STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Many	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35045 37385 Based on observation, record review, and interview during the extended recertification and abbreviated (NY00331669) surveys conducted 6/4/2024-7/11/2024, the facility did not ensure the physician was consulted and the resident's representative was notified when there was a significant change in the resident's physical, mental, or psychosocial status for 4 of 4 residents (Residents #37, #147, #153, and #528) reviewed. Specifically: - Resident #37 did not receive their Lyrica (used to treat nerve pain) on the day shift (7:00 AM-3:00 PM from 6/22/2024-6/24/2024 due to the facility not having the medication and the provider was not notified. Subsequently, the resident had complaints of uncontrolled pain. - Resident #147 refused heparin (a blood thinner), insulin (used to treat diabetes), and labs as ordered for a period of 6 months, the medical provider was not notified and there was not an assessment by the provider to determine the outcome of the refusals. - Resident # 153 had a critically low blood glucose level reported to the facility by the contracted laboratory service on 6/22/2024 and the provider was not notified. - Resident #528 had a change in condition including lethargy, loose stools, medication refusal, and poor food/fluid intakes and was not assessed by a qualified professional when the change was noted, the medical provider was not notified, and the resident's representative was not notified. Subsequently, the resident was hospitalized with severe dehydration. This resulted in harm to Residents #528 and #37 that was not immediate jeopardy. Findings include: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Many	The facility policy, Change in Condition Notification, revised 8/2022, documented residents would be monitored for changes in their condition, the facility staff would respond appropriately to those changes, and notify the physician and responsible party/family member of changes. The licensed nurse was to notify the resident's next of kin/responsible party when there was a significant change in the resident's condition, physical, clinical, or psychosocial well-being. In the event of a non-life threatening but significant change in the resident's condition, the facility would notify the physician. The licensed nurse would record in the resident's medical record any significant changes in the resident's condition or medical status. The facility policy, Medication Administration, last revised 1/2021 documented medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. 1) Resident #528 had diagnoses including Alzheimer's disease (a type of dementia), post-traumatic stress disorder, and anxiety disorder. The 12/29/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, was independent with bed mobility, transfers, and walking, required set-up assistance for eating, substantial assistance for dressing, and was dependent for hygiene. The comprehensive care plan initiated 12/26/2023 documented: - the resident required assistance with self-care and mobility related to Alzheimer's Disease. Interventions included supervision and set up assistance for eating and drinking, supervision with walking, and was independent with transfers and bed mobility. - The resident had behavioral symptoms such as wandering/pacing, aggression, and refusal of care. Interventions included check for hunger/thirst, toileting needs, and reapproach. - The resident used psychoactive medications related to anxiety and depression. Interventions included monitor, record, and report to the physician side effects and adverse reactions including unsteady gait, falls, refusal to eat, dry mouth, depression, diarrhea, fatigue, loss of appetite, weight loss, and behavior not usual for the person. The 1/2024 Documentation Survey Report (care log) documented the following fluid intakes (recorded in ranges): - on 1/1/2024, 480 cubic centimeters (same as milliliters) to 600 cubic centimeters; - on 1/2/202, 1320 cubic centimeters (higher intakes noted with one amount versus a range); - on 1/3/2024, 1 cubic centimeter to 160 cubic centimeters; - on 1/4/2024, 303 cubic centimeters to 663 cubic centimeters; - on 1/5/2024, 968 cubic centimeters to 1199 cubic centimeters; - on 1/6/2024, 450 cubic centimeters to 1047 cubic centimeters; (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	- on 1/7/2024, 2 cubic centimeters to 330 cubic centimeters; - on 1/8/2024, 1710 cubic centimeters to 2060 cubic centimeters; - on 1/9/2024, 881 cubic centimeters to 1080 cubic centimeters; and - on 1/10/2024, refused or not recorded due to hospitalization . The 1/2024 Documentation Survey Report documented the following food intakes (recorded in percentage ranges): - on 1/1/2024, breakfast, lunch, dinner, and evening snack refused; - on 1/2/2024, breakfast and lunch not documented, dinner 76-100%, and an evening snack; - on 1/3/2024, breakfast, lunch, dinner refused, and no evening snack (marked not applicable); - on 1/4/2024, breakfast and lunch 0-25%, dinner 51-75%, and an evening snack; - on 1/5/2024, breakfast 0-25%, lunch 26-50%, dinner 51-75%, and an evening snack; - on 1/6/2024, breakfast and lunch 0-25%, dinner 76-100%, and an evening snack; - on 1/7/2024, breakfast 0-25%, lunch 51-75%, dinner, and evening snack refused; - on 1/8/2024, breakfast and lunch 51-75%, dinner 76-100%, and an evening snack; - on 1/9/2024, breakfast not applicable, lunch 26-50%, dinner refused, and an evening snack; - on 1/10/2024, breakfast and lunch refused, dinner resident not available (hospital). The 1/2024 Medication Administration Record documented: - on 1/1/2024, 1/5/2024, and 1/7/2024, Senna (constipation medication) was held; - on 1/5/2024, all the 7:00 PM- 9:00 PM medications were spit out; - on 1/8/2024, all the 7:00 PM to 9:00 PM medications were refused; and - on 1/9/2024, melatonin (hormonal sleep aid) was held. The electronic medication administration notes (documented separately from daily nursing progress notes) documented: - on 1/5/2024 at 8:51 PM, entered by Licensed Practical Nurse #4, the Senna (constipation medication) was held due to loose stools, the registered nurse was aware. Vital signs were stable, the resident was very tired, and fluids were encouraged. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	- on 1/7/2024 at 9:25 AM, entered by Licensed Practical Nurse #4, Senna was held due to loose stools, vital signs were stable, the resident was very tired, and the registered nurse was aware. - on 1/8/2024 at 7:55 PM, entered by Licensed Practical Nurse #8, the resident refused their medications and was very lethargic. - on 1/9/2024 at 1:05 PM, entered by Licensed Practical Nurse #9, the resident's appetite remained poor, and they were very tired this shift. Staff assisted the resident back to bed; they appeared unsteady on their feet and was not ambulating on the unit this shift. - on 1/9/2024 at 5:36 PM, entered by Licensed Practical Nurse #4, the resident was very tired, appeared depressed, the day shift reported reduced intakes at breakfast and lunch. Their vital signs were stable, they accepted 240 milliliters of chocolate nutritional drink on the 3:00 PM-11:00 PM shift, the Registered Nurse Unit Manager was informed at 3:00 PM. - on 1/9/2024 at 8:19 PM, entered by Licensed Practical Nurse #4, melatonin was held due to the resident being very lethargic on both day and evening shifts. The registered nurse was aware. There was no documented evidence of registered nurse assessments, medical provider notification, or evaluation related to the resident's symptoms of lethargy, loose stools, medication refusal, and loss of appetite/poor intakes from 1/5/2024 to 1/9/2024. There was no documented evidence the resident's representative was notified of the resident's change in status from 1/5/2024 to 1/9/2024. A 1/10/2024 at 1:46 PM Registered Nurse Manager #5 progress note documented the resident was unresponsive to verbal commands, their blood pressure was 121/89, pulse 99, respirations 22, oxygen was placed on the resident at 8 liters per minute, Code Blue (emergency) was called, and a crash cart (emergency supply cart) was placed at the bedside for precautions. The nurse practitioner provided orders to send the resident to the hospital for evaluation. The 1/10/2024 hospital record documented the resident was admitted for severe dehydration. Per emergency medical services, facility staff reported the resident was last seen well at 10:30 AM, and found just after 1:30 PM, minimally responsive with irregular breathing. Emergency medical services reported the resident's Glasgow Coma Scale (scale that describes the extent of impaired consciousness in all types of acute medical and trauma patients) was 5 (scale of 3-15, with 8 or less meaning severe brain injury). During an interview on 6/11/2024 at 9:45 AM, Licensed Practical Nurse #4 stated they noted a change in Resident #528's condition in the days prior to their hospitalization . The resident was normally up and walking about the unit, visiting with the nurse at the medication cart, and wanting to help staff and other residents. It was a change for the resident to be in bed, lethargic, and not eating or drinking much. The resident had reduced voiding as well. The licensed practical nurse notified the registered nurse supervisor each time they documented it on 1/5/2024, 1/7/2024, and 1/9/2024. They could not recall which registered nurse responded and was unaware if they registered nurse assessed the resident at those times. The licensed practical nurse also notified Registered Nurse Manager #5 on 1/9/2024. The licensed practical nurse stated they did not notify the medical provider due to following the chain of command and notifying the registered nurse. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	During an interview on 6/11/2024 at 11:48 AM, Registered Nurse Manager #5 stated a change in condition included falls, symptoms of illness, behaviors, loose stools, change in baseline functioning, fatigue, or responsiveness. When a change in condition was noted, an assessment should be completed. The licensed practical nurse should call the medical provider or a registered nurse supervisor for assessment. If the licensed practical nurse notified a registered nurse supervisor, the licensed practical nurse could still notify the physician. The registered nurse assessment and/or medical provider contact should be documented in the progress notes. The Registered Nurse Manager stated an assessment should have been completed or the medical provider notified when Resident #528 refused their medications, exhibited fatigue, loss of appetite, and loose stools. The family should have been notified once there was an assessment or a plan from the physician. They were unaware of any registered nurse or medical provider evaluations from 1/5/2024 to 1/9/2024 and was not able to access their 24-hour reports. They could not recall what happened with Resident #528 and they were not made aware of any change in their condition prior to 1/10/2024. They stated following a weekend or off-shift, they would review 24-hour shift report notes and anything the registered nurse supervisors documented. The Registered Nurse Manager could not recall being notified on 1/9/2024 by Licensed Practical Nurse #4 related to the resident's fatigue and loss of appetite. During an interview on 6/11/2024 at 2:08 PM the Director of Nursing stated a change in condition included falls, an event, or a decline in condition. A resident with reported poor intakes and lethargy should be assessed by a registered nurse and the medical provider should be notified. A licensed practical nurse could notify a medical provider, however they typically would have a registered nurse assessment prior to notification to provide the relevant information. If the licensed practical nurse notified a registered nurse for a resident's change in condition, they expected the registered nurse to notify the medical provider, not the licensed practical nurse. The family/resident representative should also be notified when the resident had a change in condition once the provider evaluated them and had a plan. When Resident #528 was noted with loose stools and a medication refusal, they would not expect a medical provider notification at that time. When the resident continued with symptoms of loss of appetite, lethargy, and poor intake, the medical provider should have been notified. Additionally, Resident #528's care plan documented to notify the medical provider of symptoms the resident had been experiencing and should have been notified immediately in accordance with their plan of care. During an interview on 6/20/2024 at 1:02 PM, Certified Nurse Aide #40 (who documented care provided on 1/1/2024, 1/3/2024, 1/6/2024, and 1/7/2024) stated they vaguely recalled Resident #528 and did not know of any concerns related to their change of condition prior to their discharge. During an interview on 6/20/2024 at 2:30 PM, Certified Nurse Aide #91 (who documented meal and care refusals on 1/7/2024 in the evening) stated the resident did not eat well due to frequent walking about the unit. The resident refused meals and needed much encouragement with offers of snacks and sandwiches. The resident could eat as they walked around. They did not recall the resident's change in condition prior to their discharge. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	During an interview on 6/21/2024 at 7:45 AM Physician #41 stated when the resident continued to exhibit changes such as loss of appetite and lethargy in the days prior to 1/10/2024, they should have been notified. The primary reason would be to evaluate the resident, possibly order laboratory tests, and to discuss treatment options with the family. The resident's behaviors contributed to the resident's overall condition, and further testing and monitoring were required to better understand their needs. The resident's sodium level was high indicating possible dehydration. The physician did not feel the facility contributed to the resident's decline; however, they should have notified the physician before the situation became emergent. During an interview on 6/21/2024 at 1:30 PM Certified Nurse Aide #90 stated they were assigned to Resident #528 on 1/10/2024. The resident remained in bed that morning and was alert when care was provided. The aide stated they heard from another (unidentified) aide that the resident had some changes noted such as not walking around as much per their normal behavior. The nurse (unidentified) advised Certified Nurse Aide #90 to let the resident remain in bed. The resident had been up and walking around during the previous day or two. Before lunch, they went to provide care to the resident and noted the resident was alert and said a few words. When the aide turned the resident, they thought there was a change in their breathing and immediately notified the nurse. The nurse (not identified) brought in oxygen and the machine for vital signs. The resident was sent out to the hospital. 2) Resident #147 had diagnoses including end stage renal disease (kidney disease), Type 1 diabetes (the body does not produce insulin) with polyneuropathy (nerve damage), and adjustment disorder with depressed mood. The 3/30/2024 Minimum Data Set quarterly assessment documented the resident had intact cognition, understood verbal content, did not exhibit behavioral symptoms, did not reject care, required set up assistance or supervision for activities of daily living, received an insulin injection 1 of the last 7 days, and received an anticoagulant (blood thinner) during the last 7 days. A 1/2/2024 physician order documented heparin sodium injection solution 5000 units per milliliter inject 1 milliliter subcutaneously 3 times daily for blood clot prevention (discontinued 6/26/2024) and insulin lispro (fast acting insulin) injected as per sliding scale (the amount of insulin injected is based on blood sugar reading) subcutaneously before meals for diabetes mellitus. The 1/2024- 6/2024 Medication Administration Record documented the resident received heparin on 6/3/2024 at 8:00 PM and on 6/23/2024 at 2:00 PM and 8:00 PM, all other doses during that time were not given due to refusal or resident out of the facility. The resident received blood glucose monitoring and sliding scale insulin zero times in January 2024, twice in February 2024, 5 times in March 2024, twice in April 2024, zero times in May 2024, and 9 times in June beginning 6/22/2024. The comprehensive care plan documented: - on 4/21/2022 the resident had a history of exhibiting behavior symptoms such as verbal aggression, combativeness, and refusing dialysis and care. Interventions included notify physician of new or escalating behavior. The care plan was updated on 6/21/2024 to include reapproach the resident for care/toileting/medication administration/treatments and other needs when resident is more agreeable. The resident refused medications. - on 8/15/2022 the resident had insulin dependent diabetes mellitus with interventions including administer medications per physician orders, and monitor blood glucose finger stick per physician orders. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	- on 10/3/2022 the resident was at risk for bleeding secondary to non-steroidal anti-inflammatory drugs/anticoagulant use prophylaxis. Interventions were to administer medications as prescribed, and monitor effectiveness of medications given and observe for adverse reactions. Drug regimen reviews completed by Registered Pharmacists #92 and #93 on 1/3/2024, 1/31/2024, 2/28/2024, 3/31/2024, 4/30/2024, 5/31/2024, and 6/30/2024 documented no recommendations. There was no mention of missed or refused medications in the reviews. Progress notes by Physician #10 dated 2/4/2024, 3/13/2024, 4/1/2024, 4/27/2024, and 5/12/2024 did not document any refusal of medications, glucose monitoring, or labs. There was no documentation of risk/benefits or alternate treatment possibilities. During an interview on 6/26/2024 at 11:33 AM Registered Nurse Unit Manager #94 stated resident refusal of medications should be communicated to the registered nurse. When refused, the medication nurse should reapproach the resident. If the resident still refused it should be documented and the registered nurse should be notified and then notify the provider. Verbal notification had been given to the physician regarding the resident's refusals. There was no evidence of documented communication with the provider. Registered Nurse Unit Manager #94 stated it was important that significant medication refusals be addressed by medical, and heparin and insulin were clinically significant medications. During an interview on 6/26/2024 at 11:46 AM Licensed Practical Nurse # 49 stated they offered resident their medications as ordered, they notified the Registered Nurse Unit Manager of refusals. They thought the Unit Manager would then notify the physician. It was important for the physician to know of refused medications. During an interview on 6/26/2024 at 1:41 PM Physician #10 stated Resident #147 was on heparin for deep vein thrombosis (blood clot) prophylaxis, and insulin sliding scale coverage for diabetes mellitus. They were notified at the beginning of June 2024 about the resident's medication refusals and had a conversation with the resident about taking medications. They did not change the orders so the medications would continue to be offered. The resident refused all labs, finger sticks, and refused heparin 90% of the time. If the resident did not receive the heparin it could lead to blood clots, and not receiving the insulin could lead to elevated blood glucose levels. During an interview on 6/27/2024 at 10:38 AM Registered Pharmacist #92 stated during the medication regimen review they looked at all medications and did look at the Medication Administration Record. If a resident refused medications and it was brought to their attention, or if they knew of refusals, they would notify the prescriber and provide options. The most important thing was notification of the provider. They ensured heparin had appropriate diagnosis, dosing per standards of practice, and lab monitoring. Refusal of medications was not included on their recommendations as the nurses should notify the medical providers. The medical provider should be made aware of refusals, and it was the medical provider's responsibility to come up with a plan. A resident who did not receive prescribed heparin could be at increased risk for a blood clots, deep vein thrombosis, pulmonary embolism (blood clot in the lung), or stroke. The physician should have been made aware of the refusal of insulin and blood glucose monitoring due to increased risk of hyperglycemia (elevated blood sugar) or hypoglycemia (low blood sugar). The pharmacist did not feel pharmacy was responsible for notifying the physician of medication refusals and nursing should be making the medical provider aware of medication refusals. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	During an interview on 6/27/2024 at 3:26 PM Nurse Practitioner #22 stated refusal of medications should be communicated to medical by nursing. Medical should know about refusals because they would need to assess the resident or make changes to medications. If a resident was ordered heparin and not receiving it, it could increase the risk for blood clots. If insulin or finger sticks were not being administered, it was clinically important to prevent hypoglycemia or hyperglycemia. During an interview on 6/28/2024 at 9:42 AM the Medical Director stated the medication regimen review should look at medications for reasonability, clinical indication, and make sure that levels are obtained as needed. They were not sure if the pharmacist looked at the medication administration record. Medications not being received should be reported to the medical provider. They were not aware Resident #147 had not been receiving medications as ordered. Not receiving heparin could lead to stroke, pulmonary embolism, or blood clots. The risk for not receiving insulin as ordered was out of control blood sugars. If medications were ordered, they should be given. 3) Resident #37 had diagnoses including diabetic neuropathy (nerve damage) and chronic venous insufficiency (damaged veins that can cause inflammation). The 5/29/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, frequently felt down, depressed, or helpless, had frequent trouble falling or staying asleep, felt bad about themself, had trouble concentrating, and had thoughts they would be better off dead, or of hurting themself in some way. The resident received a scheduled pain medication regime, received as needed pain medication, had almost constant pain that made it hard for them to sleep at night. and the pain constantly limited their day-to-day activities. The resident's worst pain was a 10 (0-10 pain scale with 10 being the highest pain level). Pain was triggered as a care area with a care plan. The Comprehensive Care Plan initiated 9/29/2022 documented the resident had an alteration in comfort related to neuropathy, back pain, and intermittent claudication (muscle pain from poor blood flow). Interventions included administer medications as ordered, report to the nurse resident complaints of pain or requests for pain treatment, notify physician if interventions were unsuccessful of if current complaint is a significant change from the resident's experience with pain, monitor for signs and symptoms of pain, if resident appears to be in pain utilize appropriate non-pharmacological interventions. Interventions were revised on 5/30/2024 and included evaluate effectiveness of pain intervention, review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, and observe for new onset or increased agitation, restlessness, confusion, hallucinations, nausea, vomiting, dizziness, and falls, and report occurrences to the physician. Physician orders documented: - on 5/22/2024 pain evaluation every shift, record pain on a 0-10 scale. - on 5/22/2024 Lyrica oral capsule 100 milligrams, give 1 capsule every 12 hours for neuropathy, maximum daily dose 2 capsules. The 6/2024 Medication Administration Record documented Lyrica oral capsule 100 milligrams, give 1 capsule by mouth every 12 hours for neuropathy at 9:00AM and 8:00 PM. - on 6/21/2024 Lyrica was last administered at 9:00 PM by Licensed Practical Nurse #86. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	- On 6/22/2024 Lyrica was documented as a 9 (other/see nurse notes) at 9:00 AM Licensed Practical Nurse #53, and at 8:00 PM by Licensed Practical Nurse #28 - On 6/23/2024 Lyrica was documented as a 9 at 9:00 AM by Licensed Practical Nurse #87, and at 8:00 PM by Licensed Practical Nurse - On 6/24/2024 Lyrica was documented as a 9 at 9:00 AM by Licensed Practical Nurse #28 and documented as administered at 8:00 PM by Licensed Practical Nurse #28. Nursing notes documented: - on 6/22/2024 at 10:37 AM by Licensed Practical Nurse #53 Supervisor aware that Lyrica needs to be ordered, not available in Pyxis (an automated medication dispensing system). - on 6/22/2024 at 8:58 PM by Licensed Practical Nurse #28 the Lyrica was on order, awaiting pharmacy to deliver. - on 6/23/2024 at 8:18 AM by Licensed Practical Nurse #87 the Lyrica was not on hand. - on 6/23/2024 at 8:44 PM by Licensed Practical Nurse #28 the Lyrica was on order, waiting for the pharmacy to deliver. - on 6/24/2024 at 9:14 AM by Licensed Practical Nurse #28 the Lyrica was on order, waiting for the pharmacy to deliver. The nursing notes did not document the resident's pain level. The 6/2024 Treatment Administration Record documented pain evaluation every shift. The residents pain level was documented: - on 6/22/2024 at an 8 for the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts; and a 0 for the 11:00PM-7:00 AM shift. - on 6/23/2024 at a 0 for the 7:00 AM-3:00 PM shift; an 8 for the 3:00 PM-11:00 PM shift; and a 0 for the 11:00 PM-7:00 AM shift. - on 6/24/2024 at a 7 for the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. There was no documented evidence the provider was notified Lyrica was not administered to the resident. The 6/24/2024 at 3:49 PM progress note transcribed by Nurse Practitioner #22 and signed by the Medical Director documented the resident's pain was a 7 on 6/24/2024 at 10:46 PM. The resident had chronic lower extremity pain. The resident did not feel their pain was fully compensated on oxycodone (an opioid pain reliever) every 12 hours and the oxycodone was increased to every 8 hours. The resident stated their neuropathic pain in the lower extremities was worse. The resident did not think they received their Lyrica that morning. They spoke with the Nurse Manager who would check on the administration of the resident's Lyrica. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Many	During an interview on 6/24/2024 at 4:44 PM, Resident #37 stated they had not received their Lyrica since 6/21/2024. They stated the Lyrica and oxycodone worked well together. They stated facility staff informed them they had ordered Lyrica last Monday 6/17/2024. They stated acetaminophen did not touch their pain. During an interview on 6/25/2024 at 9:32 AM, Licensed Practical Nurse #28 stated Resident #37 had consistent pain. The resident ran out of scheduled Lyrica on 6/21/2024 and they ordered the medication through the pharmacy. On 6/22/2024, they notified the supervisor that the resident did not have medication available. Resident #37 did not receive their Lyrica on 6/22/24, 6/23/24, and 6/24/24 morning dose. During an interview on 6/25/2024 at 9:32 AM, Licensed Practical Nurse #28 stated the resident was in constant pain. The resident's Lyrica ran out on 6/21/2024. The Licensed Practical Nurse Unit Manager #2 called the pharmacy on 6/21/2024. Licensed practical nurses notified the supervisor if medications were not given to a resident. They notified the supervisor on 6/22/2024 that the Lyrica was not there, and they would contact the provider directly. The policy in the facility was for the licensed practical nurse to call the supervisor and then the supervisor would notify the provider. During an interview on 6/25/2024 at 9:54 AM, Licensed Practical Nurse Unit Manager #2 stated the resident constantly had pain in their lower back and legs from diabetic pain, wound pain, and vascular pain. The resident's Lyrica was low on 6/21/2024 so it was ordered. The medication was supposed to be on the 4:00 PM pharmacy run on 6/21/2024. They did not work the weekend and were informed on 6/24/2024 that they medication still had not come in. The medication nurse was responsible for notifying the supervisor if medications were refused or not available and document when a supervisor was notified. They stated all nurses had access to the pyxis system. During an interview on 6/25/2024 at 10:31 AM, Nurse Practitioner #22 stated that any missed dose of medication was unacceptable. They expected to be notified about missed doses but was not. The nursing staff did not inform them about the missed doses of Lyrica. The resident notified them on 6/24/2024 when the resident pulled them aside to tell them they did not feel well. During an interview on 7/8/2024, at 1:47 PM, Licensed Practical Nurse #28 stated the supervisor was notified and informed them the Lyrica was not available. They stated during the 8:00 PM medication pass on both 6/22/2024 and 6/23/2024, they notified the supervisor the medication was unavailable. They were unsure which nursing supervisor they spoke with on 6/23/2024. They stated they spoke with the Licensed Practical Nurse Unit Manager on 6/24/2024 who spoke with the pharmacy. They stated they had never received training on the Pyxis system (automated medication dispenser). During an interview on 7/9/2024 at 10:27 AM, Registered Nurse #94 stated they worked on both 6/22/2024 and 6/23/2024. They stated the first thing to do if a scheduled medication was not available was to check the Pyxis and call the pharmacy to see if an emergency run could be done. They would then call the provider to get directions on how to proceed until the medication was available. It was important for residents to receive medications as ordered. It is important that pain medications were given as pain can be a contributing factor that affects several areas of life, from therapy to sleep. They did not recall being notified that the resident's Lyrica was not available. The registered nurse supervisor or Unit Manager would be responsible for notifying the provider. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Many	During an interview on 7/9/2024 at 1:47 PM, the Medical Director stated if a resident did not get their narcotic medication, they would expect to be notified. 10NYCRR 415.3(e)(2)(ii)(b,c) 44838 48895

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27522 Based on record review, observation, and interview during the recertification survey conducted 6/4/2024-6/12/2024, the facility did not ensure a safe, clean, comfortable, and homelike environment for 8 of 8 resident floors (Units 1, 2, 3, 4, A, B, C, and D), the main kitchen, and 1 of 2 basement floors (918 basement) reviewed. Specifically, walls, windows, ceiling, floors, furniture, and sinks were damaged or unclean on Units 1, 2, 3, 4, A, B, C, and D; rodent droppings were on the Unit D floor; the main kitchen had a water leak; and the cage area of the 918 basement laundry area had a damaged section of solid ceiling. Findings include: The facility policy, Maintenance-Preventative revised 12/2023, documented upon rounding and findings of non-compliance, work orders and maintenance related issues should be put in either the yellow binders located on all unit nursing stations and/or placed electronically via the kiosks on the units. The facility could not provide work orders for any of the environmental issues identified during the tour of the facility. The following was observed on Unit 4: - on 6/4/2024 at 10:22 AM, there were two chairs behind the Unit 4 South Nursing Station that were torn and in disrepair. - on 6/4/2024 at 10:30 AM, the Unit 4 South Medication Room had two broken light covers. - on 6/4/2024 at 10:35 AM, the Unit 4 kitchenette sink had a 5-gallon bucket under it that was half full of water, and there was a wet towel behind the sink faucets. The following was observed on Unit D: - on 6/4/2024 at 10:37 AM, Unit D's dining room plastic molding was coming off by the wall heaters. - on 6/4/2024 at 10:57 AM, and 6/6/2024 at 10:00 AM, resident room D23 had scuffed walls near both resident beds, and there was an unclean privacy curtain with brownish stains. - on 6/4/2024 at 12:21 PM, Unit D North Medication Room had a cabinet drawer that was heavily stained and soiled with an unknown black substance, and a liquid spilled on the floor. - on 6/4/2024 at 12:27 PM, the Unit D North Clean Utility Room had fast food bags, take out boxes, and food debris. - on 6/4/2024 at 1:00 PM, the Unit D hallway near resident room D44 had a stained ceiling tile. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 6/4/2024 at 1:59 PM, 6/5/2024 at 12:43 PM, and 6/6/2024 at 9:36 AM, the Unit D dining room clock was frozen at 1:20 PM. - on 6/6/2024 at 10:41 AM, the Unit D Day Room closet had food debris and rodent droppings. The following was observed on Unit 3: - on 6/4/2024 at 11:07 AM, the Unit 3 solid ceiling near the staff elevator had a 2 inch circular black stain. - on 6/4/2024 at 11:20 AM, the Unit 3 hallway had a chair near resident room [ROOM NUMBER] that was torn with exposed foam. - on 6/10/2024 at 11:07 AM and at 3:45 PM, resident room [ROOM NUMBER]'s window blinds would not raise or lower, there was a wet towel under the air conditioning unit, the filter for the air conditioning unit was moldy and wet, there was a slight water leak by the sink handle, there were rolled up blankets at the base of the window, and there was no remote for the window side electrical bed. - on 6/10/2024 at 3:52 PM, resident room [ROOM NUMBER]'s window blinds would not raise or lower. The following was observed on Unit 2 on 6/4/2024: - at 11:40 AM, the Unit 2 North Soiled Utility Room's counter was in disrepair. - at 11:45 AM, the Unit 2 North Shower Room had a broken call bell cord cover plate that was chipped with sharp edges, and there was a butter knife on top of the sharp's container. - at 12:20 PM, the Unit 2 South Shower Room had a missing call bell cord near the shower area, and there was a call bell cord near the sink that was 5 inches long. - at 12:28 PM, resident room [ROOM NUMBER] had a damaged/scraped section of wall behind the door side resident bed. - at 12:30 PM, resident room [ROOM NUMBER]'s bed pillow was ripped in multiple spots, there was a 18 x 6 solid ceiling near the window that was damaged/bubbled, and there were sections of the wall with spackle on it. The following was observed on Unit 1: - on 6/4/2024 at 1:12 PM, the Unit 1 Soiled Utility Room countertop was damaged with a hole in it. The following was observed on Unit C: - on 6/4/2024 at 1:12 PM, the Unit C North Medication Room had a bin with dried red liquid labeled pharmacy returns. There were numerous stained and moldy ceiling tiles. Licensed Practical Nurse #49 stated the bin with the red liquid should not have been in the medication room and should have been thrown away. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 6/4/2024 at 1:45 PM, the Unit C Pantry had no hot water coming out of the hand-wash sink. The Director of Maintenance stated they were not aware there was no hot water in the pantry sink. - on 6/24/2024 at 10:36 AM, room C23 was observed to have a strong foul smell of urine and at 4:47 PM, room C23 remained with a strong smell of urine and stool and the floor was sticky. - on 6/30/2024 at 4:37 PM, near rooms C37- C40 there was a strong urine smell. - on 7/1/2024 at 10:44 AM, outside of resident rooms C40 and C39 there was a strong odor of urine. During an interview at 10:51 AM, Registered Nurse Unit Manager #94 stated they planned to speak to the Housekeeping Manager because they noticed the unit was not being cleaned properly and there were strong odors of urine in two different corners of the unit. The following was observed on Unit B: - on 6/4/2024 at 3:00 PM, the B Floor Clean Utility Room had a 2 foot x 2 foot section of ceiling that was stained; and - on 6/4/2024 at 3:07 PM, the B Floor Nursing Station had a wall with a small rectangular hole in it, and there was a missing electrical cover plate. The following was observed on Unit A: - on 6/5/2024 at 10:38 AM, the Unit A Activity Storage Room had a damaged and stained 1 foot x 4 foot ceiling tile, and there was an active water leak causing tile damage. There was a wet storage rack that contained gardening supplies (pots, soil, activities boxes and totes). There was a large, stained puddle on the floor from the drying active leak. - on 6/5/2024 at 10:42 AM, the Unit A Shower Room sink faucet had running water that could not be shut off. The wall hand-wash sink was loose as the caulk had pulled away from the wall seal. On 6/5/2024 at 9:26 AM, the cage area of the 918 basement laundry area had a damaged 2 inch by 4 inch section of solid ceiling. On 6/5/2024, the following was observed in the main kitchen: - at 11:16 AM, there was water coming through the wall from the main kitchen cart spray area into the adjoining cafeteria room. The concrete curb around the base of this wall was cracked, chipped, discolored, and showed signs of moisture. During an interview on 6/7/2024 at 9:04 AM, Certified Nurse Aide #46 stated if equipment was not working, they would let a nurse know who would then fill out a work order. They stated no one had ever mentioned any environmental issues to them, and that once the maintenance department was notified it would take a day or two to fix the problem. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/7/2024 at 10:58 AM, Assistant Administrator #48 was replacing the clock battery in the D floor dining room. They stated that it was important for all the facility clocks to work so residents would know the time of day, especially since the D floor was the facility memory unit. They stated all staff were able to observe the clocks in the facility, and that all staff had been trained to put in work orders. During an interview on 6/10/2024 at 9:16 AM, the Director of Maintenance stated there was a yellow work order binder at every nursing station. They stated there were computer kiosks on every unit with the maintenance application on it. Work order requests went directly to their phone. The Director of Maintenance stated the work order binders were checked every morning and on the second shift and were sometimes checked twice on the day shift. During an interview on 6/10/2024 at 11:26 AM, Certified Nurse Aide #47 stated if staff identified a broken item, it should be entered into the maintenance logbook or the computer kiosk. They stated they had entered resident room [ROOM NUMBER] and none of the controls at the foot of the bed worked, and they were not able to find a hand remote. They stated they were told two weeks ago by management that a new electrical bed was going to be brought into resident room [ROOM NUMBER]. They stated the blankets had been placed at the base of the window to stop wind from coming in, and the wet blankets on the floor were a slipping hazard. During an interview on 6/11/2024 at 9:22 AM, Assistant Administrator #48 stated if a bed was broken, staff should complete a work order by entering it on the computer kiosk or by writing it in the yellow binder located at each nursing station. They stated the maintenance staff would try to fix electrical beds every day, and that every bed should have a remote control for residents to use. They were not aware of any electrical beds that were missing a remote control. The facility did not have extra parts that could be swapped from another bed. There were extra electrical beds that could have been moved into resident room [ROOM NUMBER]. They stated they were in resident room [ROOM NUMBER] two weeks ago to look at the air conditioner unit, had seen mold on the air conditioner filter, and was not aware the window side bed in the room was broken. A work order should have been placed for the issues identified in resident room [ROOM NUMBER]. They stated that filters should be changed within two days, and they thought a work order had been put in for the moldy air conditioner filter. During an interview on 6/11/2024 at 11:12 AM, Certified Nurse Aide #51 stated if they saw scraped walls or malfunctioning equipment they should tell a Nurse Manager, and they would put in a work order. They stated they were newer to the facility and had not been in resident room D23 that week. Any staff could do environmental rounds and if they noticed unclean privacy curtains, they should tell a housekeeper. They stated it was not homelike or dignified for walls in resident rooms to be scraped or for privacy curtains to be unclean. During an interview on 6/11/2024 at 11:15 AM, Housekeeper #52 stated the laundry department was responsible for washing privacy curtains. During an interview on 6/11/2024 at 11:20 AM, Licensed Practical Nurse #9 noticed the wall scrapes in resident room D23 and was not sure if anyone told the maintenance department. Any staff could enter work orders into the computer or tell the Unit Manager who would then tell the maintenance department. The laundry department was responsible for cleaning privacy curtains, and they were not sure of the cleaning frequency for the curtains. Any staff who entered resident rooms should report environmental issues they see. Scraped walls and unclean privacy curtains were not homelike. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2024 at 10:58 AM, the Director of Maintenance stated they were not aware of the environmental issues identified during the tour of the 918 and 906 buildings. They stated the bed in resident room [ROOM NUMBER] should have been fixed in a timely manner. They did not know how frequently a resident room was cleaned as that was the responsibility of the housekeeping department. They stated they could not find any work orders for the issues identified, and it was important for the residents to have a homelike and safe environment. 10 NYCRR 415.29(j)(1) 35045 40803

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F 0658 Level of Harm - Actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. 48895 Based on observation, record review, and interview during the extended recertification and abbreviated (NY00335306, NY00334736, NY00331600, NY00335937, NY00337529, NY00340292, NY00340725, and NY00335379) surveys conducted 6/4/2024-7/11/2024, the facility did not ensure services provided met the professional standards of quality in 5 of 5 areas (pressure ulcers, medication administration, respiratory care, activities of daily living, and laboratory testing notifications). Specifically, medication administration was not completed in accordance with accepted standards of clinical practice (see F 554); provider notification was not completed for residents with significant changes in condition (see F 580); oral care and feeding assistance was not completed as ordered or planned (see F 677); pressure ulcer prevention services were not completed as ordered (see F 686); splints were not applied as ordered (see F 688); recommendations for appetite stimulant were not discussed with the provider for a resident with significant weight loss (see F 692); respiratory equipment was not maintained appropriately (see F 695); residents had unresolved pain that affected their daily functional abilities (see F 697); medically related social services were not provided to residents with significant mental health diagnoses (see F 745); and routine laboratory testing and the results were not reviewed by facility staff in a timely manner, and the medical provider was not notified in a timely manner of the abnormal lab results (see F 773) . Additionally, the inability to meet the professional standards led to the outcome of abuse and neglect (see F 600). Findings include: The New York State Education Law Article 139, Section 6902 documented the practice of the profession of nursing included the executing of medical regimens prescribed by a licensed physician. The facility policy, Charting and Documentation dated 10/2019, documented the following information was to be in the resident's record: objective observations; medication administered; treatments or services performed; changes in resident's condition, events, incidents, or accidents involving the resident; and progress toward or changes in the care plan goals. Self-Administration of Medication (F554): - Resident #21 was observed with ammonium lactate 12% cream, pink liquid stomach relief, and bottle of surgical scrub in their room. - Resident #64 was observed with 3 pills at the bedside on 6/4/2024, and a pill on the floor on 6/7/2024. - Resident #72 was observed with eye drops at bedside. - Resident #207 was observed with 1 pill on the bedside table. - Resident #239 was not observed by nursing staff to ensure medication administration was complete for a controlled substance. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Many	- All 5 residents did not have documented evidence they were assessed to determine their ability to safely self-administer their medications or of a physician order for self-administration of medication. The facility's failure to ensure residents' medications were safely administered placed all 248 residents at risk for serious harm or serious adverse outcomes. This resulted in Immediate Jeopardy to resident health and safety. Physician Notification for Change in Condition (F580): - Resident #37 did not receive their Lyrica from the day shift (7:00 AM-3:00 PM) of 6/22/2024 until day shift of 6/24/2024 due to the facility not having the resident's ordered medication and the provider was not notified. This resulted in putting residents who received pain medication, at risk for harm that was Immediate Jeopardy and Substandard Quality of Care. - Resident #147 refused heparin, insulin, and labs as ordered for a period of 6 months, the medical provider was not notified and there was not an assessment by the provider. - Resident #153 had a low blood glucose level that was reported to the facility by the lab on 6/22/2024 and the provider was not notified. This resulted in the likelihood of serious injury, serious harm, or death that was Immediate Jeopardy to resident's health and safety. - Resident #528 had a change in condition and was not assessed by a qualified professional when the change was noted, the medical provider was not notified, and the resident's representative was not notified. Subsequently, the resident was hospitalized with severe dehydration. This resulted in harm to Residents #528 and #37 that was not immediate jeopardy. Activities of Daily Living (F677): - Resident #154 did not receive oral hygiene as ordered. - Resident #226 did not receive assistance with eating as care planned. Pressure Ulcer Services (F686): - Resident #826 was readmitted from the hospital with pressure injuries of the sacrum and heel, the areas were not assessed by a qualified professional, and there were no treatments provided for the areas. The resident was re-hospitalized on two subsequent occasions, had pressure injuries of the sacrum and heels, the areas were not assessed timely by a qualified professional or provided with treatments following readmission. - Resident # 271 had orders for pressure relief boots to be worn while in bed and the boots were not applied. Subsequently, the resident developed a deep tissue injury (localized area of purple/maroon discolored intact skin due to damage of underlying tissue) area to their right heel. Additionally, there were wound care recommendations for a wheelchair cushion evaluation and for the resident's brief to be left open to air that were not implemented. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Many	- Resident #222 and #265 both had documented pressure ulcers with orders for daily dressing changes that were not completed as ordered. This resulted in harm and Substandard Quality of Care to Residents #271 and #826 that was not immediate jeopardy. Limited Range of Motion (F688): - Resident #64 did not have bilateral hand splints in place as ordered and care planned. Maintaining Acceptable Parameters of Nutritional Status (F692): - Resident #133 had a significant weight loss and recommendations for an appetite stimulant were not discussed with the medical provider. Respiratory Care (F695): - Resident #64's did not receive the appropriate Bilevel Positive Airway Pressure (mechanical non-invasive ventilator for breathing assistance) mask. Pain Management (F697) -Resident #28's physician ordered pain cream was not administered as ordered and was documented as administered. -Resident #37 did not receive Lyrica (used to treat nerve and muscle pain) as ordered for 3 days; -Resident #64 was not aware of an as needed order for acetaminophen (pain reliever) and was not offered the medication when in pain. Subsequently, Residents #28, #37, #64 had unresolved pain that affected their daily functional abilities, psychosocial well-being, and diminished quality of life. This placed all residents with pain, who received pain medication, at risk for harm that was Immediate Jeopardy and Substandard Quality of Care. Medically Related Social Services (F745): - Resident #41 did not have person-centered mental health interventions, licensed psychologist's recommendations were not implemented into the resident's plan of care. There were no documented social services follow up with the resident following their behaviors. - Resident #126 did not have person-centered mental health interventions for their behaviors or refusals of care and medications. There were no documented social services follow up with the resident following their behaviors. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Many	- Resident #153's licensed psychologist's recommendations were not implemented into the resident's plan of care, a recommendation for a traumatic brain injury program was not investigated, and recommendations to continue psychotherapy were not followed. There were no documented social services follow up with the resident following their behaviors. - Resident #235 had behaviors of taking things off the nurses' cart and throwing them leading up to an episode of threatening staff with scissors, requiring police intervention and hospitalization for the resident. There were no documented interventions from social services and the resident did not have person-centered interventions for their history of delusions and taking/throwing things off the nurses' cart. - Resident #250 did not have person-centered mental health interventions for their behavioral symptoms. - This placed all residents with mental health disorders at risk for physical, mental, and psychosocial harm that was Immediate Jeopardy and Substandard Quality of Care. Laboratory Services Notification of Results (F773): - Resident #529 had routine laboratory testing and the results were not reviewed by facility staff in a timely manner, and the medical provider was not notified in a timely manner of the abnormal lab results. Subsequently, the resident was hospitalized 3 days later with pneumonia and dehydration. This resulted in harm to Resident #529 that was not immediate jeopardy. - Resident #153 had a critically low blood glucose (blood sugar) of 49 milligrams/deciliter and the provider was not notified in a timely manner and the resident was not assessed. - Resident #260 had a high international normalized ratio (INR, used to determine blood clotting times for residents on anticoagulant therapy) and the provider was not notified timely, and the resident was not assessed. - This resulted in the likelihood of serious injury, serious harm, or death that was Immediate Jeopardy to resident's health and safety. During a telephone interview on 6/10/2024 at 10:05 AM, Nurse Practitioner #16 stated if they ordered acute labs for a resident, they typically followed up the next day to review the results. If routine scheduled labs were completed, they expected nursing to notify them as soon as possible of any alterations. Lab results such as a high white blood cell count and elevated blood urea nitrogen were labs they wanted to be notified about. They stated they believed they did not work on 2/16/2024 and did not review the resident's labs until after the resident was discharged to the hospital. If they had known the resident's white blood cell count was high, they would have intervened and ordered a chest x-ray and/or urinalysis (often used to check for urinary tract infections). For the elevated blood urea nitrogen, they would have ordered extra hydration (fluids) by mouth or intravenously (through a vein). Earlier intervention could have resulted in a different outcome for the resident. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Many	During an interview on 6/10/2024 at 11:50 AM, Licensed Practical Nurse #34 stated Resident #28 had not yet received their 9:00 AM dose of pain relief gel. The nurse stated they signed off for all medications in the morning and did treatments after they finished the oral medications. They made a list for tasks they signed off on and had to come back to complete, including application of cream and dressing changes. They stated they should not sign off on medications they did not give. If the resident refused after they already signed off, they would strike out the entry. During an interview on 6/10/2024 at 12:35 PM, Certified Nurse Aide #40 stated the resident had dementia and required assistance with their meals. They stated the resident was on their assignment and they did not help the resident. They had a lot of residents that needed assistance, and they needed more staff to help. During an interview on 6/10/2024 at 12:54 PM, Licensed Practical Nurse #30 stated they were supposed to complete a dressing change for Resident #222 but did not get to complete it. They made a list of items they signed off for in the electronic medical record to make sure they completed the tasks, and their actions matched what they previously charted. If they were unable to complete a task on their list, they tried to go back into the electronic medical record and edit their entry, but they did not always have time. During an interview on 6/11/2024 at 9:18 AM, Nurse Practitioner #22 stated recommended interventions should have been brought to the provider's attention after the interdisciplinary team meeting in May 2024. The medical provider was not notified in a timely manner of the significant weight loss and recommendations for an appetite stimulant. During an interview on 6/11/2024 at 11:54 AM, Assistant Director of Nursing #24 stated medications should not be left at the bedside. Documentation should not be completed before the treatment was done, as the resident could refuse, leave the unit, or staff could forget or get too busy to come back later. During an interview on 6/12/2024 at 10:00 AM, Licensed Practical Nurse #33 stated they were trained to complete all oral medications and sign off on all the medications. They would write down the medications and tasks that needed to be completed based on what they signed off on as completed. If a resident refused or was not in their room, they would strike out the entry and write a progress note. They stated it was not a good idea to sign off on things they had not yet completed, because the sign off documents it as complete. During an interview on 6/12/2024 at 12:29 PM, the Nurse Educator stated they discussed medication administration at orientation, and nurses should document that medications were administered right after being given. They did not train staff to sign for things that were not done, that was unethical. Signing for something that was not done was falsification of documentation, and the nurse did not do it. The expectation was that all medications were signed for at the point of care. If something was not done, it should not be signed for. They expected to see dressing changes done the day they were dated, and the dates should be done as ordered. Respiratory equipment should be placed properly, if not the resident could have problems with breathing when sleeping. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Many	During an interview on 6/12/2024 at 12:29 PM, the Director of Nursing stated it was expected that the staff completed treatments as ordered, they were medically necessary for the resident and the provider deemed them appropriate. Staff should not sign off on tasks ahead of time, but if they had and the resident refused, or they were unable to complete the ordered treatment they should edit their documentation to reflect that. They should also let the supervisor know they were unable to complete the required task. Signing off on tasks before completing them, did not meet the professional standard for care. Medications should not be signed off as completed before the medication was administered to the resident. Signing off on medications before administration did not meet the professional standard. It was expected that splints were placed on residents as ordered. The electronic medical record should not be sign off without the splints being placed on the resident. The signature documented the task was complete when it was not. If the task was signed as completed and the resident refused, the documentation should reflect the actual care of the resident. Signing off on splint placement and not placing the splint did not meet the professional standard. It was expected that residents would have their teeth brushed as ordered and should not be signed for if it was not completed. Signing off the task of oral hygiene without completing it, did not meet the professional standard. During an interview on 6/25/2024 at 9:09 AM Registered Nurse #89 stated on 6/21/2024 at 5:26 PM they received a call from the lab stating Resident #153 had a glucose of 49 milligrams/deciliter. They were completing an admission assessment on another resident at the time of the call, but they called the unit to check on Resident #153. They were told the resident had taken all their medications. They should have called a medical provider to let them know the resident had a critical result of 49 milligrams/deciliter to get further orders. 415.11(c)(3)(i) 49448

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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. 40803 48446 Based on observation, record review, and interviews during the extended recertification and abbreviated (NY00331600, NY00335937, NY00337529, NY00340292, and NY00340725) surveys conducted 6/4/2024-7/11/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 11 residents (Residents #154 and #226) reviewed. Specifically, Resident #154 did not receive oral hygiene as ordered; and Resident #226 did not receive assistance with eating as planned. Findings include: The facility policy, Activities of Daily Living Support, revised 10/2019 documented appropriate care and services would be provided for residents who were unable to carry out activities of daily living independently, with the consent of the resident and according to the plan of care, including appropriate support and assistance with: hygiene (including bathing, dressing, grooming and oral care); mobility (transfer and ambulation including walking); elimination (toileting); dining (meals and snacks); and communication (speech, language and any functional communication systems). 1) Resident #154 had diagnoses including cerebral vascular accident (stroke), left sided hemiplegia (paralysis), and dysphagia (difficulty swallowing). The 4/16/2024 Minimum Data Set assessment (health assessment screening tool) documented the resident had moderate cognitive impairment, did not refuse care, was dependent on staff for most activities of daily living, had impaired upper and lower extremity range of motion on one side, and received nutrition through a feeding tube. The 1/26/2024 dental record documented Resident #154 was scheduled for cleaning and scaling (removal of plaque and tartar above and below the gumline). The procedure was not tolerated because the resident was choking. The 4/10/2024 physician order documented toothbrush and toothpaste followed by suctioning twice a day, and suction resident every four hours and as needed. The comprehensive care plan, revised 4/29/2024, documented the resident required assistance with activities of daily living due to weakness. The resident had oral/dental health problems with interventions including mouth care and dental consultation and follow up. The 6/2024 resident care instructions documented oral care: toothbrush and toothpaste followed by suctioning/toothettes twice a day. During an observation and interview on 6/4/2024 at 11:08 AM, Resident #154 was sitting in a wheelchair in their room with family. The family member stated the resident did not have their teeth brushed because there was a white substance around the resident's teeth and gums, and the resident reported their teeth were not brushed. The resident's toothbrush was dry, and the suction canister was clean and empty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/7/2024 at 9:30 AM, Resident #154 had a white substance between their lower teeth and around the gums of their lower teeth. The upper teeth could not be observed. The resident stated they did not have their teeth brushed and would like them brushed. The suction canister was clean and was dated 6/7/2024. During an observation and interview on 6/7/2024 at 11:34 AM, Resident #154 was in a wheelchair in the day room. Their bottom teeth had a white substance between each tooth and around the gums. The upper teeth could not be observed. The resident stated they did not have their teeth brushed and would like them brushed. The suction canister in their room was clean and was dated 6/7/2024. The 6/2024 Treatment Administration Record documented oral care-toothbrush and toothpaste followed by suctioning twice daily between 7:00 AM-10:00 AM and from 7:00 PM- 9:00 PM. The 6/4/2024 7:00 AM-9:00 AM treatment was signed by Licensed Practical Nurse #33 with a 9 (other/see nurse's note) and signed by Licensed Practical Nurse #33 as administered on 6/7/2024. The corresponding nursing progress note for 6/4/2024 at 11:11 AM by Licensed Practical Nurse #33 documented the family member refused to have staff do care that morning. During an interview on 6/5/2024 at 9:34 AM, Certified Nurse Aide #26 stated they just completed morning care for Resident #154. They gave them a bed bath and provided oral care with a swab. They stated the nurses brushed the resident's teeth and it was not a task for certified nurse aides because the resident required suctioning when their teeth were brushed. During an interview on 6/7/2024 at 12:18 PM, Nurse Practitioner #22 stated Resident #154 had an order to have their teeth brushed twice a day and suctioned every four hours including when brushing their teeth. They stated they did not believe it was being done as ordered and they had to be sent to the dentist more frequently. They stated teeth brushing and suctioning was done at the same time, therefore if the suction canister was empty, the resident did not have their teeth brushed. If teeth were not brushed as ordered, the resident could get plaque buildup and other oral diseases. During an interview on 6/11/2024 at 11:54 Assistant Director of Nursing #22 stated they expected oral care to be completed as ordered. They stated if teeth were not brushed as ordered the resident could have increased bacteria in their mouth and damage to their teeth. They stated oral care should be signed off only when completed. During an interview on 6/12/2024 at 10:00 AM, Licensed Practical Nurse #33 stated they worked on 6/4/2024 and 6/7/2024. They always brushed Resident #154's teeth and suctioned them after they were done, around 11:00 AM. The family was very particular about care and notified them many times that oral care was not provided. If oral care was not provided the resident could get gingivitis (inflammation of the gums) and even lose their teeth. If the suction canister was empty on 6/4/2024 when family arrived around 11:00 AM, the resident's teeth were not brushed. They should not have signed they completed that treatment since it was not completed. They stated they should have completed the 6/7/2024 ordered oral care for 8:00 AM and did not. 2) Resident #226 had diagnoses of Alzheimer's disease (a form of dementia), and adult failure to thrive (a state of overall decline). The 4/12/2024 Minimum Data Set assessment (health assessment screening tool) documented the resident had severe cognitive impairment and required substantial to maximal assistance with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan last reviewed 4/2024 documented the resident had a nutritional problem related to dementia diagnosis that included a significant weight loss in 4/2024. The goal included resident oral intake would improve and move towards or above consuming 76% of all their meals. Interventions included provide encouragement and cueing at meals, and supplements as ordered. The resident also required assistance with their activities of daily living related to dementia. The resident required substantial assistance (helper completed more than half of the activity) of one for eating. The 4/9/2024 Social Worker #37's progress note documented the resident had an interdisciplinary team meeting and the team discussed the resident had a significant weight loss due to progression with dementia. The resident was not able to focus on meals and wandered away at mealtime. Therapy and nursing were working with the resident. The resident was dependent with feeding and needed assistance with meals. The 5/10/2024 Dietetic Technician #38's progress notes documented the resident required substantial assistance with eating. The significant weight loss in three months was not desirable and was likely related to poor intakes due to dementia. The resident was constantly redirected during mealtime with some success. The Unit Manager was notified of the weight change. The 6/5/2024 care instructions documented the resident required maximum assistance of one for meals and to provide encouragement and cues at mealtime. During an observation on 6/5/2024 at 1:08 PM, Licensed Practical Nurse #9 set the resident's lunch meal up in front of them and left the resident unattended without assistance. At 1:36 PM, the resident continued to attempt to eat lunch without assistance. During an observation on 6/6/2024 at 8:53 AM, the resident was sitting in the dining room eating breakfast without staff assistance. At 9:26 AM, the resident had consumed 100% of their muffin, juice, and eggs, and 50-75% of the pudding; at 9:46 AM, a staff member removed the resident's tray. There was no staff assistance or encouragement provided during the meal. At 1:54 PM, during the lunch meal, the resident was not assisted with their meal and was pouring their fruit cocktail on their tray. They had eaten 50% of the pork and less than 25% of the potatoes and vegetable. At 1:59 PM, the resident was stepping away from the table. There resident was not assisted with their lunch meal. The resident's consumption record for 6/5/2024 and 6/6/2024 did not document the resident's meal intake. During an interview on 6/10/2024 at 11:31 AM, Registered Nurse Unit Manager #5 stated the resident had weight loss and staff should assist them with their meal. If staff were not helping, encouraging, or providing verbal cues this could impact the resident's intake. They stated substantial maximal assistance for eating meals meant the resident required help with holding items, and someone should sit with the resident. During an interview on 6/10/2024 at 11:59 AM, Licensed Practical Nurse # 9 stated substantial/maximal assistance meant staff were required to sit with the resident and aid them during the meal. If the resident was not provided the assistance as care planned, it could impact their intake and weight status. Staff should provide verbal assistance, cueing, and pointing to things on the resident's plate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2024 at 12:17 AM, Certified Nurse Aide #39 stated the care instructions showed what level of assistance each resident required. It was important for staff to review the care instructions. Resident #226 required assistance with eating. They could feed themself, but staff should get the resident started and come back to provide verbal cues and encouragement. During an interview on 6/10/2024 at 12:35 PM, Certified Nurse Aide #40 stated the resident had dementia and required assistance with their meals. They stated the resident was on their assignment and they did not help the resident. They had a lot of residents that needed assistance, and they needed more staff to help. During an interview on 6/11/2024 at 10:17 AM, Dietetic Technician #38 stated the resident was supposed to be assisted with their meals. 10NYCRR 415.12(a)(3)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37385 44838 Based on observations, record review, and interviews during the extended recertification and abbreviated (NY00335306) surveys conducted 6/4/2024-7/11/2024, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 4 of 7 residents (Residents #222, #265, #271, and #826) reviewed. Specifically, Resident #826 had pressure injuries that were not assessed, and was not provided treatments to promote healing. Subsequently, Resident #826 was admitted to the hospital with a chronic sacral osteomyelitis (inflammation of bone tissue related to infection) with overlying cellulitis (skin infection). The resident underwent surgical debridement (removal of dead tissue), was in a great deal of pain, was unable to sit, which hindered their ability to attend dialysis while in the hospital. Resident #271 developed a deep tissue injury after orders to aid in the prevention of pressure injuries were not followed. Resident #271 had orders for pressure relief boots to be worn while in bed, which were not applied, in addition to other wound care recommendations that were not completed. Resident #265's pressure ulcer treatments were not administered daily as ordered. Resident #222 pressure ulcer treatment and off-loading heel boots were not administered daily as ordered. This resulted in harm and Substandard Quality of Care to Residents #271 and # 826 that was not immediate jeopardy. Findings include: The facility policy, Risk and Skin Assessments, last revised 1/2021, documented prevention of pressure ulcers required early identification of at risk residents and the implementation of prevention strategies. Skin assessments were done by a licensed nurse weekly. The facility policy, Skin and Pressure Injury Prevention, revised 3/2023, documented staff would conduct a comprehensive skin assessment upon admission /re-admission including skin integrity, any evidence of existing or developing pressure injuries, or other skin abnormalities or areas of impaired integrity. The risk assessment should be conducted as soon as possible after admission. Once the assessment was conducted and risk factors identified and characterized, the resident-centered care plan would be created. 1) Resident #826 had diagnoses including prostate cancer, bone cancer, and dependance on renal dialysis (a process that filters blood during kidney failure). The 6/8/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, was at risk for pressure ulcers, and did not have unhealed pressure ulcers. The 6/1/2023 admission evaluation completed by Registered Nurse Unit Manager #23 documented the resident had padded dressings to both heels and no other open areas were noted. The resident had a Braden score of 15, (a scale that determines risk for development of pressure ulcers) and was at low risk. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The comprehensive care plan initiated 6/1/2023 documented the resident was at risk for pressure injury development related to immobility. Interventions included apply moisturizer as needed, monitor nutritional status, and monitor and report changes in skin status. The 6/2023 Documentation Survey Report (daily care log) documented to off load heels with pillows or boots as tolerated and turn and reposition every 2 to 4 hours as indicated and as needed. The 6/9/2023 at 9:17 AM Registered Nurse #1 (former Assistant Director of Nursing) progress note documented the resident went to a medical appointment, was sent to the hospital from the appointment due to fatigue. The resident was admitted to the hospital. The 6/16/2023 hospital discharge summary documented the resident had an unstageable pressure injury (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) to the sacral region and a deep tissue injury (discolored skin due to damage of underlying soft tissue from pressure or shear) to the right heel. Discharge instructions included follow up with the wound care center. The 6/16/2023 Nursing Admission Evaluation completed by the Assistant Director of Nursing #1 documented the resident had 5 wounds: a bicep fistula, a chest port site, deep tissue injury to both heels, and an unstageable pressure injury to their sacrum. The left heel measured 3 centimeters x 4 centimeters, and the right heel measured 4 centimeters x 2 centimeters and treatments were in place. The heel wounds were noted to have absorbent pads. There was no documentation of wound measurements or a treatment for the unstageable pressure injury on the sacrum. There were no documented treatment orders for the resident's deep tissue injury as referenced in the Assistant Director of Nursing #1's 6/16/2023 Admission Evaluation. The comprehensive care plan initiated 6/19/2023 documented the resident was at risk for impaired skin integrity related to fragile skin, impaired mobility, and renal disease. Interventions included apply protective/preventive skin care, minimize extended exposure of skin to moisture with frequent incontinence care and prompt removal of wet clothing/bedding as needed, and report any signs of deterioration or significant change to area of impairment. The care plan did not address the unstageable pressure injury to the sacrum. The 6/19/2023 Nurse Practitioner #6 progress note documented they saw the resident for an admission evaluation. There was no documentation related to the pressure injuries on the resident's sacrum or heels. The 6/20/2023 Nurse Practitioner #6 progress note documented the resident was seen for a follow up visit related to not feeling well. The resident had severe pain in their back. The review of systems included skin impairments of unstageable sacral ulcer and heel ulcers (not specified) to both heels. There were no recommendations or orders for treatments documented. The 6/20/2023 physician order documented weekly skin evaluation every Tuesday on the day shift. The 6/2023 Treatment Administration record did not include treatments for the heel deep tissue injuries or the unstageable sacral ulcer. The record documented the weekly skin evaluation was completed on 6/20/2023 and 6/27/2023. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	There was no documented evidence of skin impairments to the sacrum or heels from the skin evaluations. There was no documented evidence of wound care or a physician's order for the sacral or heel wounds from 6/16/2023 to 6/28/2023 (when the resident was re-hospitalized). There was no documented referral to wound care center. A 6/28/2023 at 3:07 PM Licensed Practical Nurse Unit Manager #2 progress note documented the resident went for a cancer care appointment and was sent to the emergency room . The 6/28/2023 hospital History and Physical documented the resident's diagnoses included deep tissue injury to the right heel and an unstageable pressure injury to the sacral region. The comprehensive care plan initiated 7/20/2023 documented the resident had an alteration in skin integrity and had an actual pressure injury to the sacrum, Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle). Interventions included evaluate wound weekly and as needed, document measurements, appearance, drainage, and surrounding tissue, monitor for changes, nutritional and therapy evaluation. (The comprehensive care plan was initiated before the resident returned from a 6/28/2023-7/21/2023 hospital stay). The 7/21/2023 hospital After Visit Summary documented the resident had deep tissue injury to both heels and an unstageable pressure injury on the sacrum. The 7/21/2023 Nursing Admission Evaluation completed by Licensed Practical Nurse Manager #2 documented the resident had no skin impairments. There was no documented evidence of an assessment by a qualified professional for the pressure injuries present to the heels or sacrum upon readmission from the hospital. There was no documented evidence of treatments for the pressure injury on the sacrum from 7/21/2023 to 7/25/2023. There was no documented evidence of treatments for the heels through 7/31/2023 (when the resident was re-hospitalized). Physician orders documented: - consultation for evaluation and treatment for sacrum pressure ulcer that the resident came with, start date 7/25/2023. - Sacrum, cleanse wound with wound cleanser, pat dry with gauze, apply medical grade honey (wound treatment) and calcium alginate (wound treatment that absorbs drainage) combination to wound bed, cover with an island bordered dressing every night shift and as needed, start date 7/25/2023. - Low air loss mattress (specialty mattress for pressure reduction), check setting closest to the resident's current weight and mattress functionality every shift for monitoring and as needed, start date 7/25/2023. There was no documented order for a treatment for the deep tissue injuries on the resident's heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A 7/25/2023 Wound Consultant Physician #3's progress note documented the resident was referred for an initial evaluation and treatment for a wound on the sacrum. The resident had an unstageable sacral wound, due to pressure, present for greater than 30 days, that measured 2.5 centimeters long, 2.5 centimeters wide, and 0.3 centimeters deep. The treatment included medical grade honey and calcium alginate and recommendations to turn and position every 1 to 2 hours if able, off-load wound, limit sitting to 60 minutes, a pressure-relieving mattress, and vitamin and mineral supplements. There was no documented evidence of referral or evaluation for the wounds on the resident's heels. The 7/31/2023 physician #11 progress note documented the resident was sent to the hospital due to low oxygen and concerns with their ability to attend dialysis. The progress note did not include why the resident had limited ability to attend dialysis. The 8/10/2023 hospital discharge summary documented the resident was admitted with a chronic sacral osteomyelitis (inflammation of bone tissue related to infection) with overlying cellulitis (skin infection). The resident underwent surgical debridement (removal of damaged tissue), was in a great deal of pain, was unable to sit, which hindered their ability to attend dialysis. The 8/10/2023 hospital discharge instructions documented wound care to the sacrum, cleanse with normal saline moistened gauze, apply collagenase (ointment that removes dead tissue) nickel thick to slough (dead tissue) areas of wound, cover entire wound with a single layer of antimicrobial absorbent dressing and apply sacral bordered dressing, change daily and as needed. Wound care to heels, cleanse with foam cleanser and apply protective ointment to help soften heels once daily. The 8/10/2023 Nursing Admission Evaluation completed by Licensed Practical Nurse #7 documented the resident had one pressure wound to the coccyx (sacrum). There was no documentation related to the pressure areas to the heels or treatment to the sacral wound. The 8/10/2023 telehealth medical provider readmission note documented the medication was reconciled with the registered nurse, and the resident would need a comprehensive exam and admission by the primary care team. There was no documentation related to the resident's wounds or treatments. The 8/11/2023 physician order documented apply skin prep (protective barrier) to bilateral (both) heels daily, offload heels every day shift, start date 8/12/2023. There was no documented evidence of assessment by a qualified professional or treatment of the wound on the resident's sacrum from 8/10/2023 to 8/15/2023. The 8/16/2023 Wound Consultant Physician #3's progress note documented the resident was seen for wounds on the sacrum, left heel, and right heel. The wound on the sacrum measured 3 centimeters long by 2 centimeters wide, and 0.5 centimeters deep. The wound was improved based on decreased necrotic (dead) tissue and revealed it was now a Stage 4 pressure injury. The treatment included alginate calcium (absorbent wound treatment), gauze island bordered dressing, and recommendations to turn and position every 1 to 2 hours if able, off-load wound, limit sitting to 60 minutes, a pressure-relieving mattress, and vitamin and mineral supplements. The areas on the heels were fully covered with dead tissue. Treatment included daily skin prep to the heels with recommendations for off-loading the wound and floating the heels in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The 8/16/2023 physician order documented for the sacrum, cleanse wound with wound cleanser, apply calcium alginate to wound bed, cover with island bordered gauze. During an interview on 6/10/2024 at 11:12 AM the former Assistant Director of Nursing #1 stated skin assessments were completed by a registered nurse when residents were admitted or readmitted . The assessments should be completed upon admission or within 24 hours. If skin impairments were noted, the physician should be notified for treatment orders. Treatment for Resident #826's unstageable pressure injury on the sacrum and deep tissue injury on the heel should have been initiated immediately with referral to the wound team to be seen on the next rounds. The identified areas should have been assessed weekly on wound rounds and observed with each treatment. They could not recall Resident #826 or the reasons there was no wound treatment documented following their admission on 6/16/2023. They stated they covered multiple units and completed admission assessments. The Unit Manager was responsible to review the hospital documentation, orders, and make any referrals needed, including wound care. Treatments were not initiated timely from 6/16/2023 until the resident was hospitalized on [DATE]. During an interview on 6/10/2024 at 12:10 PM Licensed Practical Nurse Manager #2 stated licensed practical nurses could complete skin evaluations upon admission. If any skin impairments were noted, a registered nurse should be notified to complete an assessment and initiate a treatment. The Unit Manager was responsible for new admissions, referrals, and reviewing the hospital documentation. Licensed Practical Nurse Manager #2 could not recall if they saw the 6/16/2023 hospital discharge summary that noted wound care follow up. The resident should have had treatment initiated immediately for the sacral wound and heel, in addition to a referral to the wound care team. When Resident #826 was readmitted on [DATE], Licensed Practical Nurse Manager #2 recalled they completed the skin evaluation and documented no skin impairments. They stated it may have been related to not being able to view the resident's back side or heels due to the resident being in pain. They could not recall if they notified a registered nurse to complete the assessment or if the hospital paperwork included information about the pressure injuries. The treatment was initiated on 7/25/2023, and this was not timely, as it should have been done immediately. When the resident was hospitalized again and readmitted on [DATE], the treatment for the sacrum should have resumed immediately and was not. Licensed Practical Nurse Manager #2 was unaware of the reason for the delay in the treatment order for the sacrum. During an interview on 6/10/2024 at 1:02 PM Wound Consultant Physician #3 stated the wound care nurses, Unit Managers, or registered nurses made referrals to the wound physician. They rounded weekly, and a registered nurse would assess the wound and initiate treatment until the wound physician saw the resident. It was their understanding that a registered nurse assessed all newly admitted residents for skin impairments. Any new skin impairments should be assessed and treated immediately. The wound physician first saw Resident #826 on 7/25/2023 and was unaware of their 6/16/2023 admission with the unstageable pressure area and deep tissue injury on the heel. When the resident was referred on 7/25/2023, staff identified the sacrum as the area of focus and the physician was unaware of any issues with the heel. The treatments for the sacrum and heels were not initiated timely. When the resident was readmitted on [DATE], the registered nurse should have assessed the sacral area and implemented the treatment on the hospital discharge instructions. If there were no hospital orders, the registered nurse could have called the wound care physician for a treatment order or revert to the prior treatment. The resident should have had treatment initiated immediately upon return from the hospital. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	2) Resident #271 had diagnoses of cerebral infarction (stroke), right sided hemiplegia (paralysis of one side of the body), and diabetes. The 4/19/2024 Minimum Data Set assessment documented the resident had intact cognition, functional limitation on one side of the upper and lower extremities, was dependent for activities of daily living, was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, did not have any unhealed pressure ulcers, and had pressure reducing devices for their chair and bed. The comprehensive care plan dated 4/12/2024 documented the resident was at risk for pressure injury development related to diabetes, impaired mobility, and incontinence. Interventions included minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp sheets and clothing, and heel protection-offload with pillows or boots as tolerated. The 6/5/2024 Wound Care Physician #3 evaluation documented the resident had wounds on their right plantar (bottom) first toe, right posterior (back) thigh, and left buttock. The plan of care recommendations for the right toe were cleanse with wound cleanser at time of dressing change; off-load wound; reposition per facility protocol; and float heels in bed. For the left buttock and right posterior thigh moisture associated skin damage recommendations were turn side to side in bed every 1-2 hours if able; upgrade offloading chair cushion: evaluate cushion, was very thin for bariatric size patient, and leave brief open in bed and ensure brief was properly sized. There was no documented evidence the resident's offloading chair cushion was evaluated or the resident's incontinence brief was to be left open while in bed was added to the care planned interventions. The 6/12/2024 Wound Care Physician #3 evaluation documented progress of wound healing for the right plantar first toe healing at goal, right posterior thigh improved, and left buttock exacerbated (worsened) due to increased maceration (exposure to moisture). There was a new unstageable deep tissue injury on the right heel with the etiology (cause) of pressure. The area measured 5 centimeters x 6 centimeters with intact purple, maroon discolored skin. The treatment plan was skin prep (protectant) daily X 30 days, with recommendations for off-loading wound, reposition per facility protocol, and pressure off loading boot. Physician orders dated 6/5/2024 documented zinc oxide (skin protectant) to buttocks every shift. The June 2024 Certified Nurse Aide task documentation included heel(s) protection: offload with pillows or boots as tolerated and was documented as completed 6/1/2024- 6/9/2024 all shifts. The resident was observed and interviewed at the following times: - on 6/4/2024 at 10:44 AM, sitting in their wheelchair. They stated they had sores on their bottom and felt it was from staying in the diaper too long, and in bed too long. They stated the cushion in their wheelchair felt deflated, and they needed an air mattress. - on 6/5/2024 at 9:20 AM, in bed wearing only a brief, with no protective boots on their feet or positioning devices for offloading. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- on 6/6/2024 at 9:54 AM, in bed with only a brief on. They stated they had not been changed since before the shift change. They asked for their brief to be left open to dry areas out, but staff closed it anyway. The brief was observed taped tightly on both sides. There were no protective boots on their feet or positioning devices for offloading. - on 6/7/2024 at 9:33 AM, they stated the boots were only worn when they were sleeping. The thin gel cushion remained in the wheelchair seat and continued to be uncomfortable. The resident stated no one had offered them a new wheelchair cushion. - on 6/7/24 at 10:49 AM, Certified Nurse Aide #6 and Licensed Practical Nurse #62 provided peri- care. Zinc oxide was applied by the nurse to the open areas on the back of the right thigh and left buttock. The resident was dark skinned with pink open irritated areas present in the inner gluteal cleft on the left buttock and posterior right thigh. The resident had been incontinent of urine, their brief was changed, and staff stated there was no care plan that included to leave the brief open. The resident refused protective boots and asked to stay in bed due to an upset stomach. - on 6/10/2024 at 11:21 AM, in bed dressed and groomed. Their wheelchair remained with a thin gel cushion in the seat. The resident stated the cushion did not provide enough pressure relief and their bottom hurt when they were in their chair. - on 6/24/2024 at 1:11 PM, sitting in their wheelchair in the therapy gym, with non-skid socks on both feet, there was no padding present on the wheelchair pedals. - on 6/24/24 at 3:20 PM, in their room sitting in their wheelchair wearing non-skid socks on both feet. The wheelchair pedals remained uncovered. - on 6/24/24 at 4:20 PM, in their bed wearing only an incontinence brief and their left foot resting directly on the mattress. There were no pillows used for positioning or a protective boot in place. - on 6/25/24 at 8:39 AM, in bed wearing only an incontinence brief, eating breakfast, wearing a protective boot on the right foot and a non-skid sock on the left foot. There was no pillow used for positioning or to relieve pressure on the heel. During an interview on 6/5/2024 at 9:42 AM, Registered Nurse Unit Manager #23 stated certified nurse aides should let a nurse know of any changes to a residents' skin. They had not been notified that Resident #271 had moisture areas on their buttocks. The current interventions in place included to encourage the resident to get up out of bed, moisture barrier cream with care, and a request for a bed trapeze (to allow the resident to be able to reposition self independently) had been sent. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 6/7/2024 at 11:33 AM, Certified Nurse Aide # 60 stated resident care information was found in the care instructions including if protective boots were needed. Resident #271 preferred the boots only at night and did not usually wear them daily. They let the nurse know in the past about the resident not wearing boots. The resident often refused to allow staff to place pillows under their heels. The aide stated they should not be charting yes if the resident refused the intervention. Pillows and boots were important to prevent skin breakdown. They noticed the areas on the resident's bottom last week on the 3:00 PM-11:00 PM shift and told the nurse. They were not sure which nurse or which day. The resident had told them the areas were painful, and they thought it may have been from their incontinence brief. The resident received incontinence care when needed and was repositioned to prevent skin breakdown. They had been using barrier cream before the order for zinc oxide. During an interview on 6/7/2024 at 11:50 AM, Licensed Practical Nurse #62 stated certified nurse aides should report any changes in skin to the Nurse Manager. They stated a certified nurse aide told them last week that Resident #271 had some irritation to their buttocks. They told the Unit Manager and asked the wound care team if there were orders for the resident's bottom. The irritated areas could be from moisture. The resident would get up most days for therapy but liked to go back to bed. Prompt treatment was important to keep the areas from getting worse. The areas could turn into pressure or could get infected. Protective boots to protect heels from breakdown should be used when the resident was in bed and staff should notify a nurse if the resident refused. The resident could not move their right leg due to hemiplegia and that was an increased risk for pressure ulcers. During an interview on 6/7/2024 at 12:46 PM, Assistant Director of Nursing #24 stated if a heel protector was documented as yes, in place in the aide tasks of the electronic record, it meant it was on. If they were refused, it should be charted refused and the nurse should be told. Protective boots were important to prevent skin damage or breakdown. If a resident consistently refused, they would look for a different intervention. Resident #271 was at risk for pressure due to obesity, diabetes, and immobility. The resident had right sided hemiplegia and could not move their right side independently. The Assistant Director of Nursing #24 had not been made aware that the resident was refusing protective boots in bed. They were not made aware the resident had skin irritation to posterior thighs and buttocks until 6/5/2024 when they were seen by wound team. Prompt notification of skin issues was important to prevent further skin breakdown or new skin breakdown. In a follow up interview on 6/10/2024 at 4:13 PM, the Assistant Director of Nursing #24 stated recommendations and orders by the wound care team were entered by wound care nurses. The Nurse Manager and wound care team made sure recommendations were carried out. A recommendation for a wheelchair cushion evaluation should be done by physical therapy and should be communicated to physical therapy by the wound care nurse. The recommendation for evaluation of the chair cushion and incontinence briefs left open was not communicated. There was no therapy referral, and no care plan to leave the incontinence briefs open/untaped. The resident was at risk for pressure, and moisture associated skin damage could lead to additional pressure areas if interventions were not implemented. During an interview on 6/10/2024 at 4:28 PM, the Director of Rehabilitation stated wheelchair cushions were decided on by the interdisciplinary team based on resident assessment. A recommendation by wound care for a wheelchair cushion evaluation would need to be communicated to therapy either via email or verbally. They had not received a request for a wheelchair cushion evaluation for Resident #271. Resident #271 could not independently reposition themself due to hemiplegia and this increased their risk for altered skin integrity. If there was a recommendation for an evaluation it should have been communicated on the day it was recommended. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 6/11/2024 at 9:00 AM, Wound Care Registered Nurse #65 stated there had not been communication to the wound care team about Resident #271's skin irritation. Wound care orders and recommendations were communicated by putting the orders in the electronic health record. This was done by the wound care nurse. A wheelchair cushion evaluation was more of a recommendation and therapy would be notified via email or verbally. If the incontinence brief was to be left open it would be a care plan directive. Resident #271 was seen by wound care team on 6/5/2024, moisture associated skin damage was identified, and orders were placed for zinc oxide three times daily. The wound care nurse did not communicate any other recommendations from that consult. Updated interventions not being implemented could lead to pressure ulcers. They remembered discussing leaving the incontinence brief open but did not realize it was on the consult. They should have made sure all recommendations were communicated. During an interview on 6/11/2024 at 9:17 AM, Wound Care Physician #3 stated they were notified of the resident's need for a consult when impaired skin was noted. The consult was placed, and the resident was seen by the Registered Nurse prior to the consult to assess the need for treatments, actual pressure wounds, skin tears, and moisture associated skin damage present longer than 1 week and not healing. On 6/5/2024, during wound rounds the resident was asked if they had any other concerns and they mentioned their bottom. They stated the resident had moisture associated skin damage and trauma to their skin from the incontinence brief. They recommended treatment of zinc oxide, offloading of the wound, leaving the incontinence brief open, and a wheelchair cushion evaluation. These interventions would provide resolution or prevent worsening. The resident was at risk for pressure due to their immobility and should have offloading boots to prevent pressure on the feet. They were not aware the resident was not wearing the boots. During an interview on 6/27/2024 at 2:44 PM, the Assistant Director of Nursing #24 stated pressure interventions should be monitored by nurses, and offloading boots should be on the Treatment Administration Record. If a resident had a pressure area on their heel, they should have a pressure relieving device on at all times. The resident's wheelchair pedal was not padded, and their non-skid sock was not protective. The certified nurse aide had notified them on the 6/26/2024 that the resident refused the boot and the repositioning of the left heel. The recommendation did not specify a time or frequency, just that the foot should be offloaded as much as possible. The certified nurse aides should not be documenting heel offloading if it was not happening. During an interview on 6/27/2024 at 3:12 PM, Advanced Practice Registered Nurse #90 stated the resident was seen today in their wheelchair. They only had non-skid socks in place and there was no padding to the wheelchair pedals. The protective preventive pressure devices should always be in place because the resident was at risk for pressure due to limited mobility, morbid obesity, hemiplegia, and diabetes. During an interview on 6/28/2024 at 10:01 AM, Wound Care Licensed Practical Nurse #64 stated the resident had a deep tissue injury to their right heel and was seen by Wound Care Physician #3 on 6/12/2024. The physician recommended a pressure off-loading boot, with the heel always protected to promote healing and prevent worsening of wound. The pressure off loading boot should be in the care plan and communicated to staff to make sure interventions were in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 7/03/24 at 8:57 AM, Wound Care Physician #3 stated there should be a boot to the right heel to offload from pressure. It did not have to be a boot, but the heel had to be floated or on multiple pillows. Nurses should be checking and documenting the boots every shift. The pressure to the right heel was avoidable if interventions had been followed. The protective boots should be worn on both feet when the resident was in bed. 3) Resident #222 was admitted to the facility with diagnoses including osteomyelitis (inflammation of the bone caused by infection) of the sacral and sacrococcygeal (buttocks) region, and unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) of the left buttocks. The 3/22/2024 Minimum Data Set assessment documented the resident was cognitively intact, was dependent for bed mobility, transfers, and toileting, had a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle pressure ulcer), received daily pressure ulcer care, applications of ointments/treatments other than to feet, had a pressure relieving device for the bed and chair, and did not reject care. The comprehensive care plan initiated 5/7/2023 documented the resident had an alteration in skin integrity and had an actual pressure injury Stage 4 to left ischium (back part of the pelvis) and a Stage 4 to the right heel. Interventions included dressings were monitored daily to ensure they were clean, dry, and intact; wounds were monitored daily for signs and symptoms of infection; weekly wound evaluations were completed; and any changes were documented and reported. The 5/28/2024 physician order documented to cleanse right heel with wound cleanser, pat dry with gauze, apply calcium a [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48052 Based on observation, record review, and interview during the extended recertification and abbreviated (NY00332367 and NY00346149) surveys conducted 6/4/2024-7/11/2024, the facility did not ensure residents received adequate supervision and assistive devices to prevent accidents for 2 of 13 residents (Resident #41 and Resident #250) reviewed. Specifically, Resident #41 exhibited exit seeking behaviors, had a history of removing their wander alert device, and the security guard allowed the resident to walk out the front door before the receptionist was able to alert them the resident had exited. Resident #250 had a wander alert device and there was inconsistent documentation of when the device was implemented. Findings include: The facility policy, Wandering Residents, revised 8/2019, documented the facility strived to prevent unsafe wandering while the least restrictive environment was maintained for residents at risk for elopement. The facility policy, Wander Alarms/ Doors, revised 11/2019, documented wander alert alarms immediately alerted staff if a resident wearing a bracelet approached or breached the door. A resident who refused to wear a bracelet was assessed by the interdisciplinary team and alternate placement sites were determined. The wander alert bracelet was checked for proper placement and documented in the medical record. If the wander bracelet was unable to be located, another bracelet was obtained and applied. The facility policy, Safety and Supervision of Residents, revised 2/1/2024, documented the interdisciplinary team developed targeted interventions that reduced individual risk factors related to identified hazards in the environment and included adequate supervision. 1) Resident #41 had diagnoses including major depressive disorder and schizoaffective disorder (mental health disorder characterized by abnormal thought process and unstable mood). The 11/8/2023 Minimum Data Set assessment (a health status screening tool) documented the resident had severely impaired cognition, could sometimes make themselves understood, sometimes understood verbal content, did not exhibit behavioral symptoms, did not wander, rejected care daily, was independent with transfers and ambulation, and used a wander/elopement alarm daily. The comprehensive care plan initiated 10/26/2023 and revised 5/30/2024 documented the resident was at risk for elopement due to cognitive impairment/decline and exit seeking. Interventions included enhanced supervision on all shifts and triggers for wandering were identified. The care plan did not include a wander alert device or the resident's history of frequently removing the device. The 1/9/2024 Physician #36's progress note documented the resident was angry, defiant, frustrated, and overwhelmed. The resident noted they wanted to leave. The 1/12/2024 physician orders documented wander guard placement to left ankle, check placement every shift, and check functionality daily. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/26/2024 at 8:15 PM Licensed Practical Nurse #53's progress note documented the resident took their wander alert device off and the Supervisor was made aware. The 1/27/2024 at 6:08 AM Licensed Practical Nurse #57's progress note documented the resident's wander alert device was reapplied to the left ankle as the resident had taken it off on the previous shift. The 1/27/2024 Treatment Administration Record documented the wander guard was off during the 7:00 AM-3:00 PM shift. There was no documentation on the 3:00 PM-11:00 PM shift. The 1/27/2024 facility incident report documented the resident left the facility through the main entrance at 6:15 PM. The door was opened by Security Guard #55 who believed the resident to be a visitor. Receptionist #56 stated the resident presented to the lobby and walked quickly toward the door. The door opened and the resident walked out the front door. The security guard followed behind and Nursing Supervisor #23 was notified who then exited the facility behind the resident and the Security Guard. -Security guard #55's statement documented they swiped their security badge to let the resident out the front door as they thought they were a visitor. As the resident exited the facility, they followed them out the door. They attempted to stop the resident who struck Security Guard #55 in the face and walked off. - Nursing Supervisor #23's statement documented they were notified the resident exited the facility by Receptionist #56. They followed the resident in their car, called 911, and maintained sight of the resident until the police arrived. The resident was returned to the facility at 6:50 PM with the assistance of the local police. The Investigation concluded the facility elopement prevention equipment and process functioned as expected. There was no documented evidence how Security Guard #55 identified residents at risk for elopement and how they differentiated between a resident and a visitor. The was no documented evidence of education provided to Security Guard #55 for identification of residents at risk for elopement. During an interview on 6/11/2024 at 4:14 PM, Security Guard #55 stated in January 2024 Resident #41 was headed toward the main door. They opened the door with their badge because they thought the resident was a visitor. They stated the resident was visibly upset and they should have been told the resident had a history of being angry. The front desk Receptionist #56 called the Nurse Supervisor #23 as soon as this happened. They did not know why the resident did not alarm at the doors with a bracelet if they had a history of exit seeking behavior. They stated they were given very little training prior to the incident. It consisted of how and when to open and close the door, when to lock the door, the policy for visitors to sign out via the kiosk at the reception desk, and a basic overview of elopement. They stated the training was very generic. They did not receive a list of elopement risk residents until after the incident happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2024 at 4:31 PM, Nursing Supervisor #23 stated in January 2024 an unidentified staff came to them in the supervisor's office and alerted them that Resident #41 was running down the street. They asked the staff member who went outside with them to keep an eye on the resident while they got their car keys. They then followed the resident down the street with their personal vehicle. They stopped the resident, and the resident was verbally abusive, so they called the police. The resident was known to remove their wander alarm device. They did not know if any other interventions were in place. During an interview on 6/12/2024 at 8:56 AM, the Assistant Director of Nursing #24 stated Resident #41 had a wander alert device as long as they could remember, and the resident frequently took the wander alert device off. They were not sure of any other interventions to prevent elopement. They were not sure if the resident was on hourly checks in 1/2024 but was on hourly checks now. They could not find any documented record of hourly checks for 1/2024. During an interview on 6/12/2024 at 9:44 AM, Front Desk Receptionist #56 stated in 1/2024 Resident #41 was headed toward the front doors, and they told Security Guard #55 not to open the doors. They stated it was too late and the security guard had already swiped their badge and the door opened and the resident started walking out. They were not aware of who the resident was, they just knew it was a resident. They had a list of elopement risk residents at the front but was not able to look at it prior to the resident exiting. When the resident got past the security guard, they immediately went to Nursing Supervisor #23 who took control of the situation and went after the resident. 2) Resident #250 had diagnoses including schizophrenia. The 1/23/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had no behavioral symptoms, did not wander, and did not have a wander alert device. The 1/16/2024 Admission assessment documented the resident was fully ambulatory, had a prior history of elopement attempts/was currently exit seeking, insisted on maintaining their preadmission lifestyle/routine and did not exhibit safe decision making or willingness/ability to adhere to facility protocols, and was a high risk for elopement. Interventions included identify triggers for wandering, document behaviors and attempt to identify pattern to target interventions, distract the resident from wandering by offering pleasant diversions, and the against medical advice procedure was explained to the resident/resident representative. There was documented evidence that interventions included a wander alert device. The 1/16/2024 comprehensive care plan documented the resident exhibited actual/potential risk for elopement. Interventions included distract the resident by offering pleasant diversions, document all behaviors, and attempt to identify patterns to target interventions, identify triggers for wandering, provide a wander management device, check wander management device placement every shift (right ankle expiration date 12/26 # FOP1A8). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/2024 and 2/2024 Medication Administration Record documented check wander management device placement to (Specify Location) every shift (Insert Device Expiration Date) every shift for Safety Check wander management device with a start date of 1/30/2024 at 7:00 AM. The task was marked as completed on the 7:00 AM to 3:00 PM shift on 1/30/2024, 1/31/2024, 2/1/2024, and 2/2/2024 by Licensed Practical Nurse #62; the 3:00 PM to 11:00 PM shift on 1/30/2024; the 11:00 PM to 7:00 AM shift on 2/1/2024 by Licensed Practical Nurse #101; on the 3:00-11:00 PM shift on 2/1/2024 by Licensed Practical Nurse #88; on the 3:00 PM -11:00 PM shift on 2/2/2024 by Registered Nurse #132; and on the 11:00 PM-7:00 AM shift on 2/2/2024 by Licensed Practical Nurse #131. The other shifts were blank. The 2/4/2024 physician order documented check wander management device placement to (Right ankle) Every Shift and functionality daily (FOD1A8 expiration 12/2026) every day shift for Safety/Functionality Check. The 2/4/2024 at 12:50 AM progress note by Registered Nurse #130 documented they found the resident in the lobby. The resident told the registered nurse that they had to run to the store, and they would be right back. The registered nurse assisted the resident back to their unit and placed a wander guard on their right ankle. There was no documented evidence if Registered Nurse #130 determined why the resident's wander guard was not in place as ordered. During an observation and interview on 6/24/2024 at 10:36 AM, the resident had a wander alert device on their right ankle. They stated they never took it off. During an interview on 6/24/2024 at 1:34 PM, Licensed Practical Nurse #71 stated either the supervisor or the unit manager completed the initial admission evaluation for a new admission. If a resident was identified as wanting to leave, they completed the elopement risk assessment. The interdisciplinary team met and decided if the resident was appropriate for a wander alert device or if the resident should be placed on hourly checks. This should be documented in a team note in the electronic medical record. If a resident was admitted on an evening shift or weekend and had a high elopement risk assessment score, they would reach out to the Director of Nursing to see what interventions should be placed. Admissions were always reviewed by the team the next business day after admission. If a resident had a high elopement risk score but was alert and orientated, or declined the placement of a device, a wander alert device would not be placed. Licensed Practical Nurse #71 was unable to locate documentation in the record about Resident #250's high initial elopement risk score. During an interview on 6/25/2024 at 10:43 AM, the Director of Nursing stated the facility did not have a log of when wander guards were placed. During a phone interview on 6/25/2024 at 12:30 PM, Registered Nurse #18 stated they usually worked 3:00 PM-11:00 PM and completed the admissions for new residents during that time. If a resident had a high elopement risk score on their initial admission assessment, the resident usually required a wander alert device. They stated they checked the boxes in the assessment to trigger the interventions for that resident and the initial care plan populated from the assessment. They stated to place a wander alert device on a resident, they needed a physician's order. After the order was obtained and the device placed, the care plan needed to be updated with the serial number of the device and what limb it was placed on. They always ensured the order was in place prior to placement of the wander alert device on the resident. They stated if there was no order, they did not document a wander alert device on Resident #250's admission evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/25/2024 at 12:58 PM, Registered Nurse #130 stated they were a supervisor on night shift a few times a month. They stated Resident #250 was in the lobby and wanted to go to the store. They walked the resident back up to their unit. They stated the nurse placed the order for the wander alert device on 2/4/2024. They did not remember if the resident had a wander alert device prior to 2/4/2024 but the resident got onto the elevator and the wander alarm did not go off. They stated the nurse put a new device on the resident that night. During an interview on 7/9/2024 at 11:03 AM, Licensed Practical Nurse #62 stated if a resident had a wander alert device it was their responsibility to check the location of the device per the order in the Medication Administration Record and verify the device was where it was supposed to be and not cut or broken off. They had to physically see the wander alert device in place to check it off as completed on the Medication Administration Record. They did not remember if they checked Resident #250 for wander alert device placement or if the resident had a wander alert device when they were located on the fourth floor. If they checked it as completed in the Medication Administration Record, the resident was wearing a wander alert device. 10NYCRR 415.12(h)(2) 49448

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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. 40803 Based on observation, interview, and record review during the extended recertification survey conducted 6/4/2024-7/11/2024, the facility did not ensure residents maintained acceptable parameters of nutritional status for 1 of 6 residents (Resident #133) reviewed. Specifically, the medical provider was not notified when Resident #133 had a severe weight loss and recommendations for an appetite stimulant were not discussed with the medical provider. Findings include: The facility policy, Nutrition Assessment, reviewed 2/2023, documented the nutritional assessment including current nutritional status and risk factors for malnutrition, shall be conducted for each resident. Assessment of nutrition concerns were documented in the medical record. Residents identified at high nutrition risk were documented on every 7-30 days as determined by effectiveness of interventions. All residents should be reviewed every 90 days, The nutritional assessment would be a systematic, multidisciplinary process that included gathering and interpreting data and using that data to help define meaningful intervention for the resident at risk or with impaired nutrition. The facility policy, Weight Assessment and Interventions, reviewed 2/2023, documented the nursing staff would measure the resident's weight within 24 hours of admission and weekly for four weeks, then monthly. Monthly weight was obtained by the 10th of each month or as ordered by the physician. Weights would be recorded in the medical record and any weight change of 5 pounds in a month and 3 pounds in a week since their last assessment would be retaken within 48 hours for confirmation and verified by nursing. The reweigh should be reviewed by a licensed nurse. The licensed nurse would notify the dietitian of the identified weight change, and the dietitian would respond within 72 hours of the notification. Negative trends would be evaluated to determine if the weight change met the criteria for significant weight change. The thresholds for undesired weight changes included: - 1 month- 5% is significant; greater than 5% is severe. - 3 months- 7.5% weight change is significant; greater than 7.5% is severe. - 6 months- 10% weight change is significant; greater than 10% is severe. The facility policy, Meal Service, reviewed 1/2023, documented each resident shall receive meals, with preferences accommodated, prompt meal service, and appropriate feeding assistance. Adequate staff should be available in the dining areas to help individuals who need assistant to handle any situation that may arise. Resident #133 had diagnosis including major depressive disorder, diabetes, and adult failure to thrive (general overall decline). The 3/1/2024 Minimum Data Set assessment (a health screening tool) documented the resident had severely impaired cognition, did not exhibit any behaviors, felt down for the last 7-11 days, did not reject care, required supervision or touching assistance for eating, weighed 86 pounds, had a significant unplanned weight loss in the past 30 to 180 days, and received a therapeutic controlled carbohydrate diet. The resident had 210 minutes of occupational therapy during the 7-day period. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/17/2023 physician order documented to weigh the resident on admission/readmission once, then weekly for 4 weeks, then monthly for weight monitoring. The monthly weights were to be done by the 7th of each month. The comprehensive care plan initiated 4/17/2023 documented the resident had a nutritional problem related to dementia and failure to thrive with a history of significant weight loss. The goals included the resident would maintain intake of 75% or greater of meal and supplements. Interventions included diet as ordered, may have rice with lunch and dinner for cultural preferences, supplements as ordered, including Boost (nutritional supplement) and Super Potatoes (fortified potatoes) at lunch and dinner and Super Cereal (fortified cereal) at breakfast. The 5/1/2023 physician order documented controlled carbohydrate diet, regular texture with extra sauce and gravy. The resident weights were documented as follows: - on 2/6/2024 97 pounds - on 3/1/2024 86.4 pounds (11% weight loss in less than one month). - on 3/8/2024 89.4 pounds (reweight, 8% weight loss in one month). The 3/8/2024 Quarterly Nutrition progress note by Registered Dietitian #43 documented the resident was on a controlled carbohydrate diet with Super Cereal at breakfast and fortified potatoes and Boost supplement twice a day. Their weight was not stable at 89.4 pounds, and this was a 7.84% weight loss since the 2/2024 weight of 97 pounds. The resident was not refusing foods and required supervision and touching assistance with eating. The documented intakes were 26-50% at meals. The undesired weight loss was likely related to dementia. The Unit Manager was informed of the weight loss, a nutritional supplement was recommended, and they would continue with the current plan of care. There was no documented evidence the medical provider was notified of the severe weight loss. The 3/11/2024 a verbal physician order documented Boost Very High Calorie meal supplement drink 240 milliliters 3 times daily. On 4/9/2024 the resident's documented weight was 90 pounds. The 4/22/2024 Physician #41's progress note documented the resident had been eating better. The family brought in the resident's favorite ethnic food for the resident to eat. The resident's current weight was 90 pounds and was stable. On 5/9/2024 the resident's documented weight was 88 pounds. The 5/20/2024 Diet Technician #38's progress note documented the resident triggered for weight loss at the 3-month mark. Their current weight was 88 pounds on 5/9/2024. The weight loss was undesirable and likely related to poor oral intake and due to progression of dementia. Ample fortified food supplementation was in place. They would discuss with the interdisciplinary the use of an appetite stimulant. The Unit Manager had been notified of the weight change. There was no documented evidence the medical provider was notified of the recommendations for an appetite stimulant. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/22/2024 quarterly nutrition assessment by Registered Dietitian #43 documented the resident was on a controlled carbohydrate diet with Boost vanilla health shake three times a day, Super Cereal at breakfast, and fortified mashed potatoes at lunch and dinner. The resident weighed 88 pounds, and their weight was not stable. Their intakes were 50% or less at meals and 50% or less consumption of their supplements. They were not refusing foods or fluids, and they required supervision or touching assistance with their meals. They reviewed and agreed with Diet Technician #38's nutritional assessment. There was no documented evidence the medical provider was notified of the resident's weight loss or recommendation for an appetite stimulant. The resident's documented meal intakes from 6/4/2024-6/9/2024 ranged 0-100% for 3 meals a day with 12 meals being 0- 25%. On 6/4/2024 the resident's documented weight was 80.2 pounds. This was a severe weight loss with a total loss of 8.86% in one month and 10.29% in 3 months. During an observation on 6/5/2024 at 1:07 PM, the resident was assisted to a table by Occupational Therapist #58 and provided lunch. The lunch included corn on the cob, BBQ chicken, hot coffee, orange juice, mashed potatoes, 2 slices of bread, and coleslaw. The resident drank 100% of the orange juice and ate 25 % of the corn on the cob. At 1:34 PM, Occupational Therapist #58 got a glass of whole milk for the resident, and they drank 100%. They ate 25-50% of their meal. During an observation on 6/6/2024 at 8:55 AM, the resident ate 100% of their banana, a spoonful of eggs, 50% of their milk, 75% of their orange juice, and did not eat their toast. At 9:36 AM, the Registered Nurse Unit Manager #5 asked the resident if they were going to eat and if they wanted another banana, and then removed the tray. The 6/6/2024 Dietetic Technician #38's progress note documented the resident currently weighed 80.2 pounds. The resident weighed 88 pounds on 5/9/2024 (8.86% loss), on 3/8/2024 weighed 89.4 pounds (10. 29 % loss), and on 12/5/2023 weighed 93.8 pounds (14.50 % loss). The resident fed themselves with supervision. The resident triggered for significant weight loss at the 1 month, 3 month and 6-month mark. The weight loss was undesirable, and the resident was a high nutritional risk. The plan was to continue to monitor weight stabilization. The Unit Manager was notified of the weight change. The Registered Dietitian would discuss use of an appetite stimulant with the medical provider. The 6/6/2024 Registered Dietitian #43's progress note documented they requested a reweight to confirm the significant weight loss. There was no documented evidence the medical provider was notified of the weight loss, or the use of an appetite stimulant was discussed. The 6/7/2024 at 12:23 PM, Diet Technician #38's progress note documented the resident's current weight was 80.2 pounds and the resident triggered for significant weight loss. The resident was able to feed themselves with supervision. The weight loss was undesirable, and the resident had dementia. Their current intakes were 0-25%. The Unit Manager and Registered Dietitian #43 were notified and were discussing an appetite stimulant. The plan was to follow the current plan of care. The 6/7/2024 physician orders documented mirtazapine (appetite stimulant) tablet 7.5 milligrams once daily at bedtime (18 days after the initial recommendation). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/7/2024 at 3:48 PM, Registered Nurse Unit Manager #5's progress note documented the resident was starting a new medication related to weight loss per Physician #41. There was no documentation the resident had been reweighed as requested. During an interview on 6/10/2024 at 11:13 AM, Registered Nurse Unit Manager #5 stated weight changes were discussed with the medical provider by the registered dietitian or the Unit Manager. They did not recall talking to any medical providers about an appetite stimulant in May. During an interview on 6/10/2024 at 12:47 PM, Physician #41 stated they usually received an electronic mail notification from the registered dietitian about weight changes. They stated they were going to try supplements to increase Resident #133 's weight. They were concerned the resident was depressed. They did not recall being notified of the resident's weight loss prior to their June 2024 visit. They wanted to be made aware of significant weight changes. The resident was at risk for further weight loss and was being seen for treatment of depression. During an interview on 6/10/2024 at 3:21 PM, Registered Dietitian #43 stated weights were collected monthly unless ordered weekly or daily. Reweights should be completed in 48 hours for a significant weight change. A significant changed would be 5% at 30 days, 7.5% at 3 month and 10% at 6 months. Medical should be notified of significant weight changes and current interventions and possible cause of weight loss should be discussed. They discussed an appetite stimulant at the interdisciplinary team meeting, and these interventions should have been discussed with medical via an electronic or verbal notification. They expected the clinical nutrition staff to document their conversations with the medical provider. They could only recommend the appetite stimulant and could not order it. During an interview on 6/10/2024 at 3:57 PM, Diet Technician #38 stated the medical provider should be notified by the nurse of significant weight changes. They stated they recommend an appetite stimulant verbally on 5/20/2024 to the registered nurse who was supposed to pass that information on to the physician. They did not hear back about their recommendations from May 2024. On 6/6/2024 they sent an electronic message to Physician #41 who added the appetite stimulant on 6/7/2024. During an interview on 6/11/2024 at 9:18 AM, Nurse Practitioner #22 stated recommended interventions should have been brought to the provider's attention after the interdisciplinary team meeting in May 2024. The medical provider was not notified in a timely manner of the significant weight loss and recommendations for an appetite stimulant. During a telephone interview on 6/25/24 at 10:15 AM, the resident's health care proxy and emergency contact stated the resident's weight prior to admission at the facility was 90 -100 pounds. The resident intakes were variable at home. They visited the facility on 6/24/2024 and the resident appeared to have lost weight since the last time they saw them. The resident's medical provider had contacted them and discussed their weight with them, and the family continued to not want tube feedings. The family brought traditional food for the resident to eat, but they only ate about 50% of the food despite their encouragement. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/25/2024 at 1:21 PM, the resident was returned from therapy and was brought into the dining room. The unidentified therapy staff member sat next to the resident and attempted to assist the resident with their lunch meal. Their meal tray had turkey meatloaf, zucchini, rice, and fortified potatoes, 1 banana, 4 ounces of fortified pudding, 4 ounces of applesauce, and 4 ounces of orange juice. At 1:41 PM, the resident motioned that they were done with their meal and had consumed less than 25% of the turkey meatloaf, zucchini, rice, and fortified mashed potatoes. They had eaten 25 - 50% of their applesauce and 0% of their fortified pudding and banana. They drank 100% of their orange juice and was provided with another 4 ounces of orange juice. 10NYCRR 415.12(i)(1)

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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. 48446 Based on observation, record review, and interview during the extended recertification and abbreviated (NY00334736) surveys conducted 6/4/2024-7/11/2024, the facility did not ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 4 residents (Resident #64) reviewed. Specifically, Resident #64's did not receive the appropriate Bilevel Positive Airway Pressure (mechanical non-invasive ventilator for breathing assistance) mask. Findings include: The facility was unable to provide a policy on Bilevel Positive Airway Pressure use. Resident #64 had diagnoses including chronic obstructive pulmonary disease (lung disease), chronic respiratory failure, and obstructive sleep apnea (a sleep-related breathing disorder causing breathing to start and stop). The 3/12/2024 annual Minimum Data Set assessment (a health related screening tool) documented the resident was cognitively intact, had trouble sleeping nearly every day, required moderate assistance with upper body dressing, was dependent for personal hygiene and rolling, received supplemental oxygen therapy, and used a non-invasive mechanical ventilator. The comprehensive care plan initiated 8/30/2023 and revised 6/5/2024 documented the resident had respiratory impairment related to chronic obstructive pulmonary disease. Interventions included the use of a Bilevel Positive Airway Pressure machine at bedtime. The 12/12/2023 physician order documented: - mechanical non-invasive ventilator Average Volume-Assured Pressure Support rate 3, tidal volume 520 milliliters, maximum pressure 35 centimeters of water, pressure support maximum 10 centimeters of water, pressure support minimum 4.0 centimeters of water, Expiratory Positive Airway Pressure maximum pressure 12.0 centimeters of water and minimum pressure 5.0 centimeters of water, breathing rate 10, iTime (time of inhalation during a breath) 1.2 trigger Auto-Trak sensitive, Rise time 3 and titrate to patient comfort at bedtime (may wear during the day to decrease carbon dioxide levels). - Wear the mechanical non-invasive ventilator for breathing assistance when sleeping and bleed in oxygen at 3 liters per minute every shift when in use. - Monitor placement of mask and check skin integrity on face and head from mask and headgear every shift. - Oxygen equipment maintenance for oxygen tubing, mask, nasal cannula, humidifier bottle, ear protectors (if applicable), and storage bags change once weekly and as needed; and - Cleanse oxygen concentrator filter as needed. The 3/28/2024 Respiratory Therapist #45 progress note documented Resident #64 did not have their mechanical non-invasive ventilator for breathing assistance applied last night. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/30/2024 Respiratory Therapist #45 progress note documented they noted orange soda in the resident's nasal cannula (oxygen tubing that enters the nostrils) and the resident stated they choked. The nurse practitioner and Unit Manager were notified about possible aspiration (food or fluids getting into the lungs). The 6/2024 medication administration record documented check to see if mechanical non-invasive ventilator for breathing assistance was placed every night shift due to the resident refusing if offered too early. Licensed Practical Nurse #19 documented the resident refused on 6/4/2024. During an interview on 6/4/2024 at 10:00 AM and 11:45 AM, Resident #64 stated staff did not always put on their mechanical non-invasive ventilator for breathing assistance every night. The ventilator was put on the night of 6/3/2024 but they were only able to tolerate it for 2 hours. The resident was observed to have supplemental oxygen on at 3 liters per minute via nasal cannula. The 6/2024 treatment administration record documented: - monitor for placement of mask and check skin integrity on face and head. The record documented this was done every shift in June. - the mechanical non-invasive ventilator for breathing assistance face mask and swivel was washed on 6/2/2024 day shift by Licensed Practical Nurse #66. - wear mechanical non-invasive ventilator for breathing assistance when sleeping and bleed in oxygen at 3 liters per minute every shift when in use. The record documented this was completed except 6/1/2024 evening shift, 6/4/2024 night shift, and 6/6/2024 night shift when the resident refused. - evaluate for shortness of breath in the evening while lying flat. The record documented this was done every evening shift; and - the oxygen equipment was changed on 6/5/2024 night shift by nursing staff. During an interview and observation on 6/5/2024 at 8:55 AM, the resident stated staff did not put on their mechanical non-invasive ventilator for breathing assistance last night. The mask was next to the machine and there were holes on each side of the mask that were not plugged. Without the plugs the air pressure was insufficient. During an interview on 6/6/2024 at 10:30 AM, Licensed Practical Nurse #20 stated resident specific care was documented in the care plan. Mechanical ventilators were for breathing at night and the nurse should put them on the resident. Breathing would be impacted without it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2024 at 1:33 PM, Respiratory Therapist #45 stated mechanical non-invasive ventilators were used for breathing assistance. Without the treatment Resident #64 could have high levels of carbon dioxide (a waste product expelled during breathing) in their body and end up in the hospital. The treatment helped the resident get more oxygen for their organs and they needed it because they had a history of respiratory failure. They stated Resident #64 was cognizant and did not refuse the treatment. They noticed the ports on the mask were not plugged and should be. They just delivered a mask for the resident that did not have ports. They stated the machine would not work properly if the ports were not plugged. Nurses were responsible for applying the mask and turning on the machine at night. They were not sure if the nurses were trained on how to use the mask and thought training should be completed for nursing staff. During an interview on 6/10/2024 at 3:36 PM, Licensed Practical Nurse Manager #13 stated some residents used mechanical ventilation as they had a higher level of carbon dioxide. Resident #46 used it for chronic obstructive pulmonary disease, did not refuse it, and liked it placed on them when they were ready for bed. The unit nurse was responsible for putting it on the resident. Not using the machine could make the chronic obstructive pulmonary disease worse for the resident. During an interview on 6/11/2024 at 9:53 AM, Licensed Practical Nurse #19 stated they worked the night shift, and they normally placed the mask on Resident #64 and turned on their mechanical non-invasive ventilator for breathing assistance. They stated the ports were not plugged as they were open to promote airflow. They did not remember being trained on how to apply the mask and felt they should have been. 10 NYCRR 415.12(k)(6)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 48446 Based on observation, record review, and interviews during the extended recertification survey conducted 6/4/2024-7/11/2024, the facility failed to ensure that pain management was provided to residents who required such services consistent with professional standards of practice for 3 of 7 residents (Resident #28, #37, and #64) reviewed. Specifically, -Resident #28's physician ordered pain cream was not administered as ordered and was documented as administered. -Resident #37 did not receive Lyrica (used to treat nerve and muscle pain) as ordered for 3 days; -Resident #64 was not aware of an as needed order for acetaminophen (pain reliever) and pain cream and was not offered the medications when in pain. Subsequently, Residents #28, #37, #64 had unresolved pain that affected their daily functional abilities, psychosocial well-being, and diminished quality of life. This placed all residents with pain, who received pain medication, at risk for harm that was Immediate Jeopardy and Substandard Quality of Care. Findings include: The facility policy, Pain Management, revised 3/2020, documented the facility was committed to reducing physical and psychosocial symptoms associated with pain to assist the resident in achieving their highest practicable level of functioning. The facility policy, Medication Administration, revised 1/2021, documented medications were administered in a safe and timely manner, and as prescribed. The individual administering the medication must initial the medication administration record after giving each medication and before administering the next. Topical medications must be recorded on the treatment administration record. If a drug was withheld or refused, the individual administering the medication initialed and circled the medication treatment record space for that drug. The 4/2020 facility policy Pharmacy Services, documented pharmacy services were available to resident 24 hours a day, seven days a week. The pharmacy was to provide and maintain the facility's emergency medication supply. Residents had sufficient supply of their prescribed medications and received medications (routine, emergency or as needed) in a timely manner. Nursing staff communicated prescriber orders to the pharmacy and were responsible for contacting the pharmacy if a resident's medication was not available for administration. Borrowing medication from another resident or from emergency medication supply because of a failure to reorder medications in time for a resident to receive a scheduled medication was not acceptable practice. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The pharmacy policy for the Automated Dispensing System, dated 2/2023, documented the purpose of the system was to allow a nurse to add a patient to the system and withdraw medication in emergency situations. The unit would provide an emergency controlled substance dose of the desired medication from the respective emergency-kit. The automatic dispensing system would allow a nurse the capability of obtaining only one dose of a medication from an emergency-kit pursuant to a prescriber's order. All medication removed from the unit must be signed out to a patient and must have a physician order. 1) Resident #28 had diagnoses including cervical disc disorder (breakdown of the spinal discs in the neck), radiculopathy (pinching of the nerves at the root), and displaced fracture (bone is out of alignment) of the right femur (thigh bone). The 4/21/2024 Minimum Data Set assessment documented the resident was cognitively intact, required substantial assistance for most activities of daily living, received scheduled and as needed pain medications, and did not have pain. The resident felt down, depressed, or hopeless half or more of the days, had trouble falling asleep or staying asleep nearly every day, and did not reject care. The Comprehensive Care Plan, initiated 8/31/2022, documented Resident # 28 had an alteration in comfort related to cervical disc disorder, radiculopathy of the lumbar spine, and displaced fracture of the right femur. Interventions included administering pain medication as ordered. A 6/23/2023 orthopedic consult documented the resident had retrograde pain in the right femur (thigh bone) and right knee. The resident had right knee pain all day and diclofenac gel (a topical pain cream) decreased the pain. The resident had osteoarthritis in the right knee. Physician orders documented: - on 9/8/2023 diclofenac gel 1% apply to bilateral (both) knees four times a day and acetaminophen (used to treat pain) 325 mg 2 tablets every six hours as needed for pain. Pain evaluation every shift record pain on a 0-10 scale. - on 4/19/2024 gabapentin (nerve pain medication) 300 milligrams three times a day for pain. - on 6/1/2024 oxycodone HCL (narcotic pain reliever) 5 milligrams every 8 hours as needed for pain. The 5/2024 Treatment Administration Record documented a pain evaluation every shift, record on a pain scale of 0-10. The resident's pain level was not documented 11 of 93 shifts and was documented as a 0 for 82 of 93 shifts. The 5/2024 Medication Administration Record documented diclofenac gel 1%, apply to bilateral knees topically four times a day for pain at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. The diclofenac was documented as administered 5/1/2024-5/31/2024 as ordered except for the 9:00 PM administrations on 5/2/2024 and 5/9/2024. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 6/2024 Medication Administration Record documented diclofenac gel 1%, apply to bilateral knees topically four times a day for pain at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. The diclofenac was documented as administered from 6/1/2024-6/9/2024, for the 9:00 AM dose on 6/10/2024, from 6/11/2024-6/17/2024, for the 9:00 AM and the 9:00 PM doses on 6/18/2024, and from 6/19/2024-6/23/2024 as ordered. The medication was marked as other see nurses note on 6/10/2024 for the 1:00 PM, 5:00 PM, and 9:00 PM doses. On 6/18/2024, the 1:00 PM dose was marked as out of facility and the 5:00 PM dose was marked as refused. The resident was discharged to the hospital prior to their first scheduled dose on 6/24/2024 and remained in the hospital for the remainder of 6/2024. During an observation and interview on 6/4/2024 at 11:57 AM, Resident #28 stated they never got their diclofenac gel as ordered and they wanted it as it helped their knee pain. During an observation and interview on 6/6/2024 at 1:18 PM, Resident #28 stated they got their diclofenac gel yesterday (6/5/2024) but did not receive it today. During an observation and interview on 6/7/2024 at 8:39 AM, Resident #28 stated they did not get their diclofenac gel yet and would like it as it helped with the pain. Resident #28 stated they were evaluated yesterday by an orthopedic doctor for shoulder pain and wanted the diclofenac gel applied to their shoulder also as they believed it would help their pain. During an observation and interview on 6/10/2024 at 9:42 AM, Resident #28 was in bed with facial grimacing. They stated they received all their medications except the diclofenac gel. They reported they were in pain and would like the medication as it helped with pain. They stated they were able to get out of bed easier when it was administered. A 6/11/2024 Nurse Practitioner #16 progress note documented a pain assessment was completed. The resident had right shoulder pain of a 6. Position changes and medication eased the pain. The resident stated the diclofenac cream to the knees was helping. The plan was to order diclofenac for bilateral shoulders four times a day for pain and discomfort. The June 2024 medication administration record documented diclofenac sodium 1 %, apply to bilateral shoulders topically four times a day for pain 2 grams with a start date of 6/11/2024 at 1:00 PM. The medication was scheduled to be applied at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. The diclofenac was documented as administered as ordered from 6/11/2024-6/17/2024, the 9:00 AM and the 9:00 PM doses on 6/18/2024, and from 6/19/2024-6/23/2024. On 6/18/2024, the 1:00 PM dose was marked as out of facility and the 5:00 PM dose was marked as refused. The resident was discharged to the hospital prior to their first scheduled dose on 6/24/2024 and remained in the hospital for the remainder of 6/2024. During an interview on 6/6/2024 at 10:30 AM, Certified Nurse Aide #20 stated Resident #28 told them on multiple occasions they did not get their diclofenac gel for pain, and they had told the nurse and the Unit Manager. They stated Resident #28 was cognizant and could experience more pain if they did not receive the diclofenac gel. During an interview on 6/6/2024 at 10:51 AM Licensed Practical Nurse #33 stated diclofenac gel was for pain and Resident #28 had an order for it to be administered to their knees. They stated many residents complained about not getting creams, inhalers, eye drops or other non-oral medications. Without the pain gel Resident #28 could experience more pain and be less mobile. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/10/2024 at 11:50 AM, Licensed Practical Nurse #34 stated diclofenac gel was used for pain, Resident #28 had an order for diclofenac gel, and they did not get it today. They stated they signed for the 9:00 AM diclofenac even though it was not administered. They only administered oral medications initially and went back to administer creams, gels, nasal sprays, inhalers, and other treatments. When they would go back to administer the gel if the resident was not in their room or if they refused, they struck out the medication on the Medication Administration Record. They signed for the 9:00 AM administration because they always signed for all morning medications when they administered the morning oral medications and would come back later to administer creams, nasal sprays, and other treatments because that is how they were trained. On 6/25/2024 at 10:16 AM, Licensed Practical Nurse #34 stated they were trained to pass oral medications first. If they are not able to do the gels, like the pain relief gel, due to a resident not being available, they came back and did it later. There was no documented evidence Licensed Practical Nurse #34 completed a competency for medication administration. During an interview on 6/10/2024 at 3:36 PM, Licensed Practical Nurse Unit Manager #13 stated Resident #28 told them on several occasions that staff did not apply their diclofenac gel for pain as ordered and they told the resident to ask the medication nurse for it. They stated residents should not have to ask for medications that were ordered routinely. They stated medications should only be signed as administered after being administered. If nursing staff documented something that was not done, they would have to go back and strike the record and write a note referencing the strikeout. During an interview on 6/11/2024 at 11:54 AM Assistant Director of Nursing #24 stated they expected residents to receive medication as ordered including diclofenac gel and they should not have to ask for the medication unless it was ordered as needed. During a phone interview on 6/25/2024 at 8:16 AM, the resident stated most days the nurses did not apply the pain relief gel. They stated they needed the pain relief gel, especially on their knees, as they could not get up in the morning because of the pain. They could not wheel their wheelchair due to pain in their arms. They stated the pain in their knees was mostly an 8 to 9 on a 1-10 pain scale when getting up with the transfer equipment or getting dressed. The pain improved with the diclofenac. They were not aware of any other pain medication available to them. They stated when they were in pain, they were miserable and felt depressed. They stated it affected them wanting to go to activities. They told staff nearly every day, including Licensed Practical Nurse Unit Manager #13, they did not get their diclofenac gel and wanted it to improve their pain. During an interview on 6/25/2024 at 10:16 AM, Licensed Practical Nurse #34 stated they were trained to pass oral medications first. If they were not able to do the gels, like the pain relief gel, due to a resident not being available, they came back and applied it later. During an observation and interview on 7/8/2024 at 11:29 AM, the resident was sitting in their wheelchair in their room and stated they had not received their pain relief gel to their shoulder or knees yet that day but had received their oral medication. Their pain in their shoulder was an 8 out of 10 and their knees were a 5 out of 10. They stated they would like their pain relief gel. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/8/2024 at 11:43 AM, Licensed Practical Nurse #89 stated they would ask a resident if they were in pain and offer pain medication. If they had nothing ordered, they called the supervisor to call the provider. They were done with the morning medication pass and had not applied the pain relief gel for Resident #28 as they had not gotten to their treatments yet. The pain relief gel was on the resident's treatment administration record not their medication administration record. They did not believe they had signed for it but if they had it would not be a good idea as the resident could refuse or not be in their room. Medications could be administered one hour before and one hour after the scheduled time. They reviewed the medication administration record and stated the diclofenac was ordered as a medication and it was not signed for. The next schedule administration time would be 1:00 PM as they missed the 9:00 AM dose and could not administer it the 9:00 AM dose now. If residents did not get pain medications, they could have more pain, and which may impact their daily living. The resident may get depressed and sad. During an interview on 7/10/2024 at 9:31 AM, Assistant Director of Nursing #25 stated they expected orders for pain medications to be administered and administered timely. If a medication was ordered for 9:00 AM, the nurse had one hour before and one hour after the scheduled time to administer the medication. If a resident did not get pain medication as ordered, they could be in pain which could compromise behaviors. If a nurse missed the medication time, they should call the supervisor and the provider to get direction. A missed medication was a medication error. They expected the nurse to call the Unit Manager or Supervisor and write a note to why it was not given. 2) Resident #37 had diagnoses including diabetic neuropathy (nerve damage) and chronic venous insufficiency (damaged veins that can cause inflammation). The 5/29/2024 Minimum Data Set assessment (a health assessment screening tool) documented the resident was cognitively intact, did not reject care, frequently felt down, depressed, or helpless, had frequent trouble falling or staying asleep, felt bad about themself, had trouble concentrating, and had thoughts they would be better off dead, or of hurting themself in some way. The resident received a scheduled pain medication regime, received as needed pain medication, had almost constant pain that made it hard for them to sleep at night, and the pain constantly limited their day-to-day activities, and the resident's worst pain was a 10 (0-10 pain scale with 10 being the highest pain level). The Comprehensive Care Plan initiated 9/29/2022 documented the resident had an alteration in comfort related to neuropathy, back pain, and intermittent claudication (muscle pain from poor blood flow). Interventions included administer medications as ordered, report to the nurse resident complaints of pain or requests for pain treatment, notify physician if interventions were unsuccessful of if current complaint was a significant change from the resident's experience with pain, monitor for signs and symptoms of pain, if resident appeared to be in pain utilize appropriate non-pharmacological interventions. Interventions were revised on 5/30/2024 and included evaluate effectiveness of pain intervention, review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, and observe for new onset or increased agitation, restlessness, confusion, hallucinations, nausea, vomiting, dizziness, and falls, and report occurrences to the physician. Physician orders documented: - on 9/27/2022 physiatry-physical medicine and rehab consult for evaluation and treatment of pain. - on 4/23/2023 monthly medications would be dispensed for 30 days unless otherwise indicated and refillable 5 times upon monthly re-evaluation and renewal of orders by prescriber. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- on 5/22/2024 pain evaluation every shift, record pain on a 0-10 scale. - on 5/22/2024 Lyrica oral capsule 100 milligrams, give 1 capsule every 12 hours for neuropathy, maximum daily dose 2 capsules. A 5/29/2024 Pain Interview completed by Licensed Practical Nurse #85 documented the resident experienced pain almost constantly. The pain almost constantly affected the resident's sleep and interfered with day-to day activities. The resident rated their pain intensity at a 10. The resident was on a scheduled pain medication regimen and received as needed pain medications without much help. The 6/2024 Medication Administration Record documented Lyrica oral capsule 100 milligrams, give 1 capsule by mouth every 12 hours for neuropathy at 9:00 AM and 8:00 PM. - on 6/21/2024 Lyrica was last administered at 9:00 PM by Licensed Practical Nurse #86. - on 6/22/2024 Lyrica was documented as a 9 (other/see nurse notes) at 9:00 AM by Licensed Practical Nurse #53, and at 8:00 PM by Licensed Practical Nurse #28 - on 6/23/2024 Lyrica was documented as a 9 at 9:00 AM by Licensed Practical Nurse #87, and at 8:00 PM by Licensed Practical Nurse #28. - on 6/24/2024 Lyrica was documented as a 9 at 9:00 AM by Licensed Practical Nurse #28 and documented as administered at 8:00 PM by Licensed Practical Nurse #28. Nursing notes documented: - on 6/22/2024 at 10:37 AM by Licensed Practical Nurse #53 Supervisor was aware that Lyrica needed to be ordered, not available in Pyxis (an automated medication dispensing system). - on 6/22/2024 at 8:58 PM by Licensed Practical Nurse #28 the Lyrica was on order, was awaiting pharmacy to deliver. - on 6/23/2024 at 8:18 AM by Licensed Practical Nurse #87 the Lyrica was not on hand. - on 6/23/2024 at 8:44 PM by Licensed Practical Nurse #28 the Lyrica was on order, waiting for the pharmacy to deliver. - on 6/24/2024 at 9:14 AM by Licensed Practical Nurse #28 the Lyrica was on order, waiting for the pharmacy to deliver. The nursing notes did not document the resident's pain level. The 6/2024 Treatment Administration Record documented pain evaluation every shift. The residents pain level was documented: - on 6/22/2024 at an 8 for the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts; and a 0 for the 11:00PM-7:00 AM shift. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- on 6/23/2024 at a 0 for the 7:00 AM-3:00 Pm shift; an 8 for the 3:00 PM-11:00 PM shift; and a 0 for the 11:00 PM-7:00 AM shift. - on 6/24/2024 at a 7 for the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts. The 6/24/2024 at 3:49 PM progress note transcribed by Nurse Practitioner #22 and signed by the Medical Director documented the resident's pain was a 7 on 6/24/2024 at 10:46 PM. The resident had chronic lower extremity pain. The resident did not feel their pain was fully compensated on oxycodone (an opioid pain reliever) every 12 hours and the oxycodone was increased to every 8 hours. The resident stated their neuropathic pain in the lower extremities was worse. The resident did not think they received their Lyrica that morning. They spoke with the Nurse Manager who would check on the administration of the resident's Lyrica. On 6/24/2024 at 9:19 PM Registered Nurse Supervisor #89's progress note documented the resident was short of breath with an oxygen concentration of 80% on 2 liters of oxygen and denied pain. Resident requested to go to the hospital and Emergency Medical Services was called. The 6/27/2024 Automatic Dispensing System's Usage Report documented 4 pregabalin (generic name for Lyrica) 25 milligrams were taken from the machine for Resident #37 on 6/24/2024 at 4:43 PM by Licensed Practical Nurse #2 and Licensed Practical Nurse #28. The 6/27/2024 Automatic Dispensing System's Inventory Summary documented pregabalin (Lyrica) 25 milligrams was available in the automatic dispensing system. The 7/11/2024 Order Audit Report documented that pregabalin (Lyrica) 100 milligrams was on-hand and dispensed on 6/24/2024. The previous distribution documented the status was reordered and exhausted on 6/24/2024. During an interview on 6/24/2024 at 10:19 AM, Resident #37 stated they had frequent chronic pain. The pain affected their regular activities, and ability to attend therapy. They had to go out to the hallway to ask for medications and that was embarrassing. Sometimes their pain limited their ability to get up and out of bed. Their pain also played into the depression they were diagnosed with after being admitted to the facility. Some days it was difficult to get up and they asked for their medications. If they were up in their chair they could go to the nurse at the cart and ask but on the night shift, they could not do that. If they did not get their pain medications at night, it made it hard to function in the morning. At 4:44 PM, the resident stated they had not gotten their Lyrica since 6/21/2024. They stated the Lyrica and oxycodone worked well together. Facility staff informed them they had ordered it last Monday 6/17/2024. During an interview on 6/25/2024 at 9:32 AM, Licensed Practical Nurse #28 stated Resident #37 had consistent pain. The resident ran out of scheduled Lyrica on 6/21/2024 and they ordered the medication through the pharmacy. On 6/22/2024, they notified the Supervisor (could not recall which Supervisor) the resident did not have medication available. Resident #37 did not receive their Lyrica on 6/22/24, 6/23/24, and 6/24/24 morning dose. During a telephone interview on 6/26/2024 at 9:58 AM, Resident #37 stated that they were sent to the hospital. The pain in their legs was so bad, they could not breathe. They stated they received their Lyrica at approximately 5:30 PM Monday night (6/24/2024) before they went to the hospital. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 6/26/2024 at 2:03 PM, the pharmacy Director of Client Services #93 stated the electronic medical record had a resupply request that sent an electronic transmission to the pharmacy. Lyrica was a controlled substance, and the records indicated the resupply was requested on 6/24/2024. The inventory log for the emergency Pyxis (an automatic medication dispensing system) documented there was a form of Lyrica on hand in the facility. At 3:15 PM, they stated the letters building of the facility was stocked to its normal stocking of 10, 25-milligram tablets. No Lyrica was removed from this machine on 6/22/2024 or 6/23/2024. Lyrica was not removed from the Pyxis until 6/24/2024, when four tablets were removed. During an interview on 6/25/2024 at 9:32 AM, Licensed Practical Nurse #28 stated the resident was in constant pain. If a resident stated they were in pain, pain medications should be given timely. The resident's Lyrica ran out on 6/21/2024. The Licensed Practical Nurse Unit Manager #2 called the pharmacy on 6/21/2024. Licensed practical nurses notified the supervisor if medications were not given to a resident. They notified the supervisor (unable to recall what Supervisor) on 6/22/2024 the Lyrica was not there. They asked to check the Pyxis and was told there was not any Lyrica in the machine. They always put a note in when medication was not given but did not always write a note that the Supervisor was notified. They would not contact the provider directly. The facility policy was for the licensed practical nurse to call the Supervisor and the Supervisor would notify the provider. During an interview on 6/25/2024 at 9:54 AM, Licensed Practical Nurse Unit Manager #2 stated the resident constantly had pain in their lower back and legs from diabetic pain, wound pain, and vascular pain. The resident's pain can stop them from doing activities, like therapy. The resident's Lyrica was low on 6/21/2024 and the resident had a refill left on the order, so it was ordered. The medication was supposed to be on the 4:00 PM pharmacy run on 6/21/2024. They did not work the weekend and was informed on 6/24/2024 that they medication still had not come in. They called the pharmacy on 6/24/2024 and was informed it would be on the next run. The Pyxis contained Lyrica, so they pulled four 25 milligram tablets. All licensed nurses had access to the Pyxis and two nurses are required to verify removal for controlled substances. During an interview on 6/25/2024 at 10:31 AM, Nurse Practitioner #22 stated that any missed dose of medication was unacceptable. They expected to be notified about missed doses but was not. The nursing staff did not inform them about the missed doses. The resident informed them on 6/24/2024 when they were rounding on the unit and pulled them aside to inform them, they did not feel well. The resident's narcotic (the Lyrica) had refills. Lyrica was available in the emergency backup Pyxis. The nurses just had to call them or the pharmacy. During an interview on 7/3/2024 at 10:23 AM, Licensed Practical Nurse #87 stated they did not give the resident their Lyrica and they informed their supervisor (could not recall what Supervisor). They stated if a resident was out of a narcotic, they would fill out a narcotic sheet but was unsure if they did. The Pyxis had 25 milligram pills of Lyrica and the 25 milligram medications could be used to equal the resident's ordered dose of 100 milligrams. They did not go to the Pyxis. If there was no note in the medical record, they did not notify the supervisor or go to the Pyxis as they did not have time. During an interview on 7/8/2024, at 1:47 PM, Licensed Practical Nurse #28 stated they had not been provided with Pyxis training. During the 8:00 PM medication pass on both 6/22/2024 and 6/23/2024, they notified the Supervisor that the medication was unavailable. They were unsure which nursing supervisor they spoke with on 6/23/2024. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/8/2024 at 3:42 PM, Registered Nurse #89 stated they worked 6/22/2024. They did not have a note in the computer they were notified of the resident's Lyrica not being available. If they were notified, they would have gotten the medication from the Pyxis. They should have been notified and the resident should have received the medication as ordered. During an interview on 7/9/2024 at 10:27 AM, Registered Nurse #94 stated they worked on both 6/22/2024 and 6/23/2024. They did not recall being notified that the resident's Lyrica was not available. They stated there was no documentation from them regarding the resident being out of their Lyrica, so they were not aware. The registered nurse supervisor or Unit Manager would be responsible to notify the provider. During an interview on 7/9/2024 at 11:44 AM, Licensed Practical Nurse #53 stated they worked 6/22/2024. The resident received Lyrica, but they did not have it in the cart, and it was not in the Pyxis. They stated if they did not give the medication, it was because it was not in the Pyxis. They would have notified the supervisor, but they did not recall what supervisor was on. 3) Resident #64 had diagnoses including gout (inflammation of the joints), chronic pain syndrome, and left knee contracture (tightening of muscles or tendons). The 3/12/2024 Minimum Data Set assessment documented the resident was cognitively intact, had trouble falling asleep or staying asleep nearly every day, felt down, depressed, or hopeless half or more of the days, had little interest or pleasure in doing things several days, did not reject care, received a scheduled pain medication regimen, did not receive as needed pain medications, and the resident did not have pain. The Comprehensive Care Plan initiated 12/31/2019 documented the resident had chronic hip pain related to chronic degenerative changes. Interventions included anticipate the resident's need for pain relief and respond immediately to any complaint of pain; identify and record previous pain history and management of that pain and impact on function; identify previous response to analgesia including pain relief, side effects, and impact on function; identify, record, and treat existing conditions which may increase pain; monitor for probable cause of each pain episode; monitor/document side effects of pain medication; monitor/record/report any signs and symptoms of non-verbal pain; notify physician if interventions were unsuccessful or if current complaint was a significant change; observe and report changes in sleep patterns, usual routine, decrease in functional abilities, decreased range of motions, withdrawal or resistance to care, or refusal to attend activities related to pain. The Comprehensive Care Plan for pain had not been revised since 1/7/2020. Physician orders documented: - on 1/24/23 diclofenac external gel 1% apply to lower extremities and shoulders topically every 6 hours as needed for pain. - on 12/12/2023 acetaminophen 325 milligrams give 2 tablets by mouth every 6 hours as needed for pain. - on 12/12/2023 acetaminophen 325 milligrams, give 2 tablets by mouth as needed for wound care, administer 30 minutes prior to dressing change. - on 12/21/2023 pain evaluation every shift, record pain on a 0-10 scale. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The June 2024 Medication Administration Record documented: - diclofenac external gel 1%. Apply 2 grams to shoulders topically every 6 hours as needed for pain. The diclofenac was not administered from 6/1/2024 through 6/30/2024. - acetaminophen 325 milligrams give 2 tablets by mouth every 6 hours as needed for pain. The acetaminophen was not administered from 6/1/2024 through 6/30/2024. - acetaminophen 325 milligrams, give 2 tablets by mouth as needed for wound care, administer 30 minutes prior to dressing change. The acetaminophen was not administered from 6/1/24-6/30/2024 (the resident received wound care to their left calf and left ankle on 6/5/2024, 6/12/2024 and 6/19/2024.) - pain evaluation every shift, record pain on a 0-10 scale. From 6/1/2024-6/30/2024 the resident had a pain level of 3 on the 6/1/2024 3:00 PM-11:00 PM shift documented by Licensed Practical Nurse #66, a pain level of 3 on the 6/2/2024 7:00 AM-3:00 PM shift by Licensed Practical Nurse #66, a 10 on the 6/2/2024 3:00 PM-11:00 PM shift by Licensed Practical Nurse #66, a pain level of 4 on the 3:00 PM-11:00 PM shift on 6/9/2024, 6/18/2024, 6/20/2024, and 6/22/2024 by Licensed Practical Nurse #88, a pain level of 6 on the 6/27/2024 7:00 AM-3:00 PM shift by Licensed Practical Nurse #33, a pain level of 5 on the 6/28/2024 7:00 AM-3:00 PM shift Licensed Practical Nurse #33, and a pain level of 5 on the 6/29/2024 3:00 PM-11L00 PM shift by Licensed Practical Nurse #33. The 11:00 PM-7:00 AM on 6/29/2024 and all shifts on 6/30/2024 were marked as the resident was hospitalized . All other pain ratings were documented as 0. There were no nursing progress notes for 6/1/2024, 6/2/2024, or 6/9/2024 addressing the resident's pain ratings. A 6/7/2024 Nurse Practitioner #16 progress note documented the resident was educated on disease management and signs and symptoms to be reported to the care team. The resident was educated on how health conditions were managed by medications, including medication actions, benefits, side effects, importance of adherence, and when to discuss with the provider. The plan was to assess needs for and/or effectiveness of medications and adjust medication regime as appropriate. During an interview on 6/24/2024 at 10:08 AM, the resident stated they had pain in their left knee and hip. The pain was a 6 out of 10 but could get as high as 10. The pain was higher when they were rolled to be changed. They did not ask for pain medication because it came automatically scheduled. They did not have anything extra ordered for pain. They stated if they had something else ordered for pain, they would ask for it. They received oxycodone four times[TRUNCATED]

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. 48052 Based on observation, interview, and record review during the extended recertification and abbreviated (NY0033160) surveys conducted 6/4/2024-7/11/2024, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 5 of 5 residents (Resident #41, #126, #153, #235, and #250) reviewed. Specifically: - Resident #41 had an extensive mental health history, did not have person-centered mental health interventions, and was seen by a licensed psychologist and their recommendations were not implemented into the resident's plan of care. There were no documented social services follow ups with the resident following their behaviors. - Resident #126 had a significant mental health history and did not have person-centered mental health interventions for their behaviors or refusals of care and medications. There were no documented social services follow ups with the resident following their behaviors. - Resident #153 was seen by a licensed psychologist and their recommendations were not implemented into the resident's plan of care, a recommendation for a traumatic brain injury program was not investigated, and recommendations to continue psychotherapy were not followed. There were no documented social services follow ups with the resident following their behaviors. - Resident #235 had behaviors of taking things off the nurses' cart and throwing them leading up to an episode of threatening staff with scissors, requiring police intervention and hospitalization for the resident. There were no documented interventions from social services and the resident did not have person-centered interventions for their history of delusions and taking/throwing things off the nurses' cart. - Resident #250 had an extensive mental health history including paranoid schizophrenia and did not have person-centered mental health interventions for their behavioral symptoms. This placed all residents with mental health disorders at risk for physical, mental, and psychosocial harm that was Immediate Jeopardy and Substandard Quality of Care. Findings Included: The facility policy, Behavior Management revised 5/2020, documented the facility provided an interdisciplinary approach for the care of residents who exhibited problem behavioral symptoms which could lead to negative consequences for themselves or others. Residents who demonstrated changes in behavior would be evaluated to ensure appropriate interventions, as needed, were instituted in a timely manner. A resident's behavioral symptoms and approaches would be placed in the resident-specific plan of care and communicated to care staff and other departments as appropriate. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility policy, Care Plans- Comprehensive revised 10/2019, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The identification of problem areas and their causes and developing interventions that were targeted and meaningful to the resident, was the goal of the interdisciplinary process. The interdisciplinary team reviewed and updated the care plan quarterly, when a significant change occurred, when a desired outcome was not met, and when a resident was readmitted from a hospital stay. The facility policy, Social Services revised 10/2019, documented the facility provided medically related social services to assure each resident can attain or maintain their practicable physical, mental, or psychosocial well-being. 1) Resident #41 had diagnoses including schizoaffective disorder (a mental health condition with a mix of schizophrenia symptoms and mood disorder symptoms), anxiety, and depression. The 4/27/2024 Minimum Data Set assessment (a health status assessment tool) documented the resident had severely impaired cognition, had no behavioral symptoms in the 7-day look back period, was independent with most activities of daily living, had a diagnosis of schizophrenia disorder (schizoaffective and schizophreniform disorders), anxiety, and depression and was taking an antidepressant and an antipsychotic medication daily. The 4/29/2024 Comprehensive Care Plan documented the resident utilized psychotropic medication related to schizoaffective disorder, anxiety, and depression with hallucinations and psychosis. Interventions included to give medications as ordered, monitor and record target behaviors and potential side effects, and have psychiatry and psychology consults as needed. There were no documented person-centered interventions. A 1/7/2024 at 1:03 PM Licensed Practical Nurse #66's progress note documented the resident told them they were leaving. They notified the Supervisor who came to the unit and spoke to the resident. The Supervisor told Licensed Practical Nurse #66 if the resident attempted to leave to not attempt to stop them and let the Supervisor know. At 12:52 PM the resident came into the main hallway with two garbage bags full of items and started walking toward the elevator. The Supervisor was called. The resident got on the elevator and the doors closed. A 1/7/2024 at 2:00 PM Registered Nurse Supervisor #19's progress note documented the resident cut off their wander alert device and took the elevator to leave the facility. Emergency Medical Services and the police department was called due to the resident's attempt at an unsafe discharge. The resident's Health Care Proxy was called and agreed to transfer the resident to the hospital. The resident was sent to the hospital for psychiatric evaluation. The 1/7/2024 hospital after visit summary documented the resident was seen for a mental health problem with a diagnosis of difficulty controlling their anger. General information on managing anger was provided in the form of a paper hand out with directions to go to the comprehensive psychiatric emergency program if symptoms worsened. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 1/9/2024 Licensed Psychologist #36 progress note documented the resident had depression, schizoaffective disorder, and adjustment disorder. The resident felt angry, defiant, frustrated, and overwhelmed. The resident stated they had been taken to the hospital for crisis management and was angry with the interaction. They had difficulty with reality testing during the session and stated they would live in the woods with the animals like they had in the past when they had been raised by bears. The resident stated they would commit suicide by cop if they were engaged by law enforcement again to be forced to go to the hospital. The Registered Nurse Manager and nurse practitioner were informed of the statement and to be aware of the intention of aggression if confronted by law enforcement. The facility nurse practitioner was looking to coordinate a transfer to a more intense psychiatric program. The plan included to continue with psychotherapy and to follow up with therapy as scheduled. The recommendation was to continue with supportive care, safety precautions per facility policy, monitoring for mood, behavior, and sleep, redirect as clinically indicated, and to continue with psychotherapy. The resident remained with altered mental status and psychosis and had been highly agitated. Approach the resident with empathy and nonthreatening language and behavior. An escalation of conflict would result in a negative outcome and the resident should be provided with space, a soft voice, and a nonthreatening tone. There was no documented evidence the resident's Comprehensive Care Plan was updated to include the recommendations from Licensed Psychologist #36. The 1/18/2024 Licensed Psychologist #36 progress note documented the resident was angry, blaming, and edgy/irritable. The resident was angry and felt trapped in the facility. This triggered the resident's history of being abused and resulted in aggressive behavior for self-defense and survival. The resident was provided with reflective listening, disarming, and thought/feeling empathy and the resident was agitated but responsive. The recommendation was the same as the 1/9/2024 psychotherapy progress note. There was no documented evidence the resident's Comprehensive Care Plan was updated to include the recommendations from Licensed Psychologist #36. The 1/29/2024 Chief Medical Officer #11's progress note documented the resident had removed their wander alert device over the weekend and was brought back by police. The resident was actively threatening to kill themselves without a specific plan. They were also threatening to harm other individuals but did not state who the intent was directed at. The licensed psychologist was present during the visit. The resident had not been taking their antipsychotic medication. The resident was sitting in their chair physically shaking their hands which appeared to be extremely aggressive movements. The resident was threatening to harm themself and everyone around them. 911 was notified with police back up. The resident was deemed a risk to themselves and other residents in the facility. After much discussion they were able to get the resident to voluntarily go to the hospital. The 1/29/2024 hospital after visit summary documented the resident had been seen for homicidal, suicidal, and aggressive behavior with diagnoses of suicidal thoughts and aggressive behavior. The resident had been cleared by psychiatry prior to discharge with a recommendation to follow-up with outpatient providers as necessary. There was no documented evidence the comprehensive care plan was revised to reflect suicidal and homicidal ideations. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 2/10/2024 at 12:00 PM Licensed Practical Nurse #31's progress note documented the resident was threatening staff stating if a certain nurse was not there to help them, the resident would harm the staff. The resident began swinging at the staff providing 1:1. A 3/20/2024 Licensed Psychologist #36 progress note documented the resident was angry, and ranted and vented their dislike and distrust. The did not want to be in long term care. The resident seemed interested in treatment, was motivated, shared appropriate thought process and seemed to benefit from the session. Recommendations included continue psychotherapy as scheduled, supportive care, safety precautions, monitoring mood/behavior/sleep, and redirect as clinically indicated. Those approaching the resident should use empathy and non-threatening language and behavior. Escalation of conflict would result in negative outcomes. The resident would be seen by the clinician in 1-2 weeks. There was no documented evidence of follow-up in 1-2 weeks by Licensed Psychologist #36 after the 3/20/2024 consultation. The 6/4/2024 comprehensive care plan documented the resident had behavioral symptoms such as refusals of medications for auditory and visual hallucinations. Interventions included to determine the cause and maintain the resident's safety, initiate psychiatric and psychology evaluation as needed, praise and reinforce appropriate behavior, and for certified nurse aides to monitor behavior symptoms as needed. There was no documentation of what interventions to implement when behavioral symptoms occurred or of the resident's history of homicidal and suicidal ideations, aggressive behavior, or history/verbal statements of planned combativeness when law enforcement was called. During an interview on 6/11/2024 at 11:15 AM, Social Worker #37 stated social work was responsible for the care plans that involved mental health and behavioral symptoms. Care plans were updated quarterly, for a significant change, and as needed when issues came up. If a resident had specific behaviors, they should be included in the plan of care. If a resident was on psychotropic medications, their behaviors would be in the interventions on the care plan. If a resident exhibited their target behaviors, staff should report those behaviors to the physician, see if there were any as needed medication that could be given, and contact the psychologist or psychiatrist. They did not list immediate specific interventions for staff to implement when a behavior occurred, but they should as the care plan was meant to be person-centered. Resident #41's behaviors were not care planned with specific interventions but should have been. There should be a care plan for a resident who had homicidal and suicidal ideations. They stated they were not aware Resident #41 had a history of homicidal and suicidal ideations. During an interview on 6/11/2024 at 11:59 AM, the Director of Social Work stated residents' behaviors should be documented on their plan of care. The resident should also have specific interventions for their behaviors. What worked for one resident may not work for another. The staff would know what interventions to implement for the resident by looking at their plan of care. If a resident had a history of suicidal ideations and homicidal ideations it should be on the plan of care. During an interview on 6/12/2024 at 10:20 AM, Resident #41 stated they did not like doing mental health appointments over the phone or via telehealth. They stated they did not like to talk to a screen so would refuse if that was offered. They stated they did participate with Licensed Psychologist #36 because they came in person to talk to them. The resident stated they had a history with their mental health which included mental health inpatient stays related to messing up their medications and being involved with a treatment team when they were living in the community. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/12/2024 at 10:33 AM, Licensed Psychologist #36 stated they had seen Resident #41 in May 2024 and June 2024 but there was a period where the resident was avoiding visits by pretending to sleep. When the resident started to become more involved in physical therapy and going out with their adult child, so they were unable to see them. They expected their recommendations for approaches and interventions for behaviors to be included in the resident's plan of care. They stated the resident's verbalization about committing suicide by cop and the need to let law enforcement knows the resident would react aggressively to law enforcement should be on their plan of care so that someone not familiar with the resident would be aware should the police need to be called. During an interview on 6/12/2024 at 12:26 PM, Nurse Practitioner #22 stated the resident had exacerbations of their schizoaffective disorder with psychotic features where they were aggressive towards staff and threatened to harm themself. They sent the resident to the hospital multiple times for being a danger to themself and others. When the resident got bad, they could not be controlled in this setting and had to be sent out. Recently, the resident's behaviors had been controlled but the resident had a history of ups and downs. Any behavioral approach recommendation from Licensed Psychologist #36 should be on the resident's plan of care. They stated specific non-pharmacological interventions for behaviors should be on the plan of care. During an interview on 6/12/2024 at 12:46 PM, Chief Medical Officer #11 stated if Licensed Psychologist #36 made any recommendations for behavioral health they needed to be known by the resident's direct care staff and should be on the care plan. 2) Resident #153 had diagnoses including intracranial injury with loss of consciousness (brain injury), major depressive disorder, hydrocephalus (fluid buildup in the brain that causes brain swelling), and vascular dementia. The 5/17/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had verbal behavioral symptoms directed towards, rejected care, and wandered 1-3 of 7 days, was independent with activities of daily living, and took antipsychotic and antidepressant medication routinely. The 3/2/2023 physician order documented to monitor for behaviors: itching, picking at skin, restlessness, hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusion, hallucinations, psychosis, aggression, and refusing care. The comprehensive care plan initiated 5/3/2022 documented the resident exhibited behavior of wandering through out the unit taking items off the nurses' station desk, taking staff and resident food from fridge, entering other residents' rooms, and taking personal items belonging to others, episodes of socially inappropriate behaviors, and episodes of verbally aggressive behavior. The interventions were to check for thirst and hunger, distract resident with preferred activity, initiate psychiatric and psychology evaluation as needed, modify the environment to reduce episodes of behavior, and to redirect negative behavior as needed. The Psychiatric Mental Health Nurse Practitioner #91 recommended the resident would benefit from talk therapy. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 3/20/2024 Licensed Psychologist #36 progress note documented the resident had been aggressive to staff as well as peers. The recommendations included to continue supportive care, continue with safety precautions per facility protocol, continue monitoring for mood, behavior, and sleep, to redirect as clinically indicated, and to continue with psychotherapy. The resident would be provided with psychotherapy 1-3 times per month to assist with monitoring of mood and behavior. The goal was to work to reduce aggressive behavior, improve coping skills for boredom, work on acceptance of circumstances, and increase prosocial skills. The resident would benefit from the investigation of a traumatic brain injury program that allows for more activity and behavioral support, possible community-based integration with supervision. There was no documented evidence a traumatic brain injury program was explored as recommended. The resident had no documented psychotherapy notes after 3/20/2024. The 6/11/2024 Psychiatric Mental Health Nurse Practitioner #73 documented the resident had increased wandering at night, intermittent medication refusals, and verbal aggression toward staff. There was no documented evidence of social work progress notes related to the resident's behaviors or increased wandering. During an observation on 6/24/2024 at 4:44 PM The resident was standing up and was acting verbally aggressive toward the nurse. The resident stated, I am going to go in everyone room, grab hold of them. The nurse was documenting on a computer and the resident pointed toward the surveyor and said, she don't know me, thinks I am a sucker. The June 2024 treatment administration record documented monitor for behaviors: itching, picking at skin, restlessness, hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusion, hallucinations, psychosis, aggression, and refusing care. Document Y if monitored and none of the above were observed. Document N if monitored and any of the above was observed, and document in progress notes as Behavior note every shift. The behaviors had documented check marks with no Y or N from 6/1/2024-6/26/2024 (12 of 78 opportunities for documentation were blank). Nursing notes from 6/1/2024-6/26/2024 documented: - 6/4/2024 at 12:42 by Licensed Practical Nurse #34 PM refused all meds. - 6/9/2024 at 2:18 PM by Licensed Practical Nurse #98, the resident refused medications after three attempts and stated. I ain't takin' that [expletive], why you standin' there watching me, like I won't knock you out. Continued to approach staff and residents stating, I've been fighting my whole life, I'll knock your ass out. Redirection was unsuccessful. - 6/11/2024 at 3:50 AM by Licensed Practical Nurse #99 resident found standing next to another resident's bed looking at them, redirection was attempted, and the resident became verbally abusive when redirected. - 6/11/2024 at 4:55 AM by Registered Nurse Supervisor #89 aware of resident entering another resident's room. Reminded staff to complete behavior notes. (continued on next page)

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Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 6/17/2024 at 1:17 PM by Licensed Practical Nurse #98 attempted to administer medications three times. Resident refused stating they were tired of this [expletive]. - 6/20/2024 at 1:00 PM by Registered Nurse Unit Manager #94 refused medication after numerous attempts. Resident then went outside with a certified nurse aide. - 6/24/2024 at 12:07 PM by Licensed Practical Nurse #98 Resident held medications in their hands for 30 minutes before placing them in their mouth. Resident continuously stated, I've been fighting my whole life, I'll [expletive] your ass up. The resident held the medications in their mouth for 30 minutes before swallowing. There was no documented evidence the social worker or physician was aware of the resident's behavioral symptoms in 6/2024. During an observation on 6/26/24 at 10:03 AM, the resident was in their room sitting on the edge of bed, dressed, no sneakers on, wrapped in a sheet, wiggling their right leg, and twisting the sheet. During an interview on 6/27/2024 at 11:06 AM, Licensed Psychologist #36 stated they saw the resident on 4/11/2024 in addition to their initial visit on 3/20/2024. They stated the recommendations from their psychotherapy note included a traumatic brain injury program that allowed for more activity and behavioral support for the resident as well as possible community integration. The resident had hydrocephaly and when the shunt became blocked, the resident's behavior could change significantly. The resident would benefit from the traumatic brain injury program as it would be more specialized care and would assist with behavior management. The resident was young, bored, and was triggered easily. The resident felt very trapped but also cognitively lacked clarity and did not understand their processes. During an interview 6/26/2024 1:35 PM, the Director of Social Work stated they reviewed Licensed Psychologist #36's notes after they were completed, and they also received a synopsis of the visits via email from the provider. They were unaware if the resident had been seen since the initial visit in March 2024. They did not think the recommendation for a traumatic brain injury program was followed up on. The social workers should meet with residents who are having behaviors or increased behaviors. During an interview on 6/27/2024 at 2:36 PM, Nurse Practitioner #22 stated the resident's behaviors were related to their traumatic brain injury and hydrocephaly; especially if the shunt for their hydrocephaly was blocked. The resident's nature was if you said hello to them, they would respond with I'm going to punch you. They did not believe the resident to be an immediate threat, but they had the potential. They had to move the resident depending on the nature of the patient population of the floor the resident was on. They did believe the recommendation for a traumatic brain injury program to assist with boredom and behaviors would be good for the resident due to need for more specialized care. A community outpatient program could be beneficial to assist the resident. They believed the resident needed more than they were getting in the facility. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3) Resident #235 had diagnoses including unspecified dementia without behavioral disturbance and major depressive disorder. The 3/28/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition with disorganized thinking and inattention, had mild depression, had a diagnosis of non-Alzheimer's dementia and depression, and received antipsychotic and antidepressant medication routinely. The comprehensive care plan initiated 4/1/2023 documented the resident had a potential for resident-to-resident altercation as evidenced by aggression, hitting, slapping, throwing objects, yelling, and using foul language. Interventions included administer medications, identify environmental triggers, maintain visual line of sight, monitor behavior and document, notify medical doctor of negative behavior, offer diversional activity, refer to psychiatry/psychology services, and separate from the aggressor/victim. The resident exhibited behavior symptoms such as aggressiveness and danger to other due to cognitive impairment. 2/18/204, the resident attempted to stab at staff with sharp scissors. Additional interventions included to send the resident to the hospital for psychological and medication evaluation due aggressiveness, attempt to hurt others, brandishing a weapon (scissors), and danger to self and others. Nursing notes documented: - on 2/13/2024 at 3:16 PM by Licensed Practical Nurse #86 the resident was extremely agitated and confused and repeatedly threw items from the nursing cart and screamed for the State Police to be called. The resident was difficult to redirect. The Supervisor and Unit Manager were notified. - on 2/18/2024 at 7:49 PM by Registered Nurse #18 the licensed practical nurse reported the resident was extremely agitated and confused and repeatedly threw items from the nursing cart and called for the State Police to be called. Telemedicine was called and an order for Haldol (antipsychotic) 5 milligrams/milliliter inject intramuscularly one time only for aggressive behavior. Obtain a stat (immediate) urinalysis for possible urinary tract infection. - on 2/19/2024 at 2:20 AM by Registered Nurse Unit Manager #23 the resident was threatening staff with a pair of scissors and lunged at staff in a threatening manner. They attempted to retrieve the scissors and the resident tried to swipe at all staff who attempted. Resident was making delusional statements, was offered, and refused oral Haldol stating there was arsenic in it. Emergency Medical Services was called. Staff was told to stay away from the resident for safety, police arrived and requested the scissors, and the resident threw the scissors at the officer and the scissors landed on the floor. The resident was sent out of the facility for psychiatric evaluation. The 2/19/2024 hospital after visit summary documented the resident was seen for a psychiatric evaluation, had a diagnosis of dementia with behavioral disturbance, and was provided with an antipsychotic at the hospital. The 2/21/24 initial psychiatric evaluation by Psychiatric Mental Health Nurse Practitioner #73 documented the resident had an incident on 2/19/2024 when the resident was threatening staff with a sharp pair of scissors and trying to lunge at staff. They also had increased paranoia and refusing medications due to the belief they had arsenic. There was a concern the resident was not taking their medications and was spitting them out which the resident's adult child stated they had a history of. They recommended to decrease the environmental stimuli, ensure all needs were met, and implement behavior interventions such as distraction measures. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There was no documented evidence the care plan was updated with the recommendations from the Psychiatric Mental Health Nurse Practitioner #73. There were no nursing progress notes on 3/31/2024 documenting the resident had behaviors or was sent to the hospital. The 3/31/2024 hospital after visit summary documented the resident was seen for aggressive behavior, had a diagnosis of dementia of unspecified type whether behavioral, psychotic, or mood disturbance, or anxiety, and was provided with psychotropic medication at the hospital. There were no documented social services progress notes in relation to the resident's increased behaviors or emergency department visits for psychiatric evaluation or aggressive behavior. During an interview on 6/26/2024 at 11:40 AM, Social Worker #92 stated the social worker's role if a resident was having behaviors was to try to find interventions for the resident and put them in their plan of care. The plan of care identified the resident's behaviors and the interventions to meet the stated goal. The plan of care should be personalized for each resident. Any interaction with the resident should be documented. If a resident had a change in condition or increased behaviors, they would make a referral for either psychiatry or psychology. If they noticed a change, they would speak with nursing to see if the change was new or if a referral had gone in. They believed Resident #235 had a personalized plan of care. The resident's history of throwing things off the nurse's medication cart, spitting out their medications, or delusions of believing their medication contained arsenic was not included on the resident's plan of care. If a resident's behaviors were resolved, they should be removed from the plan of care. They did not include the resident's history of behaviors on their plan of care. During an interview on 6/26/2024 at 1:35 PM, the Director of Social Work stated if a resident went to the emergency department for psychiatric reasons, the social worker should check on them when they returned. Care plans were not only for active behaviors. If someone has not had a behavior in a while, the care plan could be changed to state a history of so the information was not completely gone and there was a trail. During a follow up interview on 7/02/2024 at 1:24 PM, they stated an intervention that documented to provide distraction measures was not personalized as it should include what the distractions were. During an interview on 6/27/2024 at 2:36 PM, Licensed Psychologist #36 stated they had seen the resident and was unsure why their psychotherapy notes were not in the electronic medical record. They stated the resident was referred for psychotherapy services after their emergency department visits in February 2024 and March 2024 for mental health. Their recommendation was to monitor the resident and continue supportive care as their dementia was progressing. The resident's family visited, and the resident did well with that. The resident really enjoyed visiting and was easily redirected. 10 NYCRR 483.40 (d) _____ Immediate Jeopardy was identified, and the Administrator was notified on 6/27/2024 at 4:00 PM. Immediate Jeopardy was removed on 7/03/2024 at 11:43 AM prior to survey exit based on the following corrective actions taken. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-100% of social work department staff had been educated on medically related social services. -Post-tests were reviewed. -Staff education sign in sheets were reviewed and compared to the current social work staff list and no discrepancies were identified. -Staff education was verified during an onsite visit on 7/1/2024, all social work department staff were interviewed to determine retention of education provided and were able to accurately report content of the education. -All five identified residents resident records were reviewed, and documentation reflected each had a social work assessment completed. -All five identified resident plans of care were reviewed and had updated person-centered interventions for their mental health.

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interview during the extended recertification and abbreviated (NY00335379) surveys conducted 6/4/2024-7/11/2024, the facility failed to ensure the ordering physician was notified promptly when a laboratory result fell outside of clinical reference range for 3 of 3 residents (Residents #153, #260, and #529) reviewed. Specifically, - Resident #529 had abnormal laboratory results including a high white blood cell count, a low lymphocyte count, and high sodium, blood urea nitrogen, and blood urea nitrogen/creatinine ratio (indicating possible dehydration and infection) that were not reviewed by facility staff in a timely manner, and the medical provider was not notified in a timely manner of the abnormal lab results. Subsequently, the resident was hospitalized 3 days later with pneumonia and dehydration. - Resident #153 had a critically low blood glucose (blood sugar) of 49 milligrams/deciliter and the provider was not notified in a timely manner and the resident was not assessed. - Resident #260 had a high international normalized ratio (INR, used to determine blood clotting times for residents on anticoagulant therapy) and the provider was not notified timely, and the resident was not assessed. This resulted in the likelihood of serious injury, serious harm, or death that was Immediate Jeopardy to resident's health and safety. Findings include: The facility policy, Laboratory Services, revised 8/2019, documented the facility would provide or obtain laboratory services to meet the needs of its residents. Licensed staff would make appointments and arrangements with the facility's laboratory for all the resident's ordered laboratory tests, obtain specimens as needed, and promptly inform the resident's physician of all abnormal test results by phone or fax. When the physician responded, the response was to be documented in the resident's chart. The facility policy, Anticoagulation Therapy, revised 3/2019, documented all residents would have labs drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. The physician would order appropriate lab testing to monitor anticoagulant therapy. Staff could use a warfarin flow sheet or comparable monitoring tool to follow trends in anticoagulant dosage and response. The policy did not include directions for communication of lab testing results to the physician. The electronic medical record Lab Results report documented a legend for flags included on the report. A red stop sign with an exclamation mark in the center indicated the report contained critical results (results in red text). A yellow triangle with an exclamation mark in the center indicated the report contained abnormal results (results with orange text). (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1) Resident #529 had diagnoses including dementia, malnutrition, and peripheral vascular disease (poor circulation). The 1/26/2024 Minimum Data Set assessment (a health status assessment tool) documented the resident had severely impaired cognition, was dependent with most activities of daily living, had 1 venous/arterial ulcer, and was on a mechanically altered diet. A 10/5/2023 Registered Dietitian #14 progress note documented the resident's estimated fluid requirements were 1480-1725 cubic centimeters per day. The 11/16/2023 Comprehensive Care Plan documented the resident had an actual/potential fluid deficit related to dehydration, was at risk of aspiration (inhaling food or fluid into the lungs) and had actual skin impairment related to an arterial wound on the left foot. Interventions included ensure resident had access to nectar/mildly thickened juice/water whenever possible; keep in an upright position while eating; blood urea nitrogen and creatinine laboratory tests per physician orders (potential indicators of dehydration); and monitor, document, and report to nurse signs/symptoms of fluid deficit including decreased or no urine output, concentrated urine, new onset confusion, increased pulse, and dizziness. The 1/18/2024 physician orders documented a complete blood count (blood test that measures the number and characteristics of blood cells) and a comprehensive metabolic panel (blood test that measures chemical balance and metabolism) every month. The 1/29/2024 Nutritional Assessment completed by Registered Dietitian #14 documented the resident was on a pureed consistency with nectar thick liquid and was dependent with eating. Their overall fluid intake was 1501-1800 cubic centimeters a day (did not document the period for the average fluid intake). The resident did not refuse fluids. The 2/2024 Certified Nurse Aide Survey Report documented the resident consumed 0-300 cubic centimeters of fluid daily between from 2/10/2024-2/17/2024. There was no documented evidence the resident's poor fluid intake was reported to the medical provider. The facility lab results report documented a lab specimen was collected on 2/15/2024 at 10:15 AM for a compete blood count and a comprehensive metabolic panel. The lab reported results to the facility on [DATE] at 2:00 PM . The lab results were flagged with a yellow triangle to indicate there were abnormal results. The results for the complete blood count and comprehensive metabolic panel laboratory report included the following abnormal laboratory values (in orange text): - high white blood cell count (potential indicator of infection) 13.3 units per microliter (normal 4.1-11.0 per microliter); - low lymphocyte % (potential indicator of infection) 5.8% (normal 16-52%); - high neutrophils % (potential indicator of infection) 86% (normal 35-75%); - high sodium (electrolyte, potential indicator of dehydration) 149 millimoles per liter (normal 136-145 millimoles per liter); (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- high blood urea nitrogen (potential indicator of dehydration) 35 milligrams/deciliter (normal 9-23 milligrams/deciliter); - high blood urea nitrogen/creatinine ratio (potential indicator of dehydration) 53.8 (normal 10-20). The bottom of the report had a space to sign and date when the results were reviewed. There was no documentation the results were reviewed on the day they were received. From 2/15/2024 to 2/17/2024, there were no documented nursing or provider notes in the resident's record regarding changes in the resident's condition. The 2/18/2024 at 1:37 PM Registered Nurse #18 progress note documented they were notified by the licensed practical nurse the resident had abnormal vital signs. The resident was assessed and found with signs of lethargy and symptoms of change in condition including a high heart rate of 152 beats per minute (normal 60-100 beats per minute) and oxygen saturation (level of oxygen in the blood) of 70% (normal level 95-100%) on room air. Oxygen was immediately administered at 5 liters per minutes with oxygen saturation increasing to 95%. The on-call provider was notified and agreed to transfer the resident to the hospital for further evaluation. The progress note did not document if Registered Nurse #18 was aware of the 2/15/2024 laboratory results or had reported the results to the on-call provider. The 2/18/2024 hospital report documented the resident presented from the facility for generalized weakness and was admitted with sepsis (life threatening complication of infection), acute respiratory failure, and severe hypovolemic (low fluid portion of blood) hypernatremia (high sodium). The resident's white blood cell count was high at 19 units per microliter and their sodium was high at 161 millimoles per liter. The resident was admitted to the intensive care unit and started on antibiotics and intravenous fluids, along with systemic steroids (medication to reduce inflammation) for severe pneumonia. The 2/15/2024 laboratory results document was electronically signed by facility Nurse Practitioner #16 on 2/22/2024 at 2:49 PM, 4 days after the resident was transferred to the hospital. During a telephone interview on 6/7/2024 at 10:24 AM, Licensed Practical Nurse Manager #13 stated every unit had a lab day and the providers followed up to review results daily. Lab values populated to all nursing and provider dashboards in the resident electronic medical record. Providers typically clicked a button indicating the labs were reviewed however nursing could do that as well. They were not sure why the resident's labs were not reviewed, and when it was reviewed, it was not done timely. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 6/10/2024 at 10:05 AM, Nurse Practitioner #16 stated if they ordered acute labs for a resident, they typically followed up the next day to review the results. If routine scheduled labs were completed, they expected nursing to notify them as soon as possible of any alterations. They wanted to be notified of lab results such as a high white blood cell count and elevated blood urea nitrogen. They believed they did not work on 2/16/2024 and did not review the resident's labs until after the resident was discharged to the hospital. If they had known the resident's white blood cell count was high, they would have intervened and ordered a chest x-ray and/or urinalysis (often used to check for urinary tract infections). For the elevated blood urea nitrogen, they would have ordered extra hydration (fluids) by mouth or intravenously (through a vein). Earlier intervention could have resulted in a different outcome for the resident. During a telephone interview on 6/11/2024 at 8:55 AM, Registered Dietitian #14 stated if there was a concern with lab values, the provider notified them. Laboratory values they would want to be notified about included a high blood urea nitrogen or high sodium because those could indicate dehydration. If they were made aware of the lab results, they would have done an assessment and discussed interventions with the provider. They were not aware the resident had altered lab values on 2/15/2024. 2) Resident #153 had diagnoses including Type 2 diabetes (the pancreas does not make enough insulin needed for control of blood sugar), traumatic brain injury, and dementia. The 5/17/2024 Minimum Data Set assessment (health assessment screening tool) documented the resident had moderate cognitive impairment, was usually understood, and received a hypoglycemic medication (used to reduce the amount of sugar in the blood). The 8/15/2022 Comprehensive Care Plan documented the resident had non-insulin dependent diabetes. Interventions included monitor for signs and symptoms of hyperglycemia (high blood sugar), administer medications per physician order, monitor blood glucose finger stick, monitor for signs and symptoms of hypoglycemia including confusion, lethargy, decreased blood sugar, diaphoresis (sweating) and tachycardia (high heart rate), and monitor labs and notify physician of abnormal values. Physician orders documented: - on 3/2/2023 provide a controlled carbohydrate diet - on 3/2/2023 finger stick (measure blood sugar) daily before breakfast and dinner. Call medical provider if less than 70 milligrams/deciliter or greater than 250 milligrams/deciliter. - on 3/2/2023 glucagon emergency kit (used to treat very low blood sugar), inject 1 milligram intramuscularly as needed for severe hypoglycemia (low blood sugar) once as needed. - on 10/19/2023 glipizide extended release (stimulates release of insulin) 5 milligrams once daily. On 5/16/2024, Physician #41 documented the resident was seen for a routine visit. The resident had type 2 diabetes and had improved with the current medication regime. The 6/14/2024 physician order documented comprehensive metabolic panel (blood test that measures chemical balance and metabolism) related to diabetes without complications. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 6/2024 Medication Administration Record documented: - metformin (an oral medication used to treat high blood sugar levels) 1000 milligrams twice daily at 7:00 AM-10:00 AM and at 7:00 PM-9:00 PM. A 6/20/2024 Licensed Practical Nurse #87 progress note documented the resident refused their 6:00 AM finger stick. The resident refused 3 attempts. A 6/20/2024 at 11:00 AM, Assistant Director of Nursing #25 progress note documented the resident was alert and able to verbalize their needs. They refused to take their medication and they were tired of taking all their medications. The resident verbalized an understanding of their need for medications, but still refused. The resident's family was called, and they encouraged the resident to take their medications. Their family stated they would come to the facility to encourage the resident to take their medications and allow staff to obtain blood work. A 6/20/2024 at 1:00 PM progress note by Registered Nurse Unit Manager #94 documented they were able to administer the resident's medications after numerous attempts. A 6/20/2024 at 3:24 PM Assistant Director of Nursing #25 progress note documented the resident's family came to the facility and convinced the resident to allow a blood draw. The Assistant Director of Nursing drew the blood for the ordered lab work with the family present. The facility lab results report documented a lab specimen was collected on 6/20/2024 at 3:13 PM and received by the laboratory on 6/21/2024 at 3:04 PM. The lab results were flagged with a red stop sign to indicate a critical glucose result of 49 milligrams/deciliter (normal 70-99). The report documented the glucose result was called to and read back by Registered Nurse #89 on 6/21/2024 at 5:46 PM. The bottom of the report had a space to sign and date when the results were reviewed. There was no documentation the results were reviewed on the day they were received. The top of the lab result documented it was reviewed by Nurse Practitioner #22 on 6/25/2024 at 9:29 AM, 4 days after the results had been reported to the facility. There was no documented evidence a medical provider was notified of the critical glucose result of 49 milligrams/deciliter, or the resident was assessed for signs and symptoms of hypoglycemia. During a telephone interview on 6/25/2024 at 8:33 AM, the laboratory services Hematology Manager #96 stated the lab called the facility's nurse call line and asked who they were speaking to and read the results to the nurse. The nurse read back the results, and the lab services would document the date and time of the call. During an interview on 6/25/2024 at 9:09 AM Registered Nurse #89 stated they were a Nursing Supervisor and mainly covered the Letter building. Resident #153 had a blood draw completed on 6/20/2024 around 3:15 PM. On 6/21/2024 at 5:26 PM they received a call from the lab stating the Resident #153 had a glucose of 49. They felt the lab should have called the facility sooner. They were completing an admission assessment on another resident at the time of the call, but they called the unit to check on Resident #153. They were told the resident had taken all their medications. They should have called a medical provider to let them know the resident had a critical result of 49 to get further orders. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/25/2024 at 9:11 AM, Medical Director #11 stated if a resident had an ordered blood draw the facility's lab services contacted the facility with abnormal/ critical results. They called the Nursing Supervisors or Registered Nurse Unit Managers, who would then contact the medical staff to get further direction. If a resident had low glucose, they should be assessed by a registered nurse and the medical staff (physician or nurse practitioner). The lab results also were posted in the electronic medical record system so all nursing and medical staff could view them. If a resident had a glucose result of 49, they should have been assessed by a Registered Nurse and the medical staff should have been contacted. They did not see any documentation in the resident's electronic medical record regarding a glucose of 49. They expected medical staff to be notified and if medical was not notified it could affect the resident's medical condition. During an interview on 6/26/2024 at 1:32 PM, laboratory services Hematology Manager #96 stated the lab services protocol for the facility was to call the nursing call line and read back critical results. On 6/21/2024, the lab services called the facility and reported a critical result glucose result of 49 for Resident #153 to Registered Nurse #89. During a follow up interview on 7/2/2024 at 9:24 AM, laboratory services Hematology Manager #96 stated they looked at the collection tube for Resident #153 from 6/202/204 and there was not collection time documented, but the lab did call Registered Nurse #89 on 6/21/2024 about the critical result. 3) Resident #260 had diagnoses including non-traumatic ischemic infarction (disrupted blood flow) of the right lower leg, mitral valve (a heart valve) replacement, and atrial fibrillation (irregular heart rhythm which can lead to blood clots in the heart). The 5/31/2024 Minimum Data Set assessment documented the resident was cognitively intact and received an anticoagulant (blood thinner). The 3/10/2024 Comprehensive Care Plan documented the resident was at risk for bleeding secondary to anticoagulant use related history of deep vein thrombosis (blood clot that forms in one or more of the deep veins in the body). Interventions included to administer medications as prescribed, monitor effectiveness of medications given and observe for adverse reactions, handle resident gently during care and support the extremities under joints during movement, monitor for signs and symptoms of abnormal bleeding (skin bruising, bleeding gums, black stools, coffee ground like emesis, blood in urine), monitor lab values as ordered and notify medical of abnormal findings (PT, INR), and refer to dietary for diet modifications as needed. Physician orders documented: - on 5/28/2024 PT/INR (prothrombin time/international normalized ratio, used to measure how long it takes blood to clot) every Monday and Thursday and INR goal of 2.5-3.5. - on 6/4/2024 warfarin sodium (Coumadin, an anticoagulant) 1 milligram at bedtime for valve (regular orders for warfarin sodium were documented based on INR results). - on 6/14/2024 PT/INR one time only to monitor INR related to non-traumatic ischemic infarction of muscle of right lower leg. (continued on next page)

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	335338	A. Building B. Wing	07/11/2024

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility lab results report documented a lab specimen was collected on 6/13/2024 at 8:07 AM and received by the laboratory on 6/13/2024 at 11:59 AM. The lab results were flagged with a red stop sign to indicate critical results of an INR of 5.77. The report documented the INR result was called to the facility and read back by (only first name documented with no title) on 6/13/2024 at 12:29 PM. The top of the lab result documented it was reviewed by Nurse Practitioner #22 on 6/13/2024 at 3:36 PM. A 6/13/2024 at 5:09 PM progress note by Registered Nurse #15 documented labs were reviewed by the nurse practitioner. Warfarin was held and labs would be repeated in the morning. There were no documented physician orders to hold warfarin on 6/13/2024. The facility lab results report documented a lab specimen was collected on 6/14/2024 at 9:12 AM and received on 6/14/2024 at 11:46 AM. The lab results were flagged with a red stop sign to indicate critical results and included an INR of 5.05. The report documented the INR result was called to the facility and read back by Assistant Director of Nursing #25 on 6/14/2024 at 1:03 PM. The bottom of the report had a space to sign and date when the results were reviewed. There was no documentation the results were reviewed on the day they were received. The top of the lab result documented it was reviewed by Nurse Practitioner #22 on 6/15/2024 at 10:29 AM. The 6/14/2024 at 10:06 PM Registered Nurse #15 progress note documented the INR was reviewed with the nurse practitioner. The warfarin would be held as ordered and repeat labs as ordered. There were no documented physician orders to hold warfarin on 6/14/2024. There were no documented medical provider progress notes referencing the critical INR values on 6/13/2024 and 6/14/2024. The 6/2024 Medication Administration Record documented the resident did not receive warfarin on 6/13/2024 and 6/14/2024. During an interview on 6/25/2024 at 9:11 AM, the Medical Director stated the facility was notified by the laboratory of critical lab results. The laboratory would usually report the labs to the Nursing Supervisor or the Unit Managers. The nurses would then call the provider to report the results and receive direction on how to proceed. The provider should be notified of critical lab results immediately so they could be urgently addressed. If an INR was out of range, it could be considered a critical lab value. If INRs were reported to the facility between 5:00 PM-7:00 AM the telehealth provider should be notified. Resident #260's INRs were addressed by Nurse Practitioner #22 after the registered nurse notified them, and the warfarin was held on 6/13/2024 and 6/14/2024. If an INR falls outside the range of 2.5-3.5 for a mechanical heart valve, the provider needed to be notified to determine if further action was needed. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Nurse Practitioner #22 on 6/25/2024 at 9:13 AM, they stated if there were any critical laboratory values the facility's contracted laboratory called the nursing supervisor and informed them of the critical values. The nursing supervisor would then call them during the day if critical values were called in during the off shifts and the on-call medical provider would be notified. They checked the Dashboard (feature in the electronic medical record that alerted staff to outstanding/ critical laboratory values) twice daily each unit. If they noticed any outstanding/ critical laboratory values, they reviewed the resident's record and saw the resident. Resident #260 had an artificial heart valve. If an INR falls outside the range of 2.5-3.5 for a mechanical heart valve, the provider needed to be notified to determine if further action was needed. Resident #260's INR was 5.35 and they ordered their scheduled warfarin to be held 6/24/2024 at 3:22 PM and ordered another INR to be completed on 6/25/2024. The resident received their warfarin in the evening, so they documented their note later in the day. If they held the resident's warfarin too much, they would get subtherapeutic (a dose that is below what is used for treating disease or producing an optimal therapeutic effect) levels. They would consider prescribing vitamin K if the resident's INR was 5 -6 and if the resident was bleeding. They thought the nursing supervisor documented when the laboratory called the facility with critical values, but they did not see any documentation at this time. 10 NYCRR 415.20 _____ Immediate Jeopardy was identified, and the Administrator was notified on 6/27/2024 at 7:00 PM. Immediate Jeopardy was removed on 7/3/2024 at 11:43 AM prior to survey exit based on the following corrective actions taken. As of 7/3/2024 at 9:00 AM, 86% of all licensed nursing staff have been educated on laboratory services. The remaining staff will be educated prior to the start of their next shift. Post-tests were reviewed. Staff education sign in sheets were reviewed and compared to the current nursing staff list and no discrepancies were identified. 100% of licensed nursing staff currently working on 7/3/2024 received education. Staff education was verified during an onsite visit(s) 7/3/2024, multiple licensed nursing staff on multiple units were interviewed to determine retention of education provided and were able to accurately report content of the education. 35045 44838 48895

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 27522 33421 35045 43754 44838 48446 48895 Based on observation and interview during the extended recertification and abbreviated (NY00336795) surveys conducted 6/4/2024-7/11/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, flavorful, and at an appetizing temperature for 3 of 3 meals reviewed (6/5/2024 lunch meal on the 2nd floor, and 6/6/2024 lunch meals on the 3rd floor and on the C Unit). Specifically, food was not flavorful and was not served at palatable and appetizing temperatures during the lunch meals on 6/5/2024 and 6/6/2024; 9 of 9 anonymous residents at the Resident Council meeting complained the food was not appetizing; and 9 residents (Residents #11, #36, #64, #105, #147, #151, #197, #255, and #265) interviewed stated the food did not taste good. Findings include: The facility policy, Meal Service, dated 1/2023, documented meals would be served promptly to maintain adequate temperature and appearance. The facility policy, Food Temperatures, dated 1/2023, documented that all employees were responsible to notify the supervisor of any food item that did not meet the regulated safe acceptable service ranges (at or below 41 degrees Fahrenheit or above 135 degrees Fahrenheit). During an interview on 6/4/2024 at 10:54 AM, Resident #151 stated that hot food was not always served hot, and the food did not taste good. During an interview on 6/4/2024 at 11:36 AM, Resident #36 stated the food was not good. The items served were too tough to eat or were cold. During a resident group interview on 6/4/2024 at 2:25 PM, 9 anonymous residents stated the food did not taste good. During a lunch meal observation on 6/5/2024 at 12:44 PM on the 2nd floor, Resident #195 was served their lunch meal tray. A replacement tray was ordered, and Resident #195's original meal tray was tested . At 12:47 PM food temperatures were taken. The corn was measured at 115 degrees Fahrenheit, the coleslaw was 57 degrees Fahrenheit, the yogurt was 62 degrees Fahrenheit, and the apple sauce was 56 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a lunch meal observation on 6/6/2024 at 12:21 PM, the meal cart arrived on the 3rd floor at 12:24 PM. Resident #189's meal tray was the last on the cart and was tested . A replacement tray was ordered for Resident #189. At 12:30 PM food temperatures were taken. The yogurt was measured at 65 degrees Fahrenheit, the fortified pudding was 67 degrees Fahrenheit, the chocolate milk was 58 degrees Fahrenheit, and the fruit salad was 54 degrees Fahrenheit. During a lunch meal observation on 6/6/2024 at 2:19 PM, the meal cart arrived on the C Unit at 2:17 PM. Resident #105's meal tray was tested , and a replacement tray was ordered. At 2:19 PM temperatures were taken. The cottage cheese and fruit platter was measured at 67 degrees Fahrenheit, the chocolate milk was 63 degrees Fahrenheit, and the pudding was 71 degrees Fahrenheit. The cottage cheese and fruit platter was not appealing in appearance due to an abundance of liquid on the plate. During an interview on 6/7/2024 at 10:50 AM, the Food Service Director stated hot food temperatures were checked by the cooks in the kitchen before the food went on the tray serving line. Temperatures were then checked every hour while the food was on the tray serving line. Cold food temperatures were not checked unless there was an issue with the refrigeration. During an interview on 6/10/2024 at 10:31 AM, Licensed Practical Nurse Unit Manager #2 stated residents complained about the temperatures of the food, the amount of food received, the food did not look appetizing, and the food did not taste good. The temperatures of the food were mostly related to the cold foods which were warm. The kitchen put cold food on the tray with the hot food and closed the doors on the food cart which warmed up the cold foods. During a follow up interview on 6/12/2024 at 10:23 AM, the Food Service Director stated they expected hot food temperatures to be above 125 degrees Fahrenheit. Cottage cheese, pudding, and chocolate milk were supposed to be served cold. The cold food was expected to be below 40 degrees Fahrenheit. Temperatures of 63, 67, and 71 degrees Fahrenheit were not acceptable for chocolate milk, cottage cheese, and pudding, respectively. 10NYCRR 415.14(d)(1)(2)