STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris Park Rehabilitation and Nursing Center	1235 Pelham Parkway North Bronx, NY 10469

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during survey the facility failed to ensure that services provided or arranged by the facility met professional standards of quality. This was evident in one (1) out of six (6) residents (Resident #1) sampled. Specifically, on 05/08/2026, Licensed Practical Nurse #1 documented in the Medication Administration Record that they administrated medications to Resident #1 and took the resident's vital signs at 7:00 AM. Additionally, Licensed Practical Nurse #1 documented in the Treatment Record that they monitored Resident #1 at 7:30 AM. According to the facility video surveillance footage, Resident #1, who was severely cognitively impaired, with a history of wandering behavior and identified as an elopement risk exited the facility grounds unsupervised on 05/08/2026 at 12:30:40 AM and has not been found. Resident #1 was last seen on 05/08/2026 at 12:15 AM by Certified Nursing Assistant #1 in a hallway on the first-floor unit. Resident #1 was not identified as missing until 8:20 AM Cross Reference: F842 - Resident- Identifiable InformationThe findings include: The facility policy and procedure titled Medication Management dated 10/18/2024 documented the purpose to establish a safe standard for ordering, dispensing, administration and documentation of medications. The nurses obtain specific vital signs and follow specific instructions before administering medication. The nurse administers the right drug to the right resident at the right time in the right dose via right route and the right documentation. Immediately after administering mediations, the nurse documents on the Medication Administration Record. The Nurse will also document in their nurses notes the reason for medication not given.The facility policy and procedure titled Treatment Administration dated 10/18/2024 states it is the policy that all treatments are administered safely, accurately, and in accordance with physician/practitioner orders, accepted standards of nursing practice, applicable federal and state regulations, and facility protocols. Treatments shall be provided in a manner that promotes resident safety, comfort, dignity, infection prevention and continuity of care. Resident #1 was admitted to the facility with diagnoses including dementia (decline cognitive function), bipolar disorder (mental health condition that causes extreme mood swings) and chronic heart failure (heart muscle do not pump enough blood). The Minimum Data Set (a resident assessment tool) dated 04/10/2026 identified Resident #1 to have severely impaired cognition. Resident #1 was assessed to be on diuretic (water pill) medication and anticonvulsant (treat and prevent seizure) medication.The Physician's Orders dated 03/31/2026 through 05/08/2026 revealed orders for Furosemide (diuretic) 20 milligram one (1) tablet once daily, Metoprolol Succinate Extended Release 25 milligram daily for essential hypertension, Valproic Acid 250 milligram per five (5) milliliter two (2) times a day for bipolar disorder, Thiamine Hydrochloride (vitamin B1) 100 milligram daily for Thiamine deficiency, and monitor blood pressure and pulse daily before administering metoprolol. The Medication Administration Record revealed that on 05/08/2026 Licensed Practical Nurse #1 administered the above medications and took Resident #1's blood pressure at 7:00 AM. Resident #1's blood pressure recorded as 130/80. The Physician's Order initiated 03/31/2026 documented monitor every shift and as needed for ID and Neon arm band (an elopement band) placement. The Treatment Administration Record dated 05/07/2026 from 11:30 PM to 7:30 AM, revealed Licensed Practical Nurse #1 documented that they monitored Resident #1 on (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/08/2026 at 7:30 AM. The facility's video surveillance was reviewed with the Administrator on 05/12/2026. The video surveillance footage dated 05/08/2026 showed Resident #1 talking to the Security Guard #1 in the lobby at 12:28:20 AM. Security Guard #1 was seen pointing to the right side of the lobby then Resident #1 proceeded towards the elevator located to the right of the lobby. At 12:29:35 AM, Resident #1 walked past the elevator. From 12:30:06 to 12:30:30 AM, Resident #1 was walking in the New Wing Hall lobby on the first floor and at 12:30:40 AM, Resident #1 exited through an exit door (equipped with an alarm). The facility's Accident Report dated 05/08/2026 documented that Registered Nursing Supervisor #1 was performing rounds at 8:15 AM (on 05/08/2026) when they observed that Resident #1 was not in their room. A unit searched was conducted and Code E (elopement) activated. Resident #1 was confirmed to be missing from the facility at 8:45 AM. At 8:50 AM, staff members searched the surrounding neighborhood and nearby areas. Local police were notified and responded at 9:00 AM. The facility reviewed their video surveillance footage and confirmed Resident #1 exited the facility on 05/08/2026 at 12:30 AM. The facility concluded Resident #1 eloped from the facility at 12:30 AM. A Nursing Progress Note, signed by Registered Nurse Supervisor #1 on 05/09/2026 at 9:01 AM, documented that Resident #1 was on 30-mimute monitoring for elopement. During morning rounds at approximately 8:15 AM, Resident #1 observed not to be in their room, bathroom or dining room. A search and head count initiated, but Resident #1 was nowhere to be found. Code E activated, staff searched, and police was notified. During an interview on 05/12/2026 at 1:15 PM, Licensed Practical Nurse #1 stated they worked on 05/07/2026 on the 11:30 PM to 7:30 AM shift, but did not do an initial rounding because they assumed the certified nursing assistants performed their rounds. Licensed Practical Nurse #1 stated they should have done their unit rounds and checked on Resident #1. Licensed Practical Nurse #1 stated they did not go to Resident #1's room because they don't want to disrupt the resident. Licensed Practical Nurse #1 stated they knew Resident #1 had a noncompliant behavior of refusing medications and does not want to be disturbed when they are sleeping. Licensed Practical Nurse #1 stated that they did not give Resident #1 their medications at 7:00 AM but they signed in the Medication Administration Record that medications were given. Licensed Practical Nurses #1 stated they should not have signed that the medications were given.During an interview on 05/12/2026 at 12:05 PM, Registered Nurse Supervisor #1 stated Resident #1 was not wearing a wander guard because they had refused to wear one and that they were placed on 30-minute monitoring due to wandering and at risk for elopement behavior. Registered Nurse Supervisor #1 stated while conducting unit rounds on 05/08/2026 at 8:15 AM, they observed that Resident #1 was not physically in their room. Registered Nurse Supervisor #1 stated that the staff searched the unit, but Resident #1 was not found. Registered Nurse Supervisor #1 stated they immediately called security and activated Code E. Registered Nurse Supervisor #1 stated Resident #1 was confirmed missing at 8:45 AM. Registered Nurse Supervisor #1 stated the Director of Nursing and Administrator were notified (unsure of time). Registered Nurse Supervisor #1 stated local police were notified and arrived at the facility on 05/08/2026 (unsure of time) and were provided with Resident #1's information and picture. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported they did not perform rounding, but they saw Resident #1 and administered medications to them at 6:00 AM. Registered Nurse Supervisor #1 stated they questioned Licensed Practical Nurse #1 as to how they administered medications to Resident #1 at 6:00 AM when the resident exited the building at 12:30 AM. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported being sorry. During an interview on 05/12/2026 at 2:45 PM, the Director of Nursing stated they confirmed that Resident #1 was missing at 8:45 AM (on 05/08/2026) and they notified the Administrator and police at 8:50 AM. The Director of Nursing stated the Medical Director and family were notified at 9:00 AM. The Director of Nursing stated the Maintenance Director and other maintenance staff reviewed the video surveillance footage at 8:45 AM and at 9:15 AM, and confirmed Resident #1 exited the facility through the New Wing Hall lobby exit alarm door (garage door going towards the parking lot) on 05/08/2026 at 12:30 AM. The Director of Nursing stated during the (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation, they found that the alarm on the exit door did not activate and was found to have malfunctioned. The Director of Nursing stated they contacted the alarm company, and they arrived at the facility on 05/08/2026 at 10:30 AM and repaired the alarm system. The Director of Nursing stated they immediately conducted a Quality Assurance Performance Improvement meeting at 10:30 AM to identify the root cause and established a plan for correction. The Director of Nursing stated that Certified Nursing Assistant #1 was suspended for not completing a 30-minute monitoring documentation for Resident #1. The Director of Nursing stated that Licensed Practical Nurse #1 was interviewed and stated they did not perform their nursing rounds to check Resident #1. The Director of Nursing stated further investigation revealed Licensed Practical Nurse #1 documented that they administered medications at 7:00 AM and that they saw Resident #1 at 6:00 AM. The Director of Nursing stated the findings revealed failures in required Resident #1's supervision and monitoring, inaccurate nursing documentation and malfunctioned exit alarm door that failed to alert staff when Resident #1 exited the facility unnoticed. During an interview on 05/12/2026 at 5:51 PM, the Administrator stated they reviewed the video surveillance footage as well and Resident #1 exited the facility on 05/08/2026 at 12:30 AM without supervision. The Administrator stated they and other staff called multiple hospitals, shelters, drove to Time Square and [NAME] Station where Resident #1 used to live and stay around. The Administrator stated they are in communication with the police and that as of today 05/12/2026, Resident #1 could not be located. The Administrator stated they were made aware Resident #1's monitoring log from 11:00 PM to 7:00 AM revealed Resident #1 was not monitored, and the Licensed Practical Nurse #1 did not perform their unit rounds during their shift. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 05/12/2026. A Plan of Correction is not required for this citation. 10 New York Codes, Rules, and Regulations 415.11(c)(3)(i) The facility took immediate corrective actions and was found to be in substantial compliance on 05/11/2026 prior to surveyors onsite 05/12/2026.Immediate Corrective Actions: On 05/08/2026 - Policy and Procedure titled Medication Management dated 10/18/2024 reviewed with no revisions. On 05/08/2026 - Policy and Procedure titled Treatment Administration Record dated 10/18/2024 reviewed with no revisions. On 05/08/2026 the facility discussed in their Quality Assurance meeting the issues related to Licensed Practical Nurse #1 signing for medications administration and monitoring of Resident #1. On 05/08/2026 at 9:00 AM, internal staff interviews were initiated regarding Resident #1 supervision and last known Resident #1 location. On 05/08/2026 at 10:00 AM, staff assignments, supervision practices and overnight accountability process were reviewed. Resident #1 records, care plans, elopement risk assessments and documentation were reviewed. On 05/08/2026 at 10:30 AM, a Quality Assurance meeting was held to review the incident, identify immediate corrective actions and implement facility wide interventions. On 05/08/2026 Licensed Practical Nurse #1 was taken off schedule. On 05/08/2026 a Discipline Notice documented Certified Nursing Assistant #1 was taken off the schedule pending investigation outcome.On 05/08/2026 to 05/11/2026 - In-service provided to nursing staff. Lesson plan titled Abuse/Neglect, Accurate Documentation, Signing Medication Administration Record after Medication is given, Treatment Record, and Doctor's Orders for 30-minute monitoring in Kiosk (Certified Nursing Assistants Instructions). Attendance sheet with signatures reviewed.On 05/10/2026 - an email dated 05/10/2026 revealed Licensed Practical Nurse #1 was reported to their agency. On 05/11/2026 - a Professional Discipline Complaint form dated 05/11/2026, revealed Licensed Practical Nurse #1 was reported to Office of Professional Discipline.On 05/11/2026 a follow-up Quality Assurance meeting was held. Attendance sheet reviewed. Reeducation: Total of nursing staff = 116 = 100 percent DepartmentCompleted % CompleteCertified Nursing Assistants71100%Licensed Practical Nurses20100% Registered Nurses25100%

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during survey, the facility failed to ensure residents received adequate supervision to prevent elopement. This was evident in one out of six residents (Resident #1) sampled for elopement. Specifically, Resident #1, who was severely cognitively impaired, with a history of wandering behavior and identified as an elopement risk exited the facility grounds unsupervised on 05/08/2026 at 12:30:40 AM per video surveillance footage and has not been found. Resident #1 exited through the New Wing Hall lobby (1st floor); the alarm on the exit door did not activate due to alarm system malfunction. Resident #1 was last seen on 05/08/2026 at 12:15 AM by Certified Nursing Assistant #1 in a hallway on the first-floor unit. Resident #1 was not identified as missing until 8:20 AM. This resulted in Immediate Jeopardy Past Noncompliance.The findings include:The facility's policy and procedure titled Care of Residents with Wandering Behavior dated 12/05/2025 states that policy is to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. The purpose is to minimize the potential for accidents resulting from a resident's wandering behavior.The facility's policy and procedure titled Wandering and Elopement dated 12/07/2025 states that it is the policy to ensure that residents will be maintained in a safe and secure manner and protected from any harm. The facility will make every effort to identify residents with potential for elopement. In the event that a resident is discovered to be missing, a search and rescue operation will commence immediately. Resident #1 was admitted to the facility with diagnoses including dementia (decline cognitive function), bipolar disorder (mental health condition that causes extreme mood swings) and chronic heart failure (heart muscle do not pump enough blood). The Minimum Data Set (a resident assessment tool) dated 04/10/2026 identified Resident #1 to have severely impaired cognition. An Elopement/Wandering Risk assessment dated [DATE] documented Resident #1 was identified as at risk for elopement. The interventions included daily monitoring and every 30-minute monitoring.A review of Physician Orders from 03/31/2026 through 05/08/2026 revealed an order for 30-minute monitoring for elopement risk and behavior. There was no documented evidence of a monitoring log sheet for 05/07/2026 during the 11:00 PM to 7:00 AM shift.A Potential for Elopement Care Plan dated 01/15/2026 was last updated on 04/13/2026 with interventions for Resident #1 to be monitored every 30-minutes, to continue to monitor behavior and moods and provide redirection during active wandering behavior. The facility's video surveillance was reviewed with the Administrator on 05/12/2026. The video surveillance dated 05/08/2026 revealed Resident #1 talking to Security Guard #1 in the lobby at 12:28:20 AM. Security Guard #1 was seen pointing to the right side of the lobby then Resident #1 proceeded toward the elevator located to the right of the lobby. At 12:29:35 AM, Resident #1 walked past the elevator. From 12:30:06 to 12:30:30 AM, Resident #1 was walking in the New Wing Hall lobby on the first floor and at 12:30:40 AM, Resident #1 exited through an exit door (equipped with an alarm). The facility's Accident Report dated 05/08/2026 documented that Registered Nursing Supervisor #1 was performing rounds at 8:15 AM (on 05/08/2026) when they observed that Resident #1 was not in their room. A unit searched was conducted and Code E (elopement) activated. Resident #1 was confirmed to be missing from the facility at 8:45 AM. At 8:50 AM, staff members searched the surrounding neighborhood and nearby areas. Local police were notified and responded at 9:00 AM. The facility reviewed their video surveillance footage and confirmed Resident #1 exited the facility on 05/08/2026 at 12:30 AM. The facility concluded Resident #1 eloped from the facility at 12:30 AM. A Nursing Progress Note, signed by Registered Nurse Supervisor #1 on 05/09/2026 at 9:01 AM, documented that Resident #1 was on 30-mimute monitoring for elopement. During morning rounds at approximately 8:15 AM, Resident #1 observed not to be in their room, bathroom or dining room. A search and head count initiated, but Resident #1 was nowhere to be found. Code E activated, staff searched, and police was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/12/2026 at 2:21 PM, Certified Nursing Assistant #1 stated they worked on 05/07/2026 during the 11:00 PM to 7:00 AM shift. Certified Nursing Assistant #1 stated that Resident #1 was regularly assigned to them. Certified Nursing Assistant #1 stated during their initial rounds at approximately 11:00 PM, Resident #1 was sitting in their bed. Certified Nursing Assistant #1 stated Resident #1 was ambulatory and at approximately 12:15 AM they came out of their room, and they (Certified Nursing Assistant #1) gave Resident #1 a sandwich and juice which they sat in a chair in the hallway and ate then walked towards their room. Certified Nursing Assistant #1 stated that between 4:00 AM and 5:00 AM, they entered Resident #1's room and provided care to their roommate but did not visually check Resident #1 but because the curtain was pulled as they thought Resident #1 was in their bed. Certified Nursing Assistant #1 stated that they were aware Resident #1 was supposed to be checked every 30 minutes, but they only checked on them at 11:00PM at the start of the shift. During an interview on 05/12/2026 at 1:15 PM, Licensed Practical Nurse #1 stated they worked on 05/07/2026 on the 11:30 PM to 7:30 AM shift, but did not do an initial rounding because they assumed the certified nursing assistants performed their rounds. Licensed Practical Nurse #1 stated they should have done their unit rounds and checked on Resident #1. Licensed Practical Nurse #1 stated they did not go to Resident #1's room because they did not want to disrupt the resident. Licensed Practical Nurse #1 stated they knew Resident #1 had a noncompliant behavior of refusing medications and does not want to be disturbed when they are sleeping. Licensed Practical Nurse #1 stated that they did not give Resident #1 their medications at 7:00 AM, but they signed in the Medication Administration Record that medications were given. Licensed Practical Nurses #1 stated they should not have signed that the medications were given.During an interview on 05/12/2026 at 12:05 PM, Registered Nurse Supervisor #1 stated Resident #1 was not wearing a wander guard because they had refused to wear one and that they were placed on 30-minute monitoring due to wandering and at risk for elopement behavior. Registered Nurse Supervisor #1 stated while conducting unit rounds on 05/08/2026 at 8:15 AM, they observed that Resident #1 was not physically in their room. Registered Nurse Supervisor #1 stated that the staff searched the unit, but Resident #1 was not found. Registered Nurse Supervisor #1 stated they immediately called security and activated Code E. Registered Nurse Supervisor #1 stated Resident #1 was confirmed missing at 8:45 AM. Registered Nurse Supervisor #1 stated the Director of Nursing and Administrator were notified (unsure of time). Registered Nurse Supervisor #1 stated local police were notified and arrived at the facility on 05/08/2026 (unsure of time) and were provided with Resident #1's information and picture. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported they did not perform rounding, but they saw Resident #1 and administered medications to them at 6:00 AM. Registered Nurse Supervisor #1 stated they questioned Licensed Practical Nurse #1 as to how they administered medications to Resident #1 at 6:00 AM when the resident exited the building at 12:30 AM. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported being sorry. During an interview on 05/12/2026 at 2:45 PM, the Director of Nursing stated they confirmed that Resident #1 was missing at 8:45 AM (on 05/08/2026) and they notified the Administrator and police at 8:50 AM. The Director of Nursing stated the Medical Director and family were notified at 9:00 AM. The Director of Nursing stated that the Maintenance Director and other maintenance staff reviewed the video surveillance footage at 8:45 AM and at 9:15 AM, and confirmed Resident #1 exited the facility through the New Wing Hall lobby exit alarm door (garage door going toward the parking lot) on 05/08/2026 at 12:30 AM. The Director of Nursing stated during the investigation, they found that the alarm on the exit door did not activate and was found to have malfunctioned. The Director of Nursing stated they contacted the alarm company, and they arrived at the facility on 05/08/2026 at 10:30 AM and repaired the alarm system. The Director of Nursing stated they immediately conducted a Quality Assurance Performance Improvement meeting at 10:30 AM to identify the root cause and established a plan for correction. The Director of Nursing stated that Certified Nursing Assistant #1 was suspended for not completing 30-minute monitoring documentation for Resident #1. The Director of Nursing stated that Licensed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Practical Nurse #1 was interviewed and stated they did not perform their nursing rounds to check Resident #1. The Director of Nursing stated further investigation revealed Licensed Practical Nurse #1 documented that they administered medications at 7:00 AM and that they saw Resident #1 at 6:00 AM. The Director of Nursing stated the findings revealed failures in required Resident #1's supervision and monitoring, inaccurate nursing documentation and malfunctioned exit alarm door that failed to alert staff when Resident #1 exited the facility unnoticed. During an interview on 05/12/2026 at 5:51 PM, the Administrator stated they were notified by the Director of Nursing on 05/08/2026 (unsure of time) that Resident #1 was missing. The Administrator stated they reviewed the video surveillance footage as well and Resident #1 exited the facility on 05/08/2026 at 12:30 AM without supervision. The Administrator stated they and other staff called multiple hospitals, shelters, drove to Time Square and [NAME] Station where Resident #1 used to live and stay around. The Administrator stated they are in communication with the police and that as of today 05/12/2026, Resident #1 could not be located. The Administrator stated they were made aware Resident #1's monitoring log from 11:00 PM to 7:00 AM revealed Resident #1 was not monitored, and the Licensed Practical Nurse #1 did not perform their unit rounds during their shift. During an interview on 05/12/2026 at 5:42 PM, the Medical Director stated they were notified by the team (unsure who notified them) that Resident #1 eloped from the facility on 05/08/2026 (unsure of time). The Medical Director stated that Resident #1 missing one dosage of their blood pressure and bipolar medications would not cause the resident harm, but missing the medications chronically could cause harm.Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 05/12/2026. A Plan of Correction is not required for this citation. 10 New York Codes, Rules, and Regulations 415.12(h)(2) The facility took immediate corrective actions and was found to be in substantial compliance on 05/11/2026.Immediate Corrective Actions:On 05/08/2026 at 8:45 AM, phone calls were made throughout New York City to determine whether Resident #1 had been presented to any emergency room or hospital. On 05/08/2026 at 8:45 AM, exit door alarms and wander guard systems were reviewed. A door watcher stayed at the door. At 11:00 AM, the exit alarm door leading to the parking lot (Magnetic lock door) was repaired. A documentation form from Tikva Fire Security dated 05/08/2026 reviewed.On 05/08/2026 at 9:00 AM, local law enforcement was called and responded on 05/08/2026 at 9:15 AM. Resident #1's information and picture were given to the local police.On 05/08/2026 at 9:00 AM, internal staff interviews were initiated regarding Resident #1 supervision and last known Resident #1 location. On 05/08/2026 - Policy and Procedure titled Wandering and Elopement dated 05/07/2025 reviewed with no revisions. On 05/08/2026 - Policy and Procedure titled Fire Door Inspection dated 02/26/2026 reviewed with revision that all fire doors shall be inspected every shift. On 05/08/2026 at 10:00 AM, staff assignments, supervision practices and overnight accountability process were reviewed. Resident #1 records, care plans, elopement risk assessments and documentation were reviewed. On 05/08/2026 at 10:30 AM, a Quality Assurance meeting was held to review the incident, identify immediate corrective actions and implement facility wide interventions. On 05/08/2026 Licensed Practical Nurse #1 was taken off the schedule. On 05/08/2026 a Discipline Notice documented Certified Nursing Assistant #1 was taken off the schedule pending investigation outcome.On 05/08/2026 an audit tool for exit door/alarms and ongoing. They were being checked every shift. On 05/08/2026, initiated an audit tool to assess residents who may be at risk for elopement. Audit is ongoing. On 05/08/2026 to 05/11/2026 - a lesson plan and facility wide reeducation on elopement prevention, Code E (Elopement), Wandering/Missing Resident, Abuse/Neglect, Accurate Documentation by Certified Nursing Assistant and Nurse, signing in the Medication Administration Record after the medication given and Medical Doctor order for 30-minute monitoring in kiosk (for Certified Nursing Assistant Instructions) and Treatment Administration Record. Attendance reviewed.On 05/10/2026 - an email dated 05/10/2026 revealed Licensed Practical Nurse #1 was reported to their agency. On 05/11/2026 - a Professional (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Discipline Complaint form dated 05/11/2026, revealed Licensed Practical Nurse #1 was reported to Office of Professional Discipline.On 05/11/2026 a follow-up Quality Assurance meeting was held. Attendance sheet reviewed. The facility wide reeducation: Total of staff = 202 = 100 percentDepartmentCompleted % CompleteAdministrator1100% Recreation8100%Certified Nursing Assistants71100%Dietary/Kitchen21100%Dietician2100%Maintenance3100%Home Health Aide/Escort3100%Housekeeping18100%Licensed Practical Nurses20100% Admissions1100%Administration Staff3100%Reception/Security3100%Rehabilitation21100%Registered Nurses25100%Social Services2100%

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the Administrator and the Director of Nursing failed to identify hazards and risks to ensure residents were adequately supervised to avoid elopement. Immediate Jeopardy was determined on 05/13/2026 when direct care and nursing staff failed to ensure Resident #1 received adequate supervision with safety monitoring to prevent an elopement. Resident #1 was able to exit the facility unsupervised on 05/08/2026 at 12:30:40 AM due to alarm system malfunction. Resident #1 who was severely cognitively impaired, with a history of wandering behavior and identified at risk for elopement has not been found. These circumstances subjected to likelihood of serious adverse outcome that was immediate jeopardy for Resident #1. Cross Reference: F689 Past Noncompliance - Free of Accident Hazards/Supervision/DevicesThe findings include:The facility's policy and procedure titled Administrator documented it is responsible for day-to-day functions of the facility with ensuring compliance maintains compliance with federal, state, and local regulations, promotes resident-centered care, and supports quality improvement initiatives. The facility Administrator shall oversee the daily operations of the facility and ensure that all departments function in accordance with applicable laws, regulations, facility policies, and standards of care.Immediate Jeopardy was determined 05/13/2026. The facility failed to ensure resident received adequate supervision to prevent an elopement to account for and monitor Resident #1, a resident with severely cognitively impaired, with a history of wandering behavior and identified as an elopement risk exited the facility grounds on 05/08/2026 at 12:30:40 AM unsupervised and has not been found. The facility failed to ensure implementation of required 30-minute monitoring for elopement risk behavior, accuracy in documentation in medication administration and treatment record. Resident #1 exited through the New Wing Hall lobby (1st floor); the alarm on the exit door did not activate due to alarm system malfunction. Resident #1 was last seen on 05/08/2026 at 12:15 AM by Certified Nursing Assistant #1 in a hallway on the first-floor unit. Resident #1 was not identified as missing until 8:20 AM. There was no documented monitoring log sheet for 05/07/2026 during the 11:00 PM to 7:00 AM shift.The facility's video surveillance was reviewed with the Administrator on 05/12/2026. The video surveillance dated 05/08/2026 revealed Resident #1 talking to Security Guard #1 in the lobby at 12:28:20 AM. Security Guard #1 was seen pointing to the right side of the lobby then Resident #1 proceeded toward the elevator located to the right of the lobby. At 12:29:35 AM, Resident #1 walked past the elevator. From 12:30:06 to 12:30:30 AM, Resident #1 was walking in the New Wing Hall lobby on the first floor and at 12:30:40 AM, Resident #1 exited through an exit door (equipped with an alarm). During an interview on 05/12/2026 at 2:45 PM, the Director of Nursing stated they confirmed that Resident #1 was missing at 8:45 AM (on 05/08/2026) and they notified the Administrator and police at 8:50 AM. The Director of Nursing stated the Medical Director and family were notified at 9:00 AM. The Director of Nursing stated that the Maintenance Director and other maintenance staff reviewed the video surveillance footage at 8:45 AM and at 9:15 AM, and confirmed Resident #1 exited the facility through the New Wing Hall lobby exit alarm door (garage door going toward the parking lot) on 05/08/2026 at 12:30 AM. The Director of Nursing stated during the investigation, they found that the alarm on the exit door did not activate and was found to have malfunctioned. The Director of Nursing stated they contacted the alarm company, and they arrived at the facility on 05/08/2026 at 10:30 AM and repaired the alarm system. The Director of Nursing stated they immediately conducted a Quality Assurance Performance Improvement meeting at 10:30 AM to identify the root cause and established a plan for correction. The Director of Nursing stated that Certified Nursing Assistant #1 was suspended for not completing 30-minute monitoring documentation for Resident #1. The Director of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. Building B. Wing	05/14/2026

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing stated that Licensed Practical Nurse #1 was interviewed and stated they did not perform their nursing rounds to check Resident #1. The Director of Nursing stated further investigation revealed Licensed Practical Nurse #1 documented that they administered medications at 7:00 AM and that they saw Resident #1 at 6:00 AM. The Director of Nursing stated the findings revealed failures in required Resident #1's supervision and monitoring, inaccurate nursing documentation and malfunctioned exit alarm door that failed to alert staff when Resident #1 exited the facility unnoticed. During an interview on 05/12/2026 at 5:51 PM, the Administrator stated they were notified by the Director of Nursing on 05/08/2026 (unsure of time) that Resident #1 was missing. The Administrator stated they reviewed the video surveillance footage as well and Resident #1 exited the facility on 05/08/2026 at 12:30 AM without supervision. The Administrator stated they and other staff called multiple hospitals, shelters, drove to Time Square and [NAME] Station where Resident #1 used to live and stay around. The Administrator stated they are in communication with the police and that as of today 05/12/2026, Resident #1 could not be located. The Administrator stated they were made aware Resident #1's monitoring log from 11:00 PM to 7:00 AM revealed Resident #1 was not monitored, and the Licensed Practical Nurse #1 did not perform their unit rounds during their shift. The Administrator also stated they were made aware of exit door alarm malfunctioned on 05/08/2026 and company arrived on 05/08/2026 at 10:30 AM and was repaired at 11AM. The Administrator stated the maintenance department responsible for checking them monthly. The Administrator stated they revised the policy of fire alarm door to be checked every shift daily on 05/08/2026.10 New York Codes, Rules, and Regulations 415.26 Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 05/12/2026. A Plan of Correction is not required for this citation.The facility took immediate corrective actions and was found to be in substantial compliance on 05/11/2026.Immediate Corrective Actions:On 05/08/2026 at 8:45 AM, phone calls were made throughout New York City to determine whether Resident #1 had been presented to any emergency room or hospital. On 05/08/2026 at 8:45 AM, exit door alarms and wander guard systems were reviewed. A door watcher stayed at the door. At 11:00 AM the exit alarm door leading to the parking lot (Magnetic lock door) was repaired. A documentation form from Tikva Fire Security dated 05/08/2026 reviewed.On 05/08/2026 at 9:00 AM, local law enforcement was called and responded on 05/08/2026 at 9:15 AM. Resident #1's information and picture were given to the local police.On 05/08/2026 at 9:00 AM, internal staff interviews were initiated regarding Resident #1 supervision and last known Resident #1 location. On 05/08/2026 - Policy and Procedure titled Wandering and Elopement dated 05/07/2025 reviewed with no revisions. On 05/08/2026 - Policy and Procedure titled Fire Door Inspection dated 02/26/2026 reviewed with revision that all fire doors shall be inspected every shift. On 05/08/2026 at 10:00 AM, staff assignments, supervision practices and overnight accountability process were reviewed. Resident #1 records, care plans, elopement risk assessments and documentation were reviewed. On 05/08/2026 at 10:30 AM, a Quality Assurance meeting was held to review the incident, identify immediate corrective actions and implement facility wide interventions. On 05/08/2026 Licensed Practical Nurse #1 was taken off from the schedule. On 05/08/2026 a Discipline Notice documented Certified Nursing Assistant #1 was taken off from schedule pending investigation outcome.On 05/08/2026 initiated an Audit tool for exit door/alarms and ongoing. They were being checked every shift. On 05/08/2026 initiated an Audit Tool initiated to assess Residents who may be at risk for elopement. Audit is ongoing. On 05/08/2026 to 05/11/2026 - a lesson plan and facility wide reeducation on elopement prevention, Code E (Elopement), Wandering/Missing Resident, Abuse/Neglect, Accurate Documentation by Certified Nursing Assistant and Nurse, signing in the Medication Administration Record after the medication given and Medical Doctor order for 30-minute monitoring in kiosk (for Certified Nursing Assistant Instructions) and Treatment Administration Record. Attendance reviewed.On 05/10/2026 - an email dated 05/10/2026 revealed Licensed Practical Nurse #1 was reported to their agency. On 05/11/2026 - A Professional (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discipline Complaint form dated 05/11/2026, revealed Licensed Practical Nurse #1 was reported to Office of Professional Discipline.On 05/11/2026 a follow-up Quality Assurance meeting was held. Attendance sheet reviewed. The facility wide reeducation: 1 Administrator -1 = 100 percent8 Recreation - 8= 100 percent71 Certified Nursing Assistants- 71= 100 percent21 Dietary/Kitchen= 21= 100 percent2 Dietician- 2= 100 percent 3 Maintenance- 3= 100 percent3 Home Health Aide /Escort- 3 = 100 percent18 Housekeeping - 18= 100 percent20 Licensed Practical Nurse- 20= 100 percent1 Admission-1 = 100 percent3 Administration Staff = 3= 100 percent3 Reception/Security - 3= 100 percent21 Rehabilitation staff -21= 100 percent25 Registered Nurses- 25= 100 percent2 Social Services- 2= 100 percent Total of staff = 202 = 100 percent

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, and interviews during survey conducted the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards and practices. Licensed Practical Nurse #1 failed to accurately document in Resident #1's medical record. This was evident for one (1) of six (6) residents (Resident #1) sampled. Specifically, on 05/08/2026, Licensed Practical Nurse #1 documented in the Medication Administration Record that they administrated medications to Resident #1 and took the resident's vital signs at 7:00 AM. Additionally, Licensed Practical Nurse #1 also documented that they monitored Resident #1 at 11:30 AM and 7:30 AM in the Treatment Record that they monitored Resident #1 at 7:30 AM. According to the facility video surveillance footage, Resident #1, who was severely cognitively impaired, with a history of wandering behavior and identified as an elopement risk exited the facility grounds unsupervised on 05/08/2026 at 12:30:40 AM and has not been found. Resident #1 was last seen on 05/08/2026 at 12:15 AM by Certified Nursing Assistant #1 in a hallway on the first-floor unit. Resident #1 was not identified as missing until 8:20 AM. Cross Reference: F658 - Services Provided Meet Professional StandardsThe findings include: The facility policy and procedure titled Medication Management dated 10/18/2024 states the purpose is to establish a safe standard for ordering, dispensing, administration and documentation of medications. The nurses obtain specific vital signs, follow specific instructions before administering medication. The nurse administers the right drug to the right resident at the right time in the right dose via right route and the right documentation. Immediately after administering mediations, the nurse documents on the Medication Administration Record. The Nurse will also document in their nurses notes the reason for medication not given.The facility policy and procedure titled Treatment Administration dated 10/18/2024 states it is the policy that all treatments are administered safely, accurately, and in accordance with physician/practitioner orders, accepted standards of nursing practice, applicable federal and state regulations, and facility protocols. Treatments shall be provided in a manner that promotes resident safety, comfort, dignity, infection prevention and continuity of care. Resident #1 was admitted to the facility with diagnoses including dementia (decline cognitive function), bipolar disorder (mental health condition that causes extreme mood swings) and chronic heart failure (heart muscle do not pump enough blood). The Minimum Data Set (a resident assessment tool) dated 04/10/2026 documented that Resident #1 had severely impaired cognition. Resident #1 was assessed to be on diuretic (Furosemide - water pill) medication and anticonvulsant (treat and prevent seizure) medication.The Physician's Orders dated 03/31/2026 through 05/08/2026 revealed orders for Furosemide (diuretic) 20 milligram one (1) tablet once daily, Metoprolol Succinate Extended Release 25 milligram daily for essential hypertension, Valproic Acid 250 milligram per five (5) milliliter two (2) times a day for bipolar disorder, Thiamine Hydrochloride (vitamin B1) 100 milligram daily for Thiamine deficiency, and monitor blood pressure and pulse daily before administering metoprolol. The Medication Administration Record dated 05/08/2026 revealed Licensed Practical Nurse #1 signed that they administered the above medications and took Resident #1's blood pressure at 7:00 AM. Resident #1's blood pressure recorded in the medication administration record as 130/80.A Physician's Order dated 03/31/2026 documented monitor every shift and as needed for ID and Neon arm band (elopement ID band) placement every day at 11:30 PM-7:30 AM, 3:30 PM-11:30 PM and as needed.The Treatment Administration Record dated 05/07/2026 from 11:30 PM-7:30 AM, revealed Licensed Practical Nurse #1 documented that Resident #1 was monitored at 7:30 AM on 05/08/2026. The facility's video surveillance was reviewed with the Administrator on 05/12/2026. The video surveillance dated 05/08/2026 at 12:28:20- 58 AM showed Resident #1 talking to the Security Guard #1 in the lobby. Security Guard #1 was seen pointing to the right side of the lobby then Resident #1 proceeded towards the elevator located to the right of the lobby. At 12:29:35 AM, Resident #1 walked past the elevator. From 12:30:06-30 AM, Resident #1 was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walking in the New Wing Hall lobby on the first floor and at 12:30:40 AM, Resident #1 exited through an exit door (equipped with an alarm). The facility's Accident Report dated 05/08/2026 documented that Registered Nursing Supervisor #1 was performing rounds at 8:15 AM (on 05/08/2026) when they observed that Resident #1 was not in their room. A unit searched was conducted and Code E (Elopement) activated. Resident #1 was confirmed to be missing from the facility at 8:45 AM. At 8:50 AM, staff members searched the surrounding neighborhood and nearby areas. Local police were notified and responded at 9:00 AM. The facility reviewed their video surveillance footage and confirmed Resident #1 exited the facility on 05/08/2026 at 12:30 AM. The facility concluded Resident #1 eloped from the facility at 12:30 AM. During an interview on 05/12/2026 at 1:15 PM, Licensed Practical Nurses #1 stated they worked on 05/07/2026 on the 11:30 PM to 7:30 AM shift, but did not do an initial rounding because they assumed the Certified Nursing Assistants performed their rounds. Licensed Practical Nurses #1 stated they should have done their unit rounds and checked on Resident #1. Licensed Practical Nurse #1 stated they did not go to Resident #1's room because the resident does not want to be disrupted. Licensed Practical Nurse #1 stated they knew Resident #1 had a noncompliant behavior of refusing medications and does not want to be disturbed when they are sleeping. Licensed Practical Nurse #1 stated that they did not give Resident #1 their medications at 7:00 AM but they signed in the Medication Administration Record the medications were given. Licensed Practical Nurses #1 stated they should not have signed that the medications were given.During an interview on 05/12/2026 at 12:05 PM, Registered Nurse Supervisor #1 stated Resident #1 was not wearing a wander guard because they had refused to wear one and that they were placed on 30-minute monitoring due to wandering and at risk for elopement behavior. Registered Nurse Supervisor #1 stated while conducting unit rounds on 05/08/2026 at 8:15 AM, they observed that Resident #1 was not physically in their room. Registered Nurse Supervisor #1 stated that the staff searched the unit, but Resident #1 was not found. Registered Nurse Supervisor #1 stated they immediately called security and activated code E (code elopement). Registered Nurse Supervisor #1 stated Resident #1 was confirmed missing at 8:45 AM and the Director of Nursing and Administrator were notified (unsure of time). Registered Nurse Supervisor #1 stated local police were notified and arrived at the facility on 05/08/2026 (unsure of time) and was provided with Resident #1 information and picture. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported they did not perform rounding, but they saw Resident #1 and administered medications to them at 6:00 AM. Registered Nurse Supervisor #1 stated they questioned Licensed Practical Nurse #1 as to how they administered medications to Resident #1 at 6:00 AM when the resident exited the building at 12:30 AM. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported being sorry. During an interview on 05/12/2026 at 2:45 PM, the Director of Nursing stated they confirmed that Resident #1 was missing at 8:45 AM (on 05/08/2026) and they notified the Administrator and police at 8:50 AM. The Director of Nursing stated the Medical Director and family were notified at 9:00 AM. The Director of Nursing stated the Maintenance Director and other maintenance staff reviewed the video surveillance footage at 8:45 AM and at 9:15 AM, and confirmed Resident #1 exited the facility through the New Wing Hall lobby exit alarm door (garage door going towards the parking lot) on 05/08/2026 at 12:30 AM. The Director of Nursing stated during the investigation they found that the alarm on the exit door did not activate and was found to have malfunctioned. The Director of Nursing stated they contacted the alarm company, and they arrived at the facility on 05/08/2026 at 10:30 AM and repaired the alarm system. The Director of Nursing stated they immediately conducted a Quality Assurance Performance Improvement meeting at 10:30 AM to identify the root cause and established a plan for correction. The Director of Nursing stated that Certified Nursing Assistant #1 was suspended for not acquiring a 30-minute monitoring documentation for Resident #1. The Director of Nursing stated that Licensed Practical Nurse #1 was interviewed and stated they did not perform their nursing rounds to check Resident #1. The Director of Nursing stated further investigation revealed Licensed Practical Nurse #1 documented that they administered medications at 7:00 AM and that they saw Resident #1 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 6:00 AM. The Director of Nursing stated the findings revealed failures in required Resident #1's supervision and monitoring, inaccurate nursing documentation and malfunctioned exit alarm door that failed to alert staff when Resident #1 exited the facility unnoticed. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 05/12/2026. A Plan of Correction is not required for this citation.10 New York Codes, Rules, and Regulations 415.22(a) (1-4)The facility implemented corrective actions and was found to be in substantial compliance on 05/11/2026, prior to start of the abbreviated survey on 05/12/2026.Immediate Corrective Actions:On 05/08/2026 - Policy and Procedure titled Medication Management dated 10/18/2024 reviewed with no revisions. On 05/08/2026 - Policy and Procedure titled Treatment Administration Record dated 10/18/2024 reviewed with no revisions. On 05/08/2026 the facility discussed in their Quality Assurance meeting the issues related to Licensed Practical Nurse #1 signing for medications administration and monitoring of Resident #1. On 05/08/2026 at 9:00 AM, internal staff interviews were initiated regarding Resident #1 supervision and last known Resident #1 location. On 05/08/2026 at 10:00 AM, staff assignments, supervision practices and overnight accountability process were reviewed. Resident #1 records, care plans, elopement risk assessments and documentation were reviewed. On 05/08/2026 at 10:30 AM, a Quality Assurance meeting was held to review the incident, identify immediate corrective actions and implement facility wide interventions. On 05/08/2026 Licensed Practical Nurse #1 was taken off schedule. On 05/08/2026 a Discipline Notice documented Certified Nursing Assistant #1 was taken off the schedule pending investigation outcome.On 05/08/2026 to 05/11/2026 - In-service provided to nursing staff. Lesson plan titled Abuse/Neglect, Accurate Documentation, Signing Medication Administration Record after Medication is given, Treatment Record, and Doctor's Orders for 30-minute monitoring in Kiosk (Certified Nursing Assistants Instructions). Attendance sheet with signatures reviewed.On 05/10/2026 - an email dated 05/10/2026 revealed Licensed Practical Nurse #1 was reported to their agency. On 05/11/2026 - a Professional Discipline Complaint form dated 05/11/2026, revealed Licensed Practical Nurse #1 was reported to Office of Professional Discipline.On 05/11/2026 a follow-up Quality Assurance meeting was held. Attendance sheet reviewed. Reeducation: Total of nursing staff = 116 = 100 percentDepartmentCompleted % CompleteCertified Nursing Assistants71100%Licensed Practical Nurses20100% Registered Nurses25100%

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interviews and record reviews, the facility failed to ensure that the direct care staffing information based on payroll data was submitted based on the schedule specified by the Centers for Medicare and Medicaid Services. Specifically, the facility failed to submit the direct care staffing data for fiscal year Quarter 1/2026 (10/01/2025 - 12/31/2025) timely.The findings include:The Centers for Medicare & Medicaid Services Electronic Staffing Data Submission Payroll-Based Journal, Long Term Care Facility Policy Manual version 2.7 dated 06/2025 documented Section 6106 of the Affordable Care Act requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate. Staffing and census data will be collected for each fiscal quarter. The deadline for submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely.The facility policy titled Staffing and Payroll-Based Journal with a last revised date of 04/2024 stated the facility was responsible for ensuring payroll-based journal submissions in compliance with Centers for Medicare & Medicaid Services regulations. The policy also documented staffing information is reported through the Payroll-Based Journal system for each fiscal quarter no later than forty-fine days after the end of the reporting quarter.The Centers for Medicare and Medicaid Services Payroll Based Journal Staffing Data Report documented that there was no data submitted by the facility for fiscal year Quarter 1 2026 (October 01 - December 31). During an interview on 05/14/2026 at 2:26PM, the Director of Payroll stated that they were responsible for submitting payroll-based journal information for the facility to Centers for Medicare and Medicaid Services after double checking all data from Human Resource department. Director of Payroll stated that after double checking data from the Human Resource department, they download a file from SBV (software report). Director of Payroll stated they used Simple Payroll-Based Journal software to analyze the report, to check any issues, then they click submit button to Centers for Medicare and Medicaid Services from Simple Payroll-Based Journal website. The Director of Payroll stated when they tried to submit the report, the software had given an error message. The Director of Payroll stated they called customer service at Simple Payroll-Based Journal, and they assured them that everything will be going through and everything is fine. The Director of Payroll stated unfortunately, nothing was submitted and nothing was issued. The Director of Payroll stated that they made it aware a couple of days ago when they tried to upload Quarter Two of 2026 data, Quarter One was not submitted. The Director of Payroll stated they reached Simple Payroll-Based Journal and Centers for Medicare and Medicaid Services with different numbers to see if the facility can rectify this error, but the answers were no. During an interview on 05/14/2026 at 2:43 PM, the Administrator stated Director of Payroll is responsible for submitting the staffing data as of January 2026. The Administrator stated that they were not aware that Payroll Base Journal for the first quarter was not submitted and became aware yesterday, 05/13/2026. 10 New York Codes, Rules and Regulations 400.2