STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335337	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schaffer Extended Care Center	16 Guion Place New Rochelle, NY 10802

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review and interview during the recertification survey from 4/29/25 to 5/6/25 the facility did not ensure the right to receive services with reasonable accommodation of needs and preferences for 1 of 3 residents (Resident #19) reviewed for positioning and mobility. Specifically, Resident #19 stated they informed the Director of Social Work their wheelchair needed to be repaired 3 months ago and the wheelchair was observed in disrepair on 4/30/25. The findings include: The policy titled Physical Medicine and Rehabilitation Wheelchair Repairs last revised 7/2023 documented any wheelchair that is found to be in need of repair must be immediately taken out of service and inform Physical Medicine and Rehabilitation department notified. The Physical Medicine and Rehabilitation department will provide a replacement wheelchair while repairs are made. Resident #19 had diagnoses including Cancer, Peripheral Vascular Disease, and Asthma. The 1/25/25 Quarterly Minimum Data Set assessment documented Resident #19 was cognitively intact, used a manual wheelchair and was dependent upon staff to be wheeled in the wheelchair. There was no documented evidence in the electronic medical record that Resident #19 was assessed by the rehabilitation department and/or nursing to determine if Resident #19 could safely use the wheelchair. There was no documented evidence in the social work notes that the resident had informed the social worker of the broken wheelchair. There was no documented evidence of work orders that the wheelchair needed to be repaired. During an interview on 4/29/25 at 10:10 AM, Resident #19 stated they informed the Director of Social Work at least 3 months ago the chair was small and needed repair and nothing was done. Resident #19 stated if they did not put a towel on the left side of wheelchair it would dig and cut into their skin. During an observation on 4/30/25 at 12:23 PM the wheelchair had a left wheel that was shredded, the left wheel lock did not touch the wheel and did not lock. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/25 at 12:23 PM the Director of Rehabilitation stated they were informed the previous night the resident's wheelchair needed repair. The Director of Rehabilitation stated the condition of the wheelchair looked like it was in need of repair for some time. The Director of Rehabilitation stated they relied on nursing staff to report concerns when wheelchairs needed to be repaired. During an interview on 5/5/25 at 10:27 AM, Certified Nurse Aide #25 stated they reported the condition of the wheelchair several times to the nursing supervisor while Registered Nurse #1 was not working. Certified Nurse Aide #25 stated the wheels on the wheelchair were falling apart and made it hard to push the resident. Certified Nurse Aide #25 stated the resident also reported the wheelchair needed repair to the nurses. Certified Nurse Aide #25 stated they were not sure when they reported it but they knew it was this year. During an interview on 5/06/25 at 10:48 AM, Registered Nurse #1 stated they were on leave and returned to work sometime in March 2025. Registered Nurse #1 stated they were informed the wheelchair needed to be repaired in March of 2025. Registered Nurse #1 stated they did not know why there was a delay in the repair of the wheelchair. Registered Nurse #1 stated it was also reported to nursing supervisors while they were on leave and they did not know why it had not been repaired during that time. During an interview on 5/06/25 at 2:10 PM, the Director of Social Work stated the resident did inform them their wheelchair needed to be repaired. The Director of Social Work stated they informed Registered Nurse #1 Resident #19's wheelchair needed to be repaired. The Director of Social Work stated they did not remember when they reported it but thought it was sometime in March 2025. The Director of Social Work stated they did not have progress notes or grievances from March 2025 about the resident's request to repair the wheelchair. 10NYCRR 415.5(e)(1)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during the recertification survey 4/29/25 to 5/6/25, the facility did not ensure a significant change Minimum Data Set (MDS) Assessment (tool to assess resident care needs) was completed within the 14-day requirement for 1 of 5 residents (Resident #48) reviewed for pressure ulcer/injury. Specifically, a Significant Change Minimum Data Set was not initiated within 14 days for Resident #48 with a decline in swallowing ability who required a 1/28/25 diet downgrade to nothing by mouth. The findings include: Resident #48 was admitted to the facility with a diagnosis of Dementia. The 12/3/24 Quarterly Minimum Data Set assessment documented no swallowing disorders present. The 12/6/24 Clinical Nutrition assessment dated [DATE] documented puree diet with nectar thick liquids, tolerating the modified texture and no swallowing issues. The 1/28/25 Physician Order documented Aspiration Precautions as necessary and nothing by mouth diet, texture and consistency. The 1/29/25 Speech Therapy Evaluation and Plan of Treatment documented resident seen with puree consistency x 1 teaspoon at this evaluation. Bolus dumped in oral cavity with bolus holding and no attempts at manipulation or transfer evidenced. Bolus removed from resident's oral cavity. No further by mouth was presented secondary to the above findings putting the resident at high risk for aspiration. The 1/29/25 Speech Therapy Treatment Encounter Notes documented precautions nothing by mouth (npo). Recommend continue nothing by mouth status as resident with a recent aspiration pneumonia and remains at high risk for aspiration. The 3/5/25 Significant Change Minimum Data Set assessment documented swallowing disorder, the resident was holding food in mouth/cheeks or had residual food in mouth after meals. During interview on 5/5/25 at 3:24 PM the Speech Therapist stated the resident was on aspiration precaution and stated the resident received comfort/pleasure feeds via teaspoon as tolerated. During interview on 5/6/25 at 9:20 AM the acting Minimum Data Set Coordinator stated the Significant Change Minimum Data Set Assessment was initiated because the resident had worsening dysphagia and inability to take oral feedings. They stated the facility waited to do the Assessment when the Quarterly Assessment was due instead of following the 14-day requirement. 10 NY CRR 415.11(a)(3)(ii)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview during the recertification survey and abbreviated survey (NY00374695) from 4/29/25 to 5/6/25 the facility did not ensure the development and implementation of comprehensive person-centered care plans for each resident, consistent with resident rights that included measurable objectives and time frames to meet a resident's needs for 1 of 5 residents (Resident #32) reviewed for pressure ulcers, 1 of 3 residents (Resident #19) reviewed for positioning and mobility and for 1 of 2 residents (Resident #8) reviewed for tube feeding. Specifically, 1) Resident #32 was incontinent of bladder and there was no documented evidence that a care plan to address an incontinence schedule/incontinence care was developed and/or implemented, 2) Resident #19 did not have an activities of daily living care plan prior to 5/5/25 and 3) the care plan to address Resident #8's feeding tube was incomplete and did not have measurable objectives, goals and interventions. The findings include: The Comprehensive Care Plan Policy last revised 1/2025 documented each resident will have a comprehensive care plan developed and updated by all members of the comprehensive care plan team as appropriate. 1) Resident #32 had diagnoses which included Schizophrenia (disorder that affects the ability to think, feel, and behave clearly), Depression and Morbid Severe Obesity. The 10/29/2024 Annual Minimum Data Set documented Resident #32 was cognitively intact, received substantial to maximum staff assistance for toileting, was incontinent of bladder, frequently incontinent of bowel, and was at risk for pressure ulcers. The 1/29/2025 Quarterly Minimum Data Set (assessment tool) documented Resident #32 had intact cognition, received substantial/maximal assistance with toileting, and was incontinent of bladder and frequently incontinent of bowel. There was no documented evidence in the Care Plans to address Resident #32's incontinence schedule/incontinence care. There was no documented evidence interventions were implemented to address Resident #32's incontinence. The 4/1/2025-4/16/2025 Documentation Survey Report documented Resident #32 was coded one (1) incontinent of bladder 15 days during the 7 AM-3 PM shift, 15 evenings during the 3:00 PM -11:00 PM shift and 15 nights during the 11:00 PM -7:00 AM shift. During an interview on 5/1/2025 at 1:40 PM the Director of Nursing was unable to provide documentation of a care plan with interventions to address Resident #32's incontinence schedule/incontinence care. 2)Resident #19 had diagnoses including Cancer, Peripheral Vascular Disease, and Asthma. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/25/25 Quarterly Minimum Data Set Assessment documented Resident #19 was cognitively intact, had upper and lower extremity impairment on both sides required substantial to maximal assist for toileting and was dependent in bed mobility/transfer/wheelchair mobility and was able to eat independently. There was no documented evidence in the Comprehensive Care Plan to address Activities of Daily Living prior to 5/5/25. During an interview on 5/06/25 at 2:00 PM, the Director of Nursing stated while Registered Nurse #1 was on leave they assigned three (3) Registered Nurse Per Diem Supervisors the role of initiating and updating care plans for the 4th floor unit. During an interview on 5/06/25 at 3:05 PM, the Director of Nursing stated they provided education to the nurse managers and supervisors and they offered classes twice a year. The Director of Nursing stated they had no documented in-services for the past year. The Director of Nursing stated the nurse managers were supposed to review the care plans and make updates during family care plan meetings. During an interview on 5/06/25 at 3:31 PM, Registered Nurse #1 stated they could not explain why the Activities of Daily Living Care Plan was not created until 5/5/25. Registered Nurse #1 stated they did know how to initiate a care plan in the system. Registered Nurse #1 stated they started using the new system in August of 2024 and were still learning how to use it. 3) Resident #8 had diagnoses including Stiff-Man Syndrome, Type 1 Diabetes, Dysphagia with G-tube feedings and Stomach Cancer. The 3/2/25 Quarterly Minimum Data Set (assessment tool) documented Resident #8 had impaired cognition, was dependent on staff for all activities of daily living and received all nutrition and hydration via G- tube. There was no documented evidence in the Comprehensive Care Plan to address goals and interventions related to G-tube feedings. During an interview on 5/6/25 at 11:21 AM Registered Nurse Unit Manager #23 stated the care plan was started but never completed and needed goals and interventions. During an interview on 5/6/25 at 3:05 PM the Director of Nursing stated the medical team developed/updated care plans and the Nurse Managers were to review care plans for completion. 10 NYCRR 415.11 (c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review conducted during the Recertification Survey from 04/29/2025 to 05/06/2025, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for one of one resident (Resident #67) reviewed for edema. Specifically, for Resident #67 a left foot ace bandage wrap was not consistently applied in the morning to allow 12 hours of use daily and legs were not elevated when out of bed as per physician order. The findings include: Resident #67 had diagnoses including but not limited to Hemiplegia following a Cerebral Infarction, Morbid Obesity, and Heart Failure. The Care Plan titled Hypertension dated 10/26/24 documented monitor for edema. The Quarterly Minimum Data Set (an assessment tool) dated 1/31/25 documented Resident #67 was cognitively intact and independent with all activities of daily living. The 2/14/25 Care Plan Note documented blood pressure stable, lower extremities remain with swelling. Continue same plan of care. The 3/7/25 Physician Order documented wrap the left foot for 12 hours every day with an ace wrap, put on in the morning and take off at bedtime. Elevate leg/s as much as possible during the day. There was no documented evidence in the Certified Nurse Aide Tasks to address directions related to elevation of Resident #67's legs. The April 2025 Treatment Administration Record documented the left foot ace wrap was applied on 4/30/25. During observation on 4/30/25 at 11:03 AM, 5/1/2025 at 11:26 AM, and 5/02/2025 at 8:56 AM, Resident #67 was sitting in a chair. Both lower legs had 2-3 plus edema. Both legs were not elevated and the left foot ace wrap was not in place as per physician order. During an interview on 04/30/25 at 11:03 AM Resident #67 stated they had swelling in their leg. They stated they would like to elevate their leg/s but had nothing to elevate them on. They stated when they began to walk, their wheelchair was taken away which left them without the ability to elevate their legs when not in bed. They stated they had asked the staff on several occasions about elevating their legs During an interview on 05/01/2025 at 11:26 AM Resident #67 stated their left foot should be wrapped every day. They stated the staff told them they would come back and wrap it, but no one came back. They stated they should have the left foot wrapped before they get out of bed, but they had to wait for the day nurse to wrap the foot. They stated the nurses were busy in the morning so most days it did not get done until the afternoon. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/05/25 at 9:58 AM Licensed Practical Nurse #24 stated the resident was encouraged to elevate their legs. They stated when they came to work the resident's left leg was usually not wrapped. They stated they usually did not get to wrapping the leg until around 10:30 AM. They stated they were aware the resident's legs should be elevated but were unaware the resident had nothing to elevate their legs on. During an interview on 05/05/25 at 10:03 AM Registered Nurse Manager #23 stated they were not aware the residents' legs should be elevated when out of bed or that the resident had not been provided with a means to elevate their legs. 10 NYCRR 415.12

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview, observation and record review during the Recertification Survey conducted from 4/29/2025 to 5/6/2025, the facility failed to ensure residents received care consistent with professional standards of practice, to prevent pressure ulcers and to prevent worsening of pressure ulcers. This was evident for one (1) of five (5) residents (Resident #32). Specifically, Resident #32 was assessed at risk for pressure ulcers, developed a sacral wound and there was no documented evidence that interventions were implemented to address off loading/incontinence schedule/incontinence care to prevent further deterioration of a sacral wound. Subsequently, when assessed by the physician on 3/4/2025 the wound was documented as Stage 3 (full thickness skin loss) and on 4/2/2025 the wound had progressed to an unstageable (damage to skin caused by constant pressure on an area for a long-time) pressure ulcer. This resulted in actual harm to Resident #32 that was not Immediate Jeopardy . The findings include: The policy titled Pressure Ulcer Prevention Protocol with a February 2025 revision date documented residents at risk for pressure ulcers could expect to receive appropriate care. Maximize mobility activity and provide pressure relief: float heels placing pillows/positioning devices under the lower extremities, use pressure relief devices such as pillows/positioning devices between bony prominence's behind the back and under the lower extremities, limit chair sitting: use a pressure relieving chair cushion, assist with toileting and monitor for incontinence at least every two (2) hours or more frequently as needed, manage incontinence-assure residents are clean, dry, moisturized and protected. Resident #32 had diagnoses which included Schizophrenia (disorder that affects the ability to think, feel, and behave clearly), Depression and Morbid Severe Obesity. The 8/12/2024 Care Plan titled Potential for Pressure Injury related to Dehydration, Immobility, documented bed to be as flat as possible to reduce shear, the resident preferred to be repositioned by one (1) person and inform the resident/family/caregiver of any new area of skin breakdown. The 10/29/2024 Annual Minimum Data Set documented Resident #32 was cognitively intact, received substantial to maximum staff assistance for toileting, supervision for rolling left to right, was incontinent of bladder, frequently incontinent of bowel, was at risk for pressure ulcers and had a pressure relieving device in bed. The 1/28/2025 Braden Scale (tool used to assess risk for developing pressure ulcers) documented a score of 17 (at mild risk). The 1/29/2025 Quarterly Minimum Data Set (assessment tool) documented Resident #32 had intact cognition, no pressure ulcers, no impairments to upper or lower extremities, received substantial/maximal assistance with toileting, partial/moderate assist with sit to lying in bed and transfers, supervision with rolling in bed, was incontinent of bladder and frequently incontinent of bowel. There was no documented evidence in the Care Plans to address Resident #32's incontinence schedule/incontinence care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 2/13/2025 Nurse Care Plan Note documented sacral wound measurement 1 cm X 1 cm, treat with hydrogel. The 2/13/2025 Care Plan titled Potential Skin Integrity Issue related to being chairfast: Intra buttock opening 1 cm X 1 cm: daily hydrogel (water-based moisture) plus Allevyn (foam) dressing, daily Balmex (skin protectant) to the sacrum/buttocks, use a draw sheet or lifting device to move the resident, keep body parts from excessive moisture, and follow facility protocols for treatment of the injury. The 2/20/2025 Physician Wound Assessment Progress Report documented coccyx (small bone at the bottom of the spine) open deep tissue injury wound, measurements 1 cm, 0.7 cm X 0.1 cm. The wound bed was a pink-purple color. There was no necrotic (injury to cells) tissue. Offloading discussed with the patient. The 2/25/2025 Physician Wound Assessment Progress Report documented coccyx wound stage 2 (open skin), measurements 1.2 cm X 0.5 cm, wound bed color pink, no necrotic tissue, no exudate (fluid),100% granulation (new) tissue. May worsen due to obesity and decreased mobility and edema. Pressure off loading. Continue present treatment and discuss offloading with the patient. The 3/4/2025 Physician Wound Assessment Progress Report documented coccyx wound stage 3, measurements 1.5 cm x 0.7 cm, wound bed color pink/yellow, no necrotic tissue, 100% granulation tissue. Recommendation: guarded healing prognosis due to incontinence, if no improvement, consider change to moisture barrier. The 3/10/2025 Physician Wound Assessment Progress Report documented coccyx wound stage 3, measurements 2.0 cm X 1.2 cm, wound bed color yellow-pink, granulation tissue 100%. Pressure relief, pressure off loading, likely to worsen due to incontinence and mobility. The 3/18/2025 Physician Wound Assessment Progress Report documented sacral wound stage 3, measurements 2.5 cm x 2.3 cm X 0.2 cm. Wound bed color pink/yellow and fibrinous (protein fibers), necrotic tissue 50%. Wound is larger and moist. The patient was very incontinent. Will change the treatment to daily Balmex with zinc and skin protectant. Will reassess at next rounds. There was no documented evidence interventions were implemented to address the resident's incontinence. The 3/25/2025 Physician Wound Assessment Progress Report documented sacral wound stage 3, measurements 2.4 cm x 1.5 cm x 0.2 cm. Wound bed color pink/yellow, necrotic tissue 20%, granulation tissue 80%. Treatment daily, Balmex to continue. Healing well. Continue the present treatment. Pressure off loading and mobilize. The Care Plan titled Potential Skin Integrity Issues updated 3/28/2025, documented apply Balmex to the sacrum every shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 4/2/2025 Physician Wound Assessment Progress Report documented unstageable coccyx wound (a wound caused by pressure on the area for a long time, that's distance from top to bottom can't be accurately determined).Measurements 2.7 cm x 1.5 cm x 0.5 cm. Wound bed color yellow. Necrotic tissue 100%. Change back to collagenase ointment (ointment that aides healthy tissue growth) and Allevyn lite dressing (thin, foam dressing designed for sensitive skin). Poor offloading compliance. No infection. The Care Plan titled Potential Skin Integrity Issues updated 4/2/2025 documented apply collagenase plus Allevyn lite dressing daily and 4/3/2025 weekly wound rounds by the wound team. The 4/8/2025 Physician Wound Assessment Progress Report documented coccyx wound unstageable, measurements 2.0 cm x 2.0 cm X 0.5 cm. wound bed yellow/gray, 100% necrotic tissue. Pressure offloading. Questionable stage 3 versus unstageable with necrotic tissue in the center. Continue collagenase. Non-compliance discussed with nursing. Out of bed to chair. The Care Plan titled Potential Skin Integrity Issues updated 4/8/2025 documented Stage 3 coccyx wound 2.6 X 2.0 cm with yellow color, 100 % necrotic tissue 100% positive serous drainage. Continue daily collagenase plus Allevyn. There was no documented evidence in the Care Plans to address Resident #32 non noncompliance related to offloading. The 4/14/2025 Assessment Progress Report documented coccyx wound unstageable. Measurement 3.0 cm X 3.0 cm x 1.0 cm. Wound bed color eschar/black, necrotic tissue 100%. Treatment collagenase and Allevyn lite. Resident with decreased mobility and decreased oral intake. The wound is likely to worsen or have delayed healing. Continue collagenase and cover with Allevyn. Pressure offloading. The 4/1/2025-4/16/2025 Documentation Survey Report documented Resident #32 was coded one (1) incontinent of bladder 15 days during the 7 AM-3 PM shift, 15 evenings during the 3:00 PM -11:00 PM shift and 15 nights during the 11:00 PM -7:00 AM shift. The Care Plan titled Potential Skin Integrity Issues updated 4/14/2025 documented weekly wound rounds for coccyx Unstageable 3.0 X 3.0 X 1.0 cm eschar (dead skin) negative for drainage, apply Santyl (ointment to remove damaged tissue) and Allevyn daily. There was no documented evidence that Resident #32 was placed on a turn and position and toileting schedule prior to 4/16/2025. There was no documented evidence that Resident #32 was provided an appropriate pressure relieving wheelchair cushion prior to 4/16/2025. During interview 5/1/2025 at 1:25 PM the Wound Physician/Medical Director stated when they documented pressure offloading in the Wound Notes, it was their expectation that nurses would implement off-loading, out of bed to the chair, and a pressure relieving cushion to the wheelchair. The Wound Physician/Medical Director stated nurses should be aware of the protocol and should have implemented at least some of them. The Wound Physician/Medical Director stated there was no documentation in the nurse's notes, that indicated interventions were in place and implemented as per wound protocol. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/1/2025 at 12:29 PM the Director of Rehabilitation stated they were not aware of Resident #32's sacral wound until 4/30/2025 when they received a phone call from the 4th floor Registered Nurse Unit Manager #1. They stated if the nurse determined the resident needed a pressure relieving device, they were supposed to call the Rehabilitation Department to request what was needed or explain what the concern was. They stated if they had been made aware of Resident #32's pressure ulcer, someone in the Rehabilitation Department would have evaluated Resident #32. During an interview on 5/1/2025 at 1:40 PM the Director of Nursing was unable to provide documentation of any interventions implementation to address Resident #32's incontinence schedule/incontinence care, and use of a pressure relieving wheelchair cushion. During Wound Care observation on 5/2/2025 at 11:07 AM during wound care, Resident #32's Sacral wound measured approximately 4.0 cm x 2.0 cm, and the wound bed was dark brown colored eschar tissue. During an interview on 5/2/2025 at 11:18 AM, Licensed Practical Nurse #2 stated Resident #32 had a regular foam cushion in their wheelchair when the wound was classified as a Stage 3 wound and when the wound was classified as an unstageable wound. During observation and interview on 5/2/2025 at 11:25 AM, Certified Nurse Aide #3 stated they were frequently responsible for Resident #32. They stated Resident #32's wheelchair did not have a ROHO (pressure relief designed to reduce the risk of pressure sores) cushion until 4/30/2025. During an interview on 5/2/2025 at 11:30 AM, the Director of Rehabilitation stated the standard foam wheelchair cushion that was used in Resident #32's wheelchair was not appropriate for a Stage 3 Pressure Ulcer or Unstageable Pressure Ulcer. They stated when Resident #32's wound worsened to a Stage 3 Pressure Ulcer they should have been given a gel wheelchair cushion or a ROHO wheelchair cushion. During an interview on 5/2/2025 at 3:50 PM, the Director of Nursing stated the Per Diem Registered Nurse Supervisor #4 who initiated the care plan for the newly identified wound on 2/13/2025, should have notified the Rehabilitation Department and should have initiated interventions to promote wound healing. They stated routine wound protocol included to offload the affected area when in bed and when in the wheelchair to reduce pressure and address incontinence schedule/incontinence care if applicable. During interview on 5/2/2025 at 4:00 PM the Per Diem Registered Nurse Supervisor #4 stated they started the care plan for the newly identified wound on 2/13/2025 and should have entered interventions to promote wound healing. They stated they should have requested a referral from the Rehabilitation Department for a pressure relieving wheelchair cushion, but they got distracted by something else. During a follow up Interview on 5/5/2025 at 10:33 AM the Wound Physician/Medical Director stated Resident #32's wound may not have deteriorated if interventions had been implemented to address the resident's incontinence schedule/incontinence care, the use of an appropriate pressure relieving wheelchair cushion. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During interview on 5/6/2025 at 10:15 AM the Director of Nursing stated when the wound stage was changed from Stage 2 to Stage 3, and from Stage 3 to unstageable, interventions should have been discussed with the team and should have been documented on the care plan by the Nurse Manager or the per diem Supervisor. The Director of Nursing stated they routinely accompanied the wound doctor on wound rounds and either the Nurse Manager or per diem Supervisor also accompanied the wound doctor on wound rounds so they could document nurse's wound notes. They stated that at that time they should have discussed any new interventions to promote wound healing, and they should have updated the care plan timely. 10 NYCRR 415.12(c)(1)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review during the recertification survey from 04/29/25 through 05/06/25, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months. Specifically, five of five Certified Nurse Aides (#13, #14, #15, #16, #17) did not have a performance review documented at least once every 12 months. The findings include: The Policy & Procedure titled Competency Based Performance Evaluation Program with a 4/2023 revision date documented it was the responsibility of administrative, managerial, and or supervisory staff to review the performance of all employees under their supervision and to complete and forward completion information to the human resource department. The individual departments will maintain a file of the actual performance appraisals. Performance Appraisals are to be completed annually. There was no documented evidence that performance reviews were completed in the last 12 months for Certified Nurse Aide #13 with a hire date of 11/6/13, Certified Nurse Aide #14 with a hire date of 11/6/13, Certified Nurse Aide #15 with a hire date of 11/6/13, Certified Nurse Aide #16 with hire date of 6/7/21 and Certified Nurse Aide #17 with hire date of 11/6/13. During an interview on 05/06/25 at 01:48 PM the Director of Nursing stated they were behind in completing Performance Appraisals. During an interview on 05/06/25 at 02:24 PM the Director of Human Resources stated they were involved in the process to complete Performance Appraisals. They stated they were aware the Performance Appraisals needed to be completed every 12 months and were aware they were not being completed timely. During an interview on 05/06/25 at 02:45 PM the Assistant Administrator stated they thought Performance Appraisals needed to be done every two years. They stated it was the responsibility of the department head to ensure the performance approvals were completed. They were unaware the performance appraisals were not being completed as required by regulation. 10NYCRR 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the recertification survey from 4/29/25 to 5/6/25, the facility did not ensure irregularities identified by the pharmacist and forwarded to the facility were acted upon for 1 of 5 residents (Resident #121) reviewed for unnecessary medications. Specifically, for Resident #121 laboratory requests were not ordered and obtained as per consultant pharmacist and physician agreement. The findings include: Resident #121 was admitted to the facility on [DATE] with the diagnosis of dementia with psychotic disturbance, anxiety, and falls. The 1/21/25 Quarterly Minimum Date Set (assessment tool) documented the resident had severely impaired cognition and was taking an antipsychotic medication. The 4/4/25 Medication Regimen Review documented laboratory monitoring as a requirement for Seroquel use and there were no recent labs on file. Physician signature documented reviewed and will order. There was no documented evidence in the physician orders that the requested laboratory tests were ordered. During an interview on 5/5/25 at 10:52 AM Licensed Practical Nurse #27 stated the medication regimen review recommendation was signed by the physician but labs were not ordered and results were not available for review. During an interview on 5/5/25 at 12:15 PM Unit Manager Registered Nurse #23 stated they did not know what the medication regimen review paper was and had never seen it before. They stated there was no order for labs and no documented physician note regarding requested labs. During an interview on 5/5/25 at 3:42 PM the Director of Nursing stated they called the physician regarding the requested labs. The physician stated Resident #121 must have refused. The Director of Nursing stated there was no documentation of refusal. 10NYCRR 415.18 (c)(2)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and interview during the recertification survey conducted 4/29/2025-5/6/2025, the facility did not ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 2 of 3 residents (Residents #113, #86) reviewed for food. Specifically, 1) Resident #113 had a physician order for mince and moist diet and was served a fruit cup and 2) Resident #86 had a physician order for nectar thick liquids and was provided a pitcher of water by the Certified Nurse Aide. The findings include: The policy titled Diet Orders, revised 4/2025 documented the purpose of the policy is to ensure the resident/patient receives meals that are consistent with clinical needs. 1)Resident #113 with diagnosis that include Hypertension, Heart Failure and Chronic Kidney Disease. The 9/14/24 Quarterly Minimum Data Set (an assessment tool) documented the resident's cognition was moderately impaired and they received set up assistance for eating. The 11/5/24 Physician Order documented minced and moist texture diet and thin liquids. The current Care Plan titled Potential for Aspiration- mechanical soft diet documented mince and moist texture, encourage to chew thoroughly and eat slowly. The current Care Plan titled Nutrition, documented minced and moist texture with aspiration precautions. During observation on 4/29/25 at 1:09 PM of the 5th floor dining room the lunch ticket on the meal tray listed minced fruit cup. Resident #113 received a regular tropical fruit cup. During an interview on 5/01/25 at 11:30 AM Registered Dietitian #7 stated the minced and moist texture was comparable to a ground texture and the tropical fruit cup that was served was not a ground texture. During a follow up interview on 5/02/25 at 9:50 AM Registered Dietitian #7 stated the facility changed to a new food system menu program on 8/1/24. The diet textures were changed from mechanical soft to minced and moist. They felt this diet was safest for residents. They stated the regular tropical fruit cup was still on the menu in error. During an interview on 5/02/25 at 10:00 AM the Food Service Director stated there was no in-service documentation for dietary staff on the new diet, minced and moist texture. They stated a huddle was held to provide education for staff. They stated there was no policy regarding diet textures and consistencies. 2) Resident # 86 with diagnoses to include Chronic Obstructive Pulmonary Disease, Schizoaffective Disorder, and Heart Disease. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/13/25 Quarterly Minimum Data Set (an assessment tool) documented Resident #86's cognition was intact, and they were independent with eating. The 8/1/25 Physician Order documented Regular Diet with Nectar mildly thick consistency for liquids The current Certified Nurse Aide Kardex documented eating and nutrition, regular diet, regular texture, nectar/mildly thick liquids with aspiration precautions. The current Care Plan titled Nutritional Problem related to swallowing difficulty documented Regular Diet with Nectar mildly thick consistency for liquids. During observation on 05/02/25 at 01:20 PM Resident # 86 had a lunch tray at the bedside. The tray had soft food, and thickened liquids. Additionally, the resident had 2 large cans of iced tea and a pitcher of non-thickened ice water on the over bed table. During an interview on 05/02/25 at 01:20 PM Certified Nurse Aides #20 stated they did not think, the resident had special diet needs, the resident received thickened milk but they thought it was their preference. They stated the resident requested water, so they provided them with a pitcher of ice water. They stated if the resident was on a special diet, the nurse would let them know. They stated they did not know if the resident's diet was available for a Certified Nurse Aide to review. During an interview on 05/02/25 at 01:34 PM Licensed Practical Nurse #2 stated they were unsure if the Certified Nurse Aides could see the residents diet order. They stated Certified Nurse Aides received report at the start of shift and would be told if the resident had a special diets. They stated they were unaware the resident was given ice water. During an interview on 05/02/25 at 01:48 PM the Director of Nursing stated the Certified Nurse Aides should know what diet residents were to receive. They stated residents who were supposed to receive nectar thick liquid should not have been given a pitcher of regular water. During an interview on 05/05/25 at 02:08 PM the Dietician stated the resident should not have received regular water. 10NYCRR 415.14 (d-e)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview conducted during the recertification survey from 4/25/25 to 5/6/25, the facility did not ensure food was distributed and served in accordance with professional standards for food service safety. Specifically, unlabeled and undated food items in kitchen and unit pantry, expired food in kitchen storage pantry and unit pantry, and dietary staff did not perform proper hand hygiene before preparing a sandwich. The findings include: The policy titled Handwashing with a 1/2022 revision date documented food service associates are expected to perform proper hand hygiene while on duty; specifically, before and after wearing gloves. The policy titled Use and Storage of Food/Beverages brought from off-site with a 4/2025 revision date documented food may be stored in the unit pantry refrigerator for up to 48 hours, labeled with current date and discarded after 48 hours of date on the label. During the initial tour of the kitchen conducted on 4/29/25 at 9:25 AM, there was a bag of unlabeled sundried tomatoes in the salad refrigerator and two containers of mayonnaise not dated in the refrigerator. At that time Staff #6 stated all food items should be labeled and dated. During the tour of the emergency food supply on 4/29/25 9:52 AM, there were protein meal bars with a 4/8/25 expiration date, canned tuna fish with a 4/6/25 expiration date, apple juice with a 3/28/25 expiration date, ensure clear supplements with a 3/1/25 and 4/1/25 expiration date and glucerna supplement with a 3/1/25 expiration date. During a tour of Unit 3 pantry on 5/1/25 at 4:35 PM there was a plastic container of blueberries not dated, a disposable plastic container of fruit salad not dated and a plastic bag of cake dated 4/23/25. During interview on 5/1/25 at 4:35 PM Licensed Practical Nurse #12 stated the items should have been thrown out after 48 hours from the recorded date. They stated it was nursing staffs responsibility to label food items for the residents with their name and current date. During an interview on 5/6/25 at 10:37 AM the Food Service Director stated the storeroom staff should have noticed the expiration dates one month prior to expiration. During an interview with the Director of Nursing on 5/6/25 at 10:47 AM, they stated nursing staff was to make sure food was labeled with name and current date and then discarded after 48 hours. The environmental department was responsible for completing general pantry cleaning. During a follow up tour of the kitchen on 5/1/15 at 11:41 AM Dietary Staff #10 was observed making a peanut butter and jelly sandwich. Staff #10 was wearing a surgical mask and coughed while holding a bare hand about 2 inches from the mask. They proceeded to put on gloves without washing hands as per policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Food Service Director on 5/6/25 at 10:41 AM regarding hand hygiene they stated it was the policy to wash hands before applying gloves and staff education had been provided. 10 NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review and interview during a Recertification Survey on 4/29/2025 - 5/6/2025, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. Specifically, the facility did not ensure an infection surveillance plan based on facility assessment was implemented for the identification, containment and prevention of infections. Findings include: The policy titled Infection Control Program last reviewed on 12/24 documented the Infection Control Committee shall investigate, control and prevent infections, decide which procedures shall be applied, such as isolation when control of infection or communicable disease is required: perform surveillance and investigation of prevention, to the extent possible, the onset and spread of infection, prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions. The Antibiotic list for March 2025 and April 2025 documented residents on antibiotic therapy for wound infection, respiratory infection, urinary tract infection, pressure ulcer, bacteremia, and local infection of the skin. The antibiotic list had no documentation that could be reviewed for infection onset dates, signs and symptoms, results of laboratory tests, isolation, and outbreak potential. During an interview on 05/01/25 at 3:40 P M the Director of Nursing/Infection Preventionist stated they were responsible for tracking and surveillance of infections. They further stated the Antibiotic list for March 2025 and Aril 2025 was the surveillance report of residents that were placed on antibiotic therapy. During a subsequent interview on 5/6/2025 at 12:55 PM and review of the Antibiotic list for March 2025 and April 2025 the Director of Nursing/Infection Control Preventionist stated the Antibiotic list which was also the surveillance list lacked documentation of infection onset date, signs and symptoms, laboratory results, radiology results, type of precaution and outbreak potential. 10 NYCRR 415.19(a)(1-3)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, during the recertification survey and abbreviated survey (NY00376185) and (NY00342713), the facility did not ensure residents were adequately equipped to call for assistance through a communication system that relays the call directly to a staff member or to a centralized staff work area. Specifically, 1) the 5th floor call bell was not audible and did not have a centralized location to alert staff when residents needed assistance for twenty nine of twenty nine rooms and the light above the door did not light up for five of the twenty nine rooms (Rooms #104A, 105B, 111P, 115A, 115B, bathroom in room [ROOM NUMBER]). Additionally, tap or hand bells were not provided/readily available as per facility plan for ten of the twenty nine rooms (Rooms #104B, 105B, 111P, 115B, 117A, 121A, 121B, 126B, 127A, 127B, 128A, 128B, 129A, and 129B). The findings include: The Policy and Procedure titled Call Bell System last revised 2/2025 documented the promptness of the call bell is key priority for patients. Addressing and responding to the patient call bell improves patient satisfaction, decreases the patients anxiety and increases their trust and provides the patient with information. The 5/23/24 In-service documented training on 15 minute monitoring initiated related to call bells not working on the 5th floor. The 8/7/24 In-service documented training on the tap bell or hand bells being used in replace of original call bell system on the 5th floor. The 11/16/24 Work Order documented the 5th floor call bell system was broken and unable to be repaired. The emails reviewed included but were not limited to the following: The email dated 1/9/24 from the Bioengineer Manager to the Director of Quality documented an apology for the delay and explained the repair had been a challenge and the vendor was coming out on that date to look at the system. The email dated 1/10/24 from the Bioengineer Manager to the Director of Quality documented the repair of the 5th floor call system and to remind staff to continue to do their rounding's. The email dated 2/22/24 to the Administrator documented the call bell system on the 5th floor was still not functioning as of 1/17/24. The Bioengineer Manager outsourced repair 1/17/24 and was still seeking parts. Continue to use tap bells and 15 minute monitoring. It also documented families had complained about nonfunctioning call bells. The email dated 2/23/24 to the Administrator documented they were collaborating with distributors to explore all avenues. Despite engaging several vendors, regrettably, they had not been successful in repairing the unit. The master stations were phased out as early as 2003. Finding a suitable replacement has been challenging and they would like to review the option of replacing the existing system. Calls would be placed to obtain a new quote. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/27/24 quote from a company provided an estimated cost for the replacement of the 5th floor call bell system. The email dated 1/27/25 documented a delay in the production of equipment, equipment would be received the week of 2/13/25 and once the documentation needed to start the installation was received, they could begin corridor installation the week of 2/17/25. The email dated 2/24/25 sent from the Senior Financial Analyst to the company documented the facility requested an update on the call system being installed, as they had passed the 2/17/25 install date. The email dated 3/14/25 from the company to the Engineer Manager documented availability to start working on the call bell system replacement. The email dated 3/20/25 from the company to the Engineer Manager documented a request to reschedule for 3/21/25 at 11 AM. During an observation with a team of surveyors on 4/29/25 between 11:15 AM and 11:54 AM the 5th floor call bell was not audible and did not have a centralized location in twenty nine rooms, the light above the door did not light up for five of twenty nine rooms (Rooms #104A, 105B, 111P, 115A, 115B, bathroom in room [ROOM NUMBER]). Tap or hand bells were not provided/readily available as per facility plan for ten of twenty nine rooms (Rooms #104B, 105B, 111P, 115B, 117A, 121A, 121B, 126B, 127A, 127B, 128A, 128B, 129A, and 129B). During an interview on 4/29/25 at 11:53 AM, Resident #93 stated when they used the hand bell at times they waited 2-3 hours. During an interview on 4/29/25 at 11:54 AM, Resident #67 stated when they used the hand bell, they were concerned about it actually working. During an interview on 4/29/25 at 11:54 AM, Resident #60 stated when they used the hand bell, the staff could not hear them. They further stated at times they waited 1-2 hours and would go and get the staff themselves. During an interview on 5/01/25 at 4:40 PM, Certified Nurse Aide #29 stated they worked the 3:00 PM to 11:00 PM shift and all residents were to have a hotel or tap bell while the call bell system remained broken. Certified Nurse Aide #29 stated they did frequent rounding every 15 minutes and signed off on a sheet to monitor the residents. During an interview on 5/02/25 at 1:31 PM, the Biomedical Manager stated they were informed about 1 year ago the call bells were not functioning on the 5th floor. They stated the plan was to try to fix and rebuild it initially. The Biomedical Manager stated they contacted vendors but were unsuccessful. They stated they were not able to provide details on how long it took to get approval for the system to be fixed. The Biomedical Manager stated the vendor provided a quote to replace it. The Biomedical Manager stated it took some time to get the plan to replace it approved, but they were scheduled to start replacement of the call bell system next week. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/02/25 at 1:55 PM, the Senior Director of Bioengineering stated the call bell system was a capital purchase that needed to be approved by a lot of people. The Senior Director of Bioengineering stated somebody had to initiate the requisition in their system, which then pinged to the next person, and so on and then the final decision needed to go through finance. The Senior Director of Bioengineering stated there were about 7 people involved in the process. The Senior Director of Bioengineering stated they felt it was urgent but needed to go through the system for it to be processed. The Senior Director of Bioengineering stated they made provisions with the malfunctioning of the call bell system which was to provide manual bells to every room. The Senior Director of Bioengineering stated they had paperwork that was needed prior to the start of construction and the process took some time to come up with plans. The Senior Director of Bioengineering stated when equipment breaks they were responsible for repair, but not responsible to replace broken capital equipment. The Senior Director of Bioengineering stated the layers added to the time it took to get the repair started. The Senior Director of Bioengineering stated it was a critical piece of equipment for the resident's safety and should have been escalated. The Senior Director of Bioengineering stated in retrospect everybody should have really tried to influence the replacement sooner. During an interview on 5/06/25 at 4:03 PM, the Administrator stated they had been following the call bell issue in Quality Assurance and Resident Council. The Administrator stated the plan was to initially repair it, but they found out it was not repairable around January 2024. The Administrator stated they immediately started the process to get the call bell replacement approved. They stated they received quotes immediately and purchasing addressed the quotes. The Administrator stated it went through the system to get approved and it took that long to get all the approvals. The Administrator stated they had to go through this process to get approval and the residents understood the process was lengthy and were comfortable with the 15 minute monitoring that was implemented. 10 NYCRR 415.29