Registered Nurse Supervisor #1 for any information, but Registered Nurse Supervisor #1 told them they would call back. The search was done on the third-floor medication carts, the medication room, and the garbage. Searches were expanded to all other nursing units immediately, with verification of all controlled substance counts. The blister pack was not found at that time. The nursing office was checked for the missing blister pack. The Director of Nursing reviewed video surveillance of the third unit nursing of the prior night, and it was noted that Registered Nurse Supervisor #1 counted narcotic medications on the third floor alone. Registered Nurse Supervisor #1 was seen entering the elevator to leave the third floor with what appeared to be a blue sheet of paper wrapped around a blister pack. Registered Nurse Supervisor #1 was also noted to be walking in the Nursing Wing hallway and entering the Nursing office. At approximately 1:30 pm, the Assistant Director of Nursing checked shredder boxes in the Nursing wing and located above a missing blister pack with all thirty pills punched out. The blister pack label had been cut from the pack, and the blue sheet was found shredded into pieces. Three additional torn blue count sheets for oxycodone were found with no corresponding blister packs. Upon further interviews with nursing staff, it was relayed that Registered Nurse Supervisor #1 would offer to count on the third floor 3-11 shift, so that the nurses could leave if an 11-7 nurse were going to arrive late. Also, it was stated Registered Nurse Supervisor #1 would ask to collect controlled substances from the third floor for discharged residents. This was not a job responsibility of Registered Nurse Supervisor #1, 3-11 shift supervisor, nor did they follow the proper protocol for removing controlled substances per policy. Interviews with nurses revealed that they had given Registered Nurse Supervisor #1 the keys to count as requested because Registered Nurse Supervisor #1 was their supervisor. A Registered Nurse #4's Written Statement #1, dated 01/23/2025, documented that on 01/22/2025, they saw the evening supervisor holding a blister pack with paper in their hands at the nursing station. A Registered Nurse #4's Written Statement #2 dated 01/23/2025 documented that last week</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, conducted during an abbreviated survey (NY00374579), the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. This was evident for 1 out of 9 residents sampled (Resident #8). Specifically, on 03/09/2025 at approximately 5:22 AM, Certified Nursing Assistant #1 noted a small area of purpura (discoloration) on Resident #8's left knee and informed Registered Nurse #1. Registered Nurse #1 did not do a physical assessment, did not document in the medical record, and failed to inform the Medical Doctor, which resulted in a delay in diagnosis and treatment. On 03/10/2025, Resident #8 was transferred to the hospital due to a swollen left knee with discoloration and was diagnosed with a closed fracture of the Left femur (the thigh bone) and required surgery. Findings are: The facility's Policy and Procedures titled Notification of Resident's Change in Condition, dated 04/2020, documented that the Licensed Nurse /Designee assesses the resident, contacts the physician, and reports pertinent findings. Initiate the action indicated by the physician/physician extender and document in the interdisciplinary notes. The physician, physician extender, or designee notifies the resident's responsible party. Criteria for reporting Change in Condition, including the following, but not limited to injury of unknown origin, including blisters or burns, abrasion, ecchymosis, purpura, skin tears, laceration. Licensed Nurse notifies Nursing Supervisor of resident's change in condition and notes such on 24-hour report, Interdisciplinary Progress Notes, and communicates changes to appropriate staff. Resident #8 was admitted to the facility with diagnoses that include Alzheimer's disease, Anemia, and Inflammatory Spondylopathies. The Minimum Data Set, dated [DATE], identified that Resident #8 had short-term and long-term memory problems. Certified Nursing Assistant #1's Written Statement dated 03/11/2025 documented Certified Nursing Assistant #1 called Registered Nurse #1 to look at Resident #8's legs on 03/09/2025. The Surveillance Video was reviewed with the Director of Nursing on 06/13/2025, at 1:30 PM. According to the Director of Nursing, the video was recorded in real-time. The Surveillance Video Camera #2 revealed that on 03/09/2025 at 05:20 AM, a Certified Nursing Assistant came to the nursing station and gestured for Registered Nurse #1 to come with them. Registered Nurse #1 got up and went in Certified Nursing Assistant #1's direction and disappeared from camera view. Registered Nurse #1 returned to the nursing station at 05:22 AM. The Surveillance Video Camera #3 revealed that on 03/09/2025 at 05:20 AM, Certified Nursing Assistant #1 came out of Resident #8's room and went in the direction of the nursing station. Registered Nurse #1 went to Resident #8's room at 05:21 AM and came out at 05:22 AM. A Review of nursing notes from 03/01/2025 to 03/10/2025, there were no documented nursing notes for 03/08/2025 or 03/09/2025. There was no documented evidence that the Medical Doctor was notified after the Certified Nursing Assistant brought to the Registered Nurse's attention that Resident #8 had discoloration on the left leg. In a Nursing Note dated 03/10/2025 at 07:19 AM, written by Registered Nurse #2, documented during routine care, Certified Nursing Assistant #2 reported to the writer that Resident #8's left knee was swollen, and bruising was observed. Diffuse ecchymosis noted to the left shin, left lateral thigh, left medial thigh, and back of left knee. The area is purple/blue, skin was intact. The left knee is markedly swollen. During Range of Motion, the resident grimaced and groaned. Tylenol 650 milligrams was given immediately. Resident #8 was re-evaluated later and was found to be sleeping. The Medical Doctor was notified and ordered a STAT (immediately) X-ray of the left knee. In a Medical Provider Discharge Summary from the facility dated 03/10/2025 documented that Resident #8 was sent to the hospital for evaluation of left leg discoloration and swelling. Found to have a fracture and was admitted. A review of the facility's investigation, dated 03/17/2025, documented that on 03/10/2025 at 6:00 AM, Resident #8 was noted with left knee swelling with ecchymosis to the posterior knee, left lateral thigh, and left shin. Resident #8 was transferred to the hospital and was admitted with an Acute Distal Fracture of the femur and Diffuse Osteopenia with degenerative changes. Resident #8's care plan was updated on 03/07/2025 to transfer with two-person assistance. Based on staff statements, Certified Nursing Assistant #1 transferred Resident #8 on 03/08/2025, in the evening with one assist, stating that they were unaware of Resident #8's transfer status and had not checked the electronic medical record. On 03/09/2025 at 5:22 AM, Certified Nursing Assistant #1 noted a small discolored area on the Resident #8's knee and reported to Registered Nurse #1. Registered Nurse #1 reported that they looked at Resident #1's leg but became busy and forgot to report the incident. The facility investigated the incident and concluded that there was no evidence of abuse, mistreatment, or neglect. A Patient Discharge</p>		