STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335351	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathan Littauer Hospital Nursing Home	99 East State Street Gloversville, NY 12078

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51317 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that each resident was treated with respect and dignity and cared for in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, residents were observed to be fed by staff wearing gloves in the west dining room and by the east nurses station. This is evidenced by: Policy titled Quality of Life- Dignity effective 05/2020 last reviewed 05/2024 documented each resident should be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Interpretation and implementation of this policy included residents should be treated with dignity and respect at all times. Treated with dignity meant the residents would be assisted in maintaining and enhancing their self-esteem and self-worth. During an observation on 02/10/2025 at 12:10 PM in the [NAME] dining room, staff wore gloves while feeding residents. During an observation on 02/12/2025 at 12:33 PM in the [NAME] dining room, staff wore gloves while feeding residents. During an observation on 02/13/2025 at 12:05 PM in the [NAME] dining room, staff wore gloves while feeding residents. During an observation on 02/14/2025 at 12:28 PM in the [NAME] dining room, staff wore gloves while feeding residents. During an observation on 02/18/2025 at 12:25 PM in the hall by the East Nurses station, a staff member wore gloves while feeding a resident. During an observation and interview on 02/14/2025, Certified Nurse Aide #1 was feeding a resident in their room and they were not wearing gloves. Certified Nursing Aide #1 stated they do not wear gloves when feeding residents because it was a dignity issue. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/14/2025 at 12:33 PM, Certified Nurse Aide # 2 stated they wore gloves when feeding residents to prevent the spread of germs. They stated they did not think it was a dignity concern, but they did not know how the residents felt about it. During an interview on 02/14/2025 at 12:28 PM, Licensed Practical Nurse #1 stated when they feed residents, they wear gloves to prevent their germs from spreading to the resident. It is a part of facility procedure to wear gloves when feeding residents. Licensed Practical Nurse # 3 stated they did not feel there was a dignity concern to feed residents while wearing gloves. During an interview on 02/14/2025 at 12:50 PM, Director of Nursing #1 stated if a resident needed total assist with feeding, staff should wear gloves. Director of Nursing #1 could not find in a facility policy where it stated staff should wear gloves when feeding a resident and stated it should be written in a policy. Director of Nursing #1 stated staff wearing gloves when feeding a resident was not a dignity concern because they want to keep the residents safe. If the residents had issues relating to dignity while being fed by staff members wearing gloves, they could put it in the resident's care plan so the staff would not wear gloves when feeding the resident. During an interview on 02/18/2025 at 11:37 AM, Nurse Manager #1 stated when a staff member fed a resident, they were to wash their hands and wear gloves. They stated it could be a dignity concern as it could make the residents feel like the staff thought they were dirty, and the residents may not realize they were wearing the gloves to protect the residents. 10 New York Code, Rules and Regulations 415.11 (c)(2)(ii)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 51317 Based on record review and interviews conducted during the Recertification survey, the facility did not ensure that the resident and resident representative had the right to participate in the development and implementation of their person-centered plan of care by facilitating the inclusion of the resident and resident representative in the planning process for 1 1(Resident #6) of 1 resident reviewed for care planning. Specifically, for Resident #6, their family member was not afforded the opportunity to participate in quarterly care plan meetings. This is evidenced by: Facility policy titled Interdisciplinary Care Plan Committee effective 09/1992 last revised 04/2024 stated a comprehensive care plan was developed within seven days after the completion of a comprehensive assessment by the interdisciplinary team with participation of the resident and revised with significant changes. Care plans were reviewed at the interdisciplinary care plan meeting every three months and as indicated by a significant change or change in condition. The policy also stated the resident and/or their designated representative would be encouraged to participate in the development of initial, significant changes, and annual care plan. Resident #6 was admitted to the facility with diagnoses of history of cerebral vascular accident (a medical condition that occurs when blood flow to the brain is suddenly interrupted which can damage brain cells and lead to neurological damage), type 2 diabetes mellitus (a chronic condition when a person has persistently high blood sugar levels), and atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart). The Minimum Data Set (an assessment tool) dated 05/07/2024 indicated Resident #6 was cognitively intact, could be understood, and understand others. Resident was able to make decisions regarding tasks of daily life. Section Q of the Minimum Data Set documented that Resident #6 participated in the assessment and goal setting. Family did not participate with the assessment and goal setting. During an interview on 02/10/2025 at 3:34 PM, Family Member #1 stated they came to visit Resident #6 every day for five-six hours a day. They stated they came to one care plan meeting when Resident #6 was first admitted to the facility. They have not been made aware of or invited to quarterly care plan meetings. During an interview on 02/13/2025 at 3:49 PM, Director of Social Work #1 stated care plan meetings occur initially when a resident was admitted to the facility, quarterly, annually, and if a significant change occurred or if a family member requested a meeting. Residents and families were invited to attend the meetings initially, annually, and for significant changes. Director of Social Work stated Family Member #1 attended Resident #6's initial care plan meeting on 05/21/2024 and a follow up meeting pertaining to discharge planning on 06/10/2024. Director of Social Work #1 stated family members were not notified of quarterly care plan meetings. If the interdisciplinary team had a concern regarding the resident to discuss with a family member, they could reach out to the family member via phone call to discuss the concern. 10 New York Code Rules & Regulations 415.11 (c)(2)(ii)

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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** 48413 Based on observation and staff interviews during a recertification survey, the facility did not ensure a safe, comfortable home-like environment and effective housekeeping and maintenance services were maintained for 2 (East and West) of 2 resident units. Specifically, (a.) the floors were soiled with dirt next to walls, in corners, along door thresholds, and where door frames meet the floor in the corridors on the East and [NAME] Units; (b.) door frames and doors were in disrepair for multiple resident rooms; walls in the East and [NAME] units were in disrepair with scrapes, smudge, chips, and marks; (c.) resident room NH. 44 wall was in disrepair and unfinished; (d.) ceiling tiles in the television rooms had water stains; (e.) shower rooms were soiled with dirt next to walls, and in corners, and (f.) handrails through unit were scuffed and scrapped exposing the underlying wood of the rails. This is evidenced by: The undated Policy &Procedure, titled Maintenance/Housekeeping Work Order Policy, documented that it was the facility's policy to ensure all areas maintained a clean, comfortable, and well-functioning environment. When problems were identified, employees were required to complete a Maintenance/Housekeeping Work Order. During observations on 02/13/2025 at 12:43 PM, the following items were observed; -Floors were soiled with dirt next to walls, in corners, along door thresholds, and where door frames meet the floor in the corridors on the East and [NAME] Units for room #s 2, 5, 18, 21, 25, 31, 36, 44, and 48. -Door frames and doors were in disrepair with scrapes, chips, and gouges for resident rooms 2, 5, 18, 21, 25, 31, 36, 44, and 48. -Walls in the East and [NAME] Units in all corridors were in disrepair with scrapes, chips, and unpainted. -Resident room NH. 44 wall was in disrepair and unfinished. -Several ceiling tiles in the East and [NAME] Unit television rooms had water stains -The floors and walls behind fire doors on the East and [NAME] Units were soiled with dirt and grime. -Shower rooms in the East and [NAME] Units were soiled with dirt next to walls, and in corners and appeared to have a dark black substance on walls. -Handrails through the East and [NAME] Units were scuffed and scrapped exposing the underlying wood of the rails. (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 02/14/2025 at 11:45 AM, Environmental Services Director #1 stated that their staff was responsible for the overall cleaning of the facility. They stated that the cleanliness of the areas that had been lacking. They stated that they were in the process of developing a duty list of responsibilities the environmental service individuals were to complete daily. In showing the areas of concern the Environmental Service Director #1 stated that the areas should have been cleaned and that was the reason they wanted to develop the lists. During an interview on 02/18/2025 at 10:22 AM, Engineering Supervisor #1 stated that they oversee the overall appearance of the facility. They stated that they do have staff that worked with them daily and took care of the daily general workload of the facility. They stated their staff were responsible for fixing minor issues on a day-to-day basis such as lighting issues, Call bell issues, and general maintenance. Engineering Supervisor #1 stated that they received approximately 6- 8 work orders per day from staff on issues in the facility. They stated that they did a walk-through each morning to identify issues for repair or maintenance. They stated that approximately a year ago they had staff do a full facility touch-up on walls and door frames. They stated that they had a 3-month plan for renovations on the unit which included but was not limited to fixing the resident room doors, installing kick plates on the doors to protect them from damage, floors in the resident rooms, and general overall appearance. Engineer Supervisor #1 stated that resident room [ROOM NUMBER] had a water pipe break in the wall of the room. They stated that before they could finish fixing the entire wall a resident was moved into the room. They stated they had a work order to finish the wall in the room. 10 New York Codes of Rules and Regulations 415.5(h)(2)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on record review and interviews during a recertification and abbreviated survey (Case #sNY00368587 and NY00370779), the facility did not ensure that residents were free from neglect for 2 (Resident #s 10 and 19) of 25 residents reviewed. Specifically, (a.) Resident #10 was not monitored, turned and positioned or received personal care for at least one full shift on 11:00 PM-7:00 AM, 1/29/2025 - 1/30/2025; (b.) Resident #19 rolled out of bed and hit their head on furniture when receiving care by a Certified Nurse Aide on 1/21/2024 at 10:35 AM. This is evidenced by: The Facility's Policy and Procedure titled, Resident Abuse revised 8/2024, documented the facility would investigate all cases of suspected resident abuse, including allegations of neglect, misappropriation, mistreatment or injuries of unknown origin. Of those cases that the facility found reasonable cause and/or evidence that a resident has been abused, corrective action would take place with those involved: In the case of an employee involvement - the corrective action procedure would be initiated by the employee's immediate supervisor and may result in suspension and/or discharge without prior warning. The term neglect meant failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a resident, while under the supervision of the facility, including, but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living. (NY Public Health Law 2803-d). Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. [See Older Americans Act, 302 (a) (19)]. It may include, but not be limited to, being left to sit or lie in urine or feces, isolating dependent residents by leaving them in their rooms or other isolated locations apart from temporary monitored separation occurring in the context of assessment and care planning, or failing to answer call bells to provide assistance. Resident #10: Resident #10 was admitted with a diagnoses of malnutrition (a state of nutritional deficiency); anxiety (repeated episodes of sudden feelings of intense fear or terror), and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls). The Minimum Data Set (an assessment tool) dated 11/15/2024, documented the resident could understand and be understood by others. The facility's Investigative Report dated 1/30/2025, documented an aide told Registered Nurse #1 at 7:00 AM on 1/30/2025 that Resident #10 was soaked and there was no way they had been cared for. Two other staff were in the room and changing resident. Resident also had a bowel movement. Investigation revealed that the resident did not receive care by staff on the previous night shift (1/29/2025-1/30/2025). There was no injury related to this incident; however, staff should have recognized that the resident was not attended to. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 11:11 AM, Registered Nurse #1 stated a Certified Nurse Aide reported to her that Resident #10 had no care during overnight shift. Registered Nurse #1 in turn reported the incident to Director of Nursing #1. Registered Nurse #1 stated they believed it was a miscommunication. Resident #10 was a no male caregiver. The Certified Nurse aide assigned to that hall was a male, Certified Nurse Aide #4. Certified Nurse Aide #3 was fairly new at time of incident, and it was not communicated to them that they were assigned to a resident on the opposites side of the unit. Both Certified Nurse Aides #3 and 4 were educated on the no male caregiver system, which was a pink dot on door of resident to indicate no male caregiver. In addition, Certified Nurse Aide #4 was counseled on documentation. Certified Nurse Aide #4 documented care was provided to Resident #10 on 1/29/2025 through 1/30/2025, when in fact they admitted they did not provide any care to this resident. During an interview on 02/13/2025 at 12:52 PM, Director of Nursing #1 stated the incident was a result of miscommunication. They stated Certified Nurse Aide #s 3 and 4 were 'very good aides,' and the assignment for Resident #10 should have been updated on the assignment sheet. They stated that Registered Nurse #3 wrote out the assignment prior to end of their shift, and at change of shift, Registered Nurse #4 was given a report. Director of Nursing #1 stated they educated both Registered Nurse #s 3 and 4 on the responsibility of making out assignments and in communication. Resident #19: Resident # 19 was admitted to the facility with diagnoses of diabetes type 2 (a disease of inadequate control of blood levels of glucose), diabetic retinopathy (having too much sugar in your blood that damages the part of the eye that detects light and sends signals to the brain), and a cataract (a clouding of the lens in the eye). The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood and understand others. The Mobility Comprehensive Care Plan dated 1/2024, documented plan of care, Toileting Hygiene, Shower/Bathe, Self-Upper Body Dressing, Lower Body Dressing, Putting On/Taking Off Footwear, Personal Hygiene all Dependent Substantial/Maximal Assistance. Adaptive Equipment used: Mechanical Lift, Geriatric chair. The facility Investigate Report dated 01/21/2024 documented Resident #19 was receiving care (in bed with a soft mattress pad called an overlay). Resident was rolled to their left side and when they moved, the overlay moved causing them to slide to the floor. Resident assessment noted bump on eyebrow/forehead on Right side. Neurological checks completed as per protocol with changes noted. Resident was sent to the emergency department at 11:15 AM. A Computed Tomography Scan (CT) (imaging of the brain) was negative, and resident returned to facility. On 01/22/2024, Resident #19 complained of Left arm and shoulder pain. X-rays were ordered which revealed osteopenia/osteoporosis, and no fracture. The facility Investigative Summary documented Certified Nurse Aide #5 acknowledged that they should have had 2 for turning this resident. Attempts to reach Certified Nurse Aide #5 by phone were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/14/2025 at 10:57 AM, Director of Nursing #1 stated Certified Nurse Aide #5 did not state why they did not use a second person when caring for Resident #19. Stated Certified Nurse Aide #5 was no longer employed at the facility, the overly went on top of the mattress, with four ends that tucked underneath the mattress. Director of Nursing #1 further stated that particular type of overlay was no longer in use at the facility following this incident. During an interview on 02/18/2025 at 12:09 PM, Administrator #1 stated they removed the overlay from Resident #19's bed. 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51317 Based on record review and interviews during a recertification and abbreviated survey (Case #NY00370103) , the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately, but not later than two hours after the allegation was made, to the State Survey Agency for 1 (Resident #7) of 1 resident reviewed for reportable incident. Specifically, an injury of unknown origin was discovered for Resident #7 on 01/23/2025. This injury of unknown origin was not reported until 01/25/2025 at 10:51 AM. This was evidenced by: The Policy titled Resident Abuse effective 10/24/2022 last reviewed 09/2023 documented resident abuse and/or misappropriation of resident property should not be tolerated by the facility. The facility shall investigate all cases of suspected resident abuse, including allegations of neglect, misappropriation, mistreatment, or injuries of unknown origin. Each covered individual (anyone who is an owner, operator, employee, manager, agent, or contractor of the facility) shall report immediately, but not later than two hours after forming the suspicion, if the events that cause suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. In addition, the facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes. In addition, employees are required to immediately report any resident incident, including all suspected cases of resident abuse, mistreatment or neglect including injuries of unknown source and misappropriation of resident property to their supervisor, department head, and/or administrator. Resident #7 was admitted to the facility with diagnoses of dementia (loss of memory, language, problem solving, and other thinking abilities that are severe enough to interfere with daily life), history of cerebral vascular accident (a medical condition that occurs when blood flow to the brain is suddenly interrupted), and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). The Minimum Data Set (an assessment tool) dated 04/03/2024 documented Resident #7 had severe cognitive impairment, could be understood, and understand others. Skin check work list for Resident #7 dated 01/23/2025 completed by Licensed Practical Nurse #3 documented there was a purple/blue area on the right foot. Nursing home facility incident report submitted to the Department of Health on 01/25/2025 at 10:51 AM by Director of Nursing #1 with incident date of 01/25/2025 and the time of occurrence as 8:56 AM indicated that a Certified Nurse Aide noted during morning (AM) care that Resident #7 had a discolored purplish -blue area on the 4th and 5th toe on the top side of the right foot. An investigation was in progress. No non-residents were accused of abuse, mistreatment, neglect, or misappropriation. There were no witnesses to this incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 01/25/2025 by Provider #1 indicated Resident #7 was seen due to right foot swelling and discoloration. The resident was not able to recall when they noticed swelling in their foot and could not recall an injury or something that could have occurred to cause the swelling. Assessment included an x-ray to rule out fracture. It was unclear if Resident #7 had an injury as there were no reports of any falls or trauma at that time. Accident and incident form completed on 01/25/2025 stated at incident time of 8:45 AM during AM care, Resident was noted to have an edematous right foot. Top of the right foot was discolored, and the 4th inner toe and little toe were purple in color. Provider #1 was notified on 01/25/2025 at 10:45 AM and an x-ray of the right foot was ordered. This form indicated this was a reportable incident of quality of care due to an injury of unknown origin. emergency room History and Physical stated Resident #7 was treated in the emergency roiagnom on [DATE] at 3:46 PM for further treatment of right foot fracture. Mechanism of unknown injury. Resident #7 developed bruising and swelling to right foot which prompted imaging. Resident #7 sustained an impact fracture of the 4th and 5th metatarsal (five long bones in the midfoot that connect the ankle to the toes). Follow up undated investigation report completed by Administrator #1 and Director of Nursing #1 documented Resident #7's 4th and 5th toe on the right foot were discolored and edematous and were x-rayed on 01/25/2025. Impression was severe osteopenia (loss of bone density). Resident #7 sustained a displaced slightly impacted fracture of the 4th and 5th metatarsal necks. Resident #7 had moderate osteoarthritis (a degenerative joint disease in which the tissues in the joint break down over time). Provider #1 stated on 1/26/2025 that Resident #7 had fairly significant osteopenia, and the fracture was likely due to minimal impact against the geri chair/bed and Resident #7 continued to be at risk for these kinds of fractures from minimal impact on turning and when sleeping. The report documented it could not be determined how the injury occurred. It was determined that this area was initially found on 01/23/2025 by Licensed Practical Nurse #3 during a routine skin check but Licensed Practical Nurse #3 failed to report the discovery to a Registered Nurse for further assessment. During an interview on 02/14/2025 at 12:50 PM, Director of Nursing #1 stated they were on call on 01/25/2025 when Resident #7's foot was noted to be purple in color by the 4th and 5th toe. They reported the incident to the Department of Health on 01/25/2025 within 2 hours of them being notified as it was an incident with unknown source and they started the investigative process. Director of Nursing #1 stated Licensed Practical Nurse #3 should have immediately notified a Registered Nurse after completing the skin check work list on 01/23/2025 so the Registered Nurse could have completed an assessment of Resident #7 and determined what to do. Director of Nursing #1 stated this incident should have been reported to the Department of Health two days earlier when it was discovered on 01/23/2025. 10 New York Codes, Rules, and Regulations 483.12 (c) (1)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48615 Based on record review and interviews conducted during the recertification survey, the facility did not ensure written notice of the facility's bed hold policy was provided to the resident and/or the resident's representative upon transfer to the hospital for 1 (Residents #12) of 1 resident reviewed for notice of bed hold policy before/upon transfer. Specifically, for Resident #12 a written notice of the facility's bed hold policy was not provided to the resident and/or their representative upon transfer to the hospital on 12/06/2024. This is evidenced by: The policy titled Admission, Discharge and Transfer effective 10/24/2022, last revised 03/2024 documented facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. When residents were sent emergently to an acute care setting, these scenarios were considered facility-initiated transfers, -not discharges, because the resident's return was generally expected. For facility-initiated transfers or discharge of a resident, prior to the transfer or discharge, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. Resident #12 was admitted to the facility with diagnoses of dementia (loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), history of cerebral vascular accident (a sudden interruption of blood flow to the brain which can damage brain cells and lead to neurological damage), and type 2 diabetes (a chronic condition that happens when a person has persistently high blood sugar levels). The Minimum Data Set (an assessment tool) dated 11/19/22 documented Resident #12 had severe cognitive impairment. It further documented Resident #12 made decisions regarding tasks of daily life. Physician order dated 12/06/2024 documented Resident #12 was to be transferred Emergency Department due to a fall and possible fracture. There was no documented evidence that a written notice of the facility's bed hold policy was provided to the resident and/or the resident's representative upon transfer to the hospital on 12/06/2024. During an interview on 02/14/2025 at 10:57 AM and 12:50 PM, Director of Nursing #1 stated nursing, social work, and the business office were all responsible for making sure the bed hold policy notification was completed. When a resident was transferred to the hospital, the notice of discharge was completed which included the bed hold policy notification. Director of Nursing #1 acknowledged the notice of discharge had not been done consistently and they were working on putting together a better plan to make sure it was completed. 10 New York Codes Rules Regulations 415.3(h)(4)(iii)(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not develop and implemented a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 3 (Residents #s 3, 9, and 19) of 25 residents reviewed for Care Plans. Specifically, (a.) Resident #3 did not have a care plan for falls that documented interventions that were in place including the use of multiple mattresses in their room; (b.) Resident #9's intervention for treatment of edema (swelling caused by fluid buildup in the body's tissues) was not care planned, and Resident #19 did not have a care plan that addressed their vision problems. This is evidenced by: A facility policy titled Interdisciplinary Care Plan Committee effective 09/1992 last revised 04/2024 documented the plan of care is a working tool that provided a profile of the needs of each resident, identified the roles of each service in meeting these needs, and the supportive measures each service, along with the resident, will use to accomplish the overall goals of care. Each discipline was responsible for identifying a problem/concern if any existed for their discipline and identify an intervention for any problem/concern that was relevant to their discipline. Resident #3 Resident #3 was admitted to the facility with diagnoses of diffuse Lewy body disease (a neurodegenerative disorder characterized by dementia, fluctuations in mental status, hallucinations, and parkinsonism), Parkinson's Disease Dementia (dementia that is associated with Parkinson's disease), and coronary atherosclerotic heart disease (buildup of plaque which causes coronary arteries to narrow, limiting blood flow to the heart). The Minimum Data Set (an assessment tool) dated 12/05/2024, documented the resident had severe cognitive impairment, and rarely or never could be understood or understand others. During an observation on 2/11/2025 at 10:21 AM, resident was sitting in a lounge chair in their room. The resident's bed was at its lowest position and has multiple mattresses propped up against the walls in the room. A record review documented Resident #3 has a Care Plan for fall risks developed upon initial entrance to the facility on [DATE]. Resident #3 was discharged to the hospital on 11/30/2024 and returned several days later on 12/05/2024. The resident care plan for falls did not include the use of mattresses in their room. A record review of the Certified Nurse Aide's daily assessment documented the daily safety precautions were to have the bed in the lowest locked position with mattresses next to the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/2025 at 10:45 AM, Certified Nurse Aide #2 stated that Resident #3 had the mattresses in their room due to having multiple falls. They stated that the mattresses were there to protect the resident from falls. They stated that their daily plan was to have the bed in the lowest locked position with mattresses next to the bed. Certified Nurse Aide #2 stated that the daily assessment was populated from the resident's care plan. They stated they did not know where in the care plan it was located as they do not deal with care plans. During an interview on 2/18/2025 at 2:33 PM, Nurse Manager #1 stated that the resident had a care plan for falls and that the mattresses on the residence floor were to be care planned. Nurse Manager #1 stated that they could not locate in the care plan where the mattress for the resident was documented. During that time Assistant Director of Nursing #1 was in the office with the Nurse Manager #1 and stated that the care plan was not implemented when the resident returned from the hospital. Resident # 9 Resident #9 was admitted to the facility with the diagnoses of hypertension (high blood pressure, a condition in which the force of the blood against the artery walls is too high), chronic kidney disease stage IV (longstanding disease of the kidneys leading to renal failure) and bilateral lower extremity edema (swelling in both legs below the knees). The Minimum Data Set, dated dated dated [DATE] documented Resident #9 had intact cognition and made decisions regarding tasks of daily life. The Comprehensive Care Plan for Edema initiated 04/11/2024 documented Resident #9 has chronic bilateral lower extremity edema. The outcome with a start date of 04/11/2024 and a target date of 04/08/2025 was Resident #9 would not have an alteration in skin integrity related to edema through the next review in 90 days. Intervention for Edema included: elevate legs as much as possible, avoid tight fitting shoes/socks, monitor skin integrity, medication as ordered, monitor weight, monitor for complaint of pain, and make provider aware of any changes/increases in amount. There was no intervention that included wrapping Resident #9 bilateral lower extremities with ACE bandages daily. Physician order with start date 01/14/2025 documented wrap bilateral lower extremities with ACE wraps daily and remove at hour of sleep. The diagnosis code/problem on this order was listed as edema, unspecified. Nurses progress note dated 01/14/2025 documented Resident #9 was seen by provider regarding bilateral lower extremity edema. New order was received to wrap bilateral lower extremities with ACE wraps during the day and off at hour of sleep. Resident #9 was agreeable to this plan. During an interview on 02/10/2025 at 11:27 AM, Resident #9 stated they have a severe case of edema, and their legs need to be wrapped with ACE bandages. They stated the nurses wrapped their legs when they get situated in the morning, and they come off in the evening. During an interview on 02/14/2025 at 11:29 AM, Licensed Practical Nurse #4 stated ACE bandages were applied to Resident #9's bilateral lower extremities after they were cleaned up in the morning and they were removed at night. Licensed Practical Nurse #4 stated they did not know if it was care planned for Resident #9's legs to be wrapped. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/14/2025 at 11:30 AM, Registered Nurse #2 Charge Nurse stated ACE bandages were applied to Resident #9's bilateral lower extremities in the morning and they were removed at night due to edema. The Licensed Practical Nurse was responsible for wrapping the legs in the morning and removing the wraps in the evening. Registered Nurse #2 Charge Nurse stated the use of these wraps should be care planned because Resident #9 has edema. They checked Resident #9's care plan for edema and skin breakdown and said the intervention for wrapping Resident #9's legs should be on one of those two care plans, but it was not on either of those care plans. During an interview on 02/14/2025 at 12:50 PM, Director of Nursing #1 stated if a resident had their legs wrapped due to edema, this intervention should be indicated on their care plan. They would expect to see it on their edema care plan for Resident #9 and Director of Nursing #1 acknowledged this intervention was not on Resident #9's edema care plan. Resident #19 Resident # 19 was admitted to the facility with diagnoses of diabetes type 2 (a disease of inadequate control of blood levels of glucose), diabetic retinopathy (having too much sugar in your blood can damage your retina - the part of your eye that detects light and sends signals to your brain), and Significant Right Eye Cataract (a clouding of the lens in your eye). The Minimum Data Set, dated dated dated ,d+[DATE], documented resident was cognitively intact, could be understood, and understand others. The Comprehensive Care Plan dated 12/2024, for Resident #19 did not include a plan for vision and or glasses. During an interview on 2/11/2025 at 11:24 AM, Resident #19 stated they had difficulty with vision. They did not wear their glasses anymore because the glasses really do not help. The glasses were really old, and they had been asking to see the eye doctor, but no appointment had been made. Ophthalmology consult dated 7/27/2020 documented diagnosis of diabetic retinopathy, significant right eye cataracts and corneal dystrophy (eye diseases that involve changes in the cornea). Recommended follow up in three months. During an interview on 02/14/2025 at 10:57 AM, Director of Nursing #1 stated resident was seen by ophthalmology in 2020, which was prior to their admission to the facility . They stated Resident #19 had not been seen by ophthalmology since admission. Residents were seen by specialist as needed, but generally once per year. They stated it was the responsibility of the unit manager to coordinate follow up specialist visits. During an interview on 02/14/2025 at 12:47 PM, Registered Nurse #1 stated Resident #19's Comprehensive Care Plan did not include vision and/or glasses. They were not aware resident wore glasses and would update the care plan. 10 New York Code of Rules and Regulations 415.11(c)(1) 48615 51317

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 48615 Based on observation, record review, and interviews during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 (Resident #10) of 25 residents reviewed. Specifically, Residents #10 did not consistently attend meaningful, accommodating activities to maintain their highest practicable quality of life. This is evidenced by: The Facility's Policy and Procedure Titled, Recreational Therapy, revised 9/2024, documented the Department of Recreational Therapy was responsible for providing meaningful leisure time programs for all residents on a seven-day-per-week basis. Each resident, regardless of their physical and cognitive status, would be offered an activities program designed to meet, in accordance with the comprehensive resident assessment, his or her interests and to encourage quality of life, preservation of leisure skills and maintenance of an optimal level of psychosocial functioning among residents. The activities should be designed to promote the physical, social and mental well-being of residents and to maintain contact and interaction with the community. Residents would be encouraged to voluntarily participate in planned group and individual programs of their choice, reserving the right to refuse to participate in any program. Such programs would consist of both individual and group activities at various times of the day, evening and weekends and shall include but would not be limited to animals, children and other community agencies. Resident #10 was admitted with a diagnoses of malnutrition; anxiety (repeated episodes of sudden feelings of intense fear or terror), and atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls). The Minimum Data Set (an assessment tool) dated 11/2024, documented a Brief Interview for Mental Status (BIMS) score of 99- unable to complete. It further documented resident could understand and be understood by others. During observations on 2/10/2025 at 12:45 PM, 2/11/2025 at 10:30 AM, and 2/12/2025 at 11:00 AM, Resident #10 was noted to be in bed, mattress wedges alongside of bed and double mattresses on floor of each side of bed. Resident arousable, but non-verbal. Resident was wearing a hospital gown. Resident had an extremely thin, frail appearance. Resident was observed all three days in same position. The lights and television were off. On 2/13/2025 at 11:00 AM resident was sitting up in bed, more alert on this day, television was on. The Comprehensive Care Plan for Social Work dated 4/29/2024 documented, Resident will continue to have ongoing needs met through next review, Resident/family will recognize need for 24-hour care, to maintain present level of functioning. Encourage resident to voice concerns, encourage participation in activities of choice, encourage interest in daily routine, Encourage participation in activities of daily living. Resident will have increased ability to cope with feelings of anxiety. Encourage activities of resident's choice in and out of their room, Offer 1:1 to provide socialization and support as needed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/2025 at 2:22 PM, Activities Director #1 stated resident #10 was assessed upon admission of likes and dislikes for activities. The Activities Department provided activities 7 days per week, which were posted on announcement board. For those residents who were unable to attend group activities, 1:1 visits were held with resident. Activities Director #1 provided an attendance roster for group activities, but unable to provide any documentation of 1:1 activity visits for Resident #10. Activities Director #1 stated at that time 1:1 visits were not documented, but going forward would document 1:1 visits. Activities Director #1 stated the radio and television are turned on for Resident #10. During an interview on 02/13/2025 at 12:52 PM, Director of Nursing #1 stated they were informed that Activities Department had not been documenting 1:1 activities. They stated going forward each visit would be documented. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on record review and interviews during a recertification and abbreviated survey (Case #sNY00368587 and NY00370779), the facility did not provide needed care and services that were resident centered and in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for 1 (Resident # 62) of 25 residents reviewed. Specifically, Resident #62 sustained a fall; 3 Certified Nurse Aides assisted resident from the floor and did not notify a nurse or report the incident, and no assessment or interventions were put into place after the fall and prior to discharge. This is evidenced by: Resident #62 was admitted to the facility with diagnoses of diabetes mellitus (a disease of inadequate control of blood levels of glucose), chronic obstructive pulmonary disease(a common lung disease causing restricted airflow and breathing problems), and end stage renal disease (the final, permanent stage of chronic kidney disease, where kidneys can no longer function on their own). The Minimum Data Set (an assessment tool) dated 10/2024, documented resident had mild cognitive impairment, could be understood, and understand others. The facility Investigate Report dated 01/10/2025 documented Resident #62 reported they fell on [DATE] prior to discharge to home on 01/02/2025. It was not report, however staff responded. During an interview on 02/18/2025 at 02:56 PM, Director of Nursing #1 stated the family of Resident #62 called Social Worker #1 on 01/06/2025 and notified them that resident had a fall prior to discharge. Director of Nursing #1 stated they were unaware of fall and at that time they initiated an investigation. They watched the video footage and identified staff who were involved that included Certified Nurse Aides #6, 7, 8 and 9, and Licensed Practical Nurse #3. Certified Nurse Aide #8 lead the other Certified Nurse Aides during the incident. Certified Nurse Aide #6 was seen entering room then left after noting other staff were in the room. They stated they obtained statements from staff involved. The video revealed Certified Nurse Aides #7, 8 and 9 entering into Resident #62's room, and Resident #62 was on floor leaning against the door frame. They placed gait belt around resident and got them up into wheelchair at the direction of Certified Nurse Aide #8. Certified Nurse Aide #8 then informed Licensed Practical Nurse #3 that Resident #62 was short of breath, but did not report resident had been on the floor. Director of Nursing #1 stated Certified Nurse Aide #8 received a final written warning and was still employed at the facility. All staff involved received education and counseling on reporting. Random care audits were now conducted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/18/2025 at 03:20 PM, Certified Nurse Aide #9 stated they were walking by and heard Resident #62 yelling for help. They went into the room along with two other Certified Nurse Aides #7 and 8. Resident was on the floor sitting on buttocks resting on hands, in the doorway. Certified Nurse Aide #8 told them to get resident up from floor and put them in the wheelchair. Certified Nurse Aid #9 stayed in the room a few minutes with resident and assumed that someone had reported the incident. After they got resident up from the floor resident was a little short of breath, but there was no pain or any signs of bruising. Certified Nurse Aide #9 stated this was their first Certified Nurse Aide job. They were told during orientation that if a resident falls or was found on the floor that it should be reported to a nurse. They were not to move resident until a nurse came to assess resident. They were following the direction of Certified Nurse Aid #8 because they were more experienced aide. During an interview on 02/18/2025 at 03:33 PM, Licensed Practical Nurse #3 stated Certified Nurse #8 reported Resident #62 was short of breath, but never mentioned resident was found on the floor. They stated Resident #62 had a history of shortness of breath with an order for nebulizer treatments as needed. After they were told resident was short of breath, they went into resident's room. Resident #62 was sitting in wheelchair, but also did not mention they had fallen. Resident #62 was anxious to go home and had been for several days. They attributed the shortness of breath to be related to patient's anxiety, which they had in the past. They noted resident respirations to be 20 and administered nebulizer treatment as orders. They stated resident had good affect and was discharged the following morning. Licensed Practical Nurse #3 stated if they had known resident was found on the floor, they would have notified the Registered Nurse Supervisor. During an interview on 02/18/2025 at 03:42 PM, Social Worker #1 stated they placed a follow up call per protocol to resident who had been discharged on [DATE]. It was at that time Resident #62's wife informed them that resident was in the hospital and that they had a fall the day before discharge. Resident #62 was discharged to home with home care services. The home nurse visited resident, resident had persistent shortness of breath and home care nurse sent resident to the emergency room where resident was admitted . Resident had since been discharged back to home and was in stable condition. Social Worker #1 notified Director of Nursing of the call and reported fall incident. During an interview on 02/18/2025 at 03:58 PM, Certified Nurse Aide #8 stated they heard the sound of a fall and went into Resident #62's room and found them on the floor leaning against the bathroom door. They stated resident had history of shortness of breath and was not wearing their oxygen. They stated because patient had noted shortness of breath, they immediately got resident off the floor so that they could place their oxygen back on. Certified Nurse Aide #8 stated they thought one of the other aides notified supervisor and they did notify Licensed Practical Nurse #3 that resident was short of breath. They were not aware they could initiate the incident and accident report. Certified Nurse Aide #8 stated they were aware that when a resident was found on the floor, they are to call nurse to assess resident. They stated they were just worried about resident's shortness of breath and getting oxygen placed, so they got resident off floor as soon as possible. They acknowledge they should have called for nurse and took full responsibility. 10 New York Codes, Rules, and Regulations 415.12

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 48615 Based on record review and interviews conducted during a recertification survey, the facility did not ensure that residents received proper treatment and assistive device to maintain vision abilities for 1 (Resident #19) of 1 resident reviewed. Specifically, Resident #19 did not receive an eye exam, glasses, and or a follow up ophthalmology appointment. This is evidenced by: Regulation 483.25(a) Vision and hearing, documented the facility is responsible to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident 83.25(a)(1) In making appointments, and S483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Resident # 19 was admitted to the facility with diagnoses of diabetes type 2 (a disease of inadequate control of blood levels of glucose), diabetic retinopathy (having too much sugar in your blood can damage your retina - the part of your eye that detects light and sends signals to your brain), and significant right eye cataract (a clouding of the lens in your eye). The Minimum Data Set (an assessment tool) dated 11/2024, documented resident was cognitively intact, could be understood, and understand others. During an interview on 02/11/2025 at 11:24 AM, Resident #19 stated they had difficulty with vision. They stated they did not wear their glasses anymore because they really do not help. The glasses were really old, and they had been asking to see the eye doctor, but no appointment had been made. Ophthalmology consult dated 7/27/2020 documented diagnosis of diabetic retinopathy, significant right eye cataracts and corneal dystrophy (eye diseases that involve changes in the cornea). Recommended follow up in three months. The Comprehensive Care Plan dated 12/2024, for Resident #19 did not include a plan for vision and or glasses. During an interview on 02/14/2025 at 10:57 AM, Director of Nursing #1 stated resident was seen by ophthalmology in 2020, which was prior to their admission the facility. Resident had not been seen by ophthalmology since admission. They stated residents were seen by specialist as needed, but generally once per year. It was the responsibility of the unit manager to coordinate follow up specialist visits. During an interview on 02/14/2025 at 12:47 PM, Registered Nurse #1 stated Resident #19's Comprehensive Care Plan did not include vision and or glasses. They stated were not aware resident wore glasses and would update the care plan. 10 New York Codes, Rules, and Regulations 415.12(2)(b)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for 2 (Resident #s 4 and 38) of 16 residents observed during a medication pass for a total of 25 observations. This resulted in a medication error rate of 8%. This is evidenced by: The facility's policy and procedure titled Medication Administration last revised ,d+[DATE] documented, all Registered Nurses and Licensed Practical Nurses must have successfully passed the written medication exam and the medication administration competency to administer medications as outlined below. Registered Nurses and Licensed Practical Nurses have the responsibility to administer medications in accordance with this policy and any other relevant education and/or certification. Right Documentation - Administration is recorded in the electronic Medication Administration Record. If medication is held or refused or not given on time, a reason for such is recorded in the electronic Medication Administration Record. If there are any signs of adverse reaction or change in resident's medical condition, there is documentation in the electronic Medication Administration Record. Check expiration date prior to administration. Verify that the medication selected is stable based on visual inspection for particulates or discoloration and that the medication has not expired. Do not administer single dose vial if seal has been broken. Check expiration date prior to administration. The Registered Nurses or Licensed Practical Nurses would make an evaluation, prior to administering any medication, of the resident's physical condition, lab values, and vital signs as indicated. Any contraindication to administering the medication would be discussed with the physician. Refused/Omitted/ Missed Dose: a. When medication is refused or omitted, select reason in electronic Medication Administration Record, selecting from drop downs. b. State reason for refusal/omission, any communication to physician and action taken in a Clinical Note. A Registered Nurse Supervisor and provider must be notified when a medication was not available. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, had determined that they have the decision-making capacity to do so safely. Resident #4: Resident # 4 was admitted to the facility with diagnoses of diabetes mellitus (a disease of inadequate control of blood levels of glucose), hip Fracture and depression (a mental health condition that involves a low mood and loss of interest in activities). The Minimum Data Set (an assessment tool) dated [DATE], documented resident had moderate cognitive impairment, could be understood, and understand others. Resident #4's current physician orders dated [DATE] and the Medication Administration Record dated , d+[DATE] documented, before meals give Insulin Lispro Injection 300 unit/3 milliliter three times a day at 08:00, 12:00, and 17:30 per sliding insulin scale. At 11:17 AM, Resident #4 had a documented blood glucose fingerstick of 347 Milligrams per deciliter. At 12:40 PM, Licensed Practical Nurse #2 administered 10 units of Lispro insulin based on the sliding insulin scale. Resident #4 had already consumed their lunch at approximately 12:10 PM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at 12:40 PM, Licensed Practical Nurse #2 stated insulin was ordered to be given before meals and should be given immediately after finger stick had been recorded. They stated it was wound rounds that day and they did not get to give the insulin until 12:40 PM. Licensed Practical Nurse #2 stated they should have prioritized and given the insulin first before passing other resident medications. Licensed Practical Nurse #2 did not obtain another blood glucose fingerstick, and did not report the late medication administration to a Registered Nurse and or physician. During an interview on [DATE] at 02:52 PM, Assistant Director of Nursing #1 stated insulin coverage should be given before meals per physician order. They stated insulin should be given as soon as possible after the blood glucose fingerstick. One hour and 20 minutes was considered an extended time between taking fingerstick and giving insulin coverage. In this case, a repeat fingerstick should have been taken and the physician should have been notified. Resident #38: Resident #38 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung); diabetes mellitus (a disease of inadequate control of blood levels of glucose), and depression (a mental health condition that involves a low mood and loss of interest in activities). The Minimum Data Set (an assessment tool) dated ,d+[DATE], documented resident had moderate cognitive impairment, could be understood, and understand others. Resident #38's Medication Administration Record dated [DATE] documented, Ipratropium/Albuterol (0XXX, d+[DATE] milligrams/3 milliliters). Nebulized two times daily at 07:30 and 16:30. Administered [DATE] at 07:17 signed by Licensed Practical Nurse #1. During an observation on [DATE] at 11:43 AM, Resident #38 was noted receiving a nebulizer treatment. During an interview on [DATE] at 11:45 AM, Resident #38 stated the medication in nebulizer was left at their bedside that morning [DATE] by Licensed Practical Nurse #1. They stated staff always left the medication at the bedside, and they took it when they were ready. Licensed Practical Nurse#2 stated, resident had the nebulizer applied and turned off nebulizer themselves when done. If the medication was not completed, the resident would restart the nebulizer when ready. Licensed Practical Nurse #2 stated, although the nebulizer was placed that morning by Licensed Practical Nurse #1, they would have done the same thing. During an interview on [DATE] at 11:50 AM, Licensed Practical Nurse #1 stated they signed for Resident #38's nebulizer treatment at 07:30 AM indicating it was administered. They stated they did not go back into resident's room to ensure medication was consumed and or to have resident rinse mouth following nebulizer treatment. During an interview on [DATE] at 12:57 PM, Director of Nursing #1 stated they had no residents at the facility who self-administered medications. They stated if resident wished to self-administer medications, they would have to be assessed for competency along with obtaining an order to self-administer medication by the physician, and a care plan would be put in place. Director of Nursing #1 stated nurses who administer medications should not leave medications at the bedside. Staff were to ensure the medication was consumed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 New York Codes, Rules, and Regulations 415.12 (m)(1)]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for 1 (West Unit Team 1) of 2 medication carts reviewed. Specifically, (a.) opened medications had no open and or expiration dates (b.) open bottles of eye drops had no label identifying patient and had no open and or expiration dates. This is evidenced by: The facility's policy and procedure last revised ,d+[DATE] documented, Multiple-Dose Vials a. Multiple-dose vials would not be used beyond the manufacturer's expiration date. Any multi-dose vial that has been opened or punctured would have an expiration date of 28 days-label the container when opened with the date of expiration (28 days from date of opening, or manufacturer's date of expiration if that is sooner) and initials. They must be stored under manufacturer's recommended conditions and discarded if potentially contaminated. Exceptions: Exceptions include when the manufacturer's stability is less than 28 days. For example, Mucomyst (Trademark) (acetylcysteine) vials should be dated upon initial entry. Acetylcysteine expires in 96 hours under refrigeration. Acetylcysteine would be issued with a fill-in-the-blank label for completion and application after the first use. Insulin vials would be dispensed as resident specific. Insulin removed from pyxis would be assigned to the resident for whom it was removed. Check expiration date prior to administration. Verify that the medication selected is stable based on visual inspection for particulates or discoloration and that the medication has not expired. Do not administer single dose vial if seal has been broken. Check expiration date prior to administration. During an observation on [DATE] at 11:34 AM, the [NAME] Unit Team 1 Medication Cart contained 1 open vial of Lispro insulin, and 1 open vial of glargine insulin both with no open and or expiration dates. The following open bottle of eye drops had no label identifying resident and had no open or expiration dates: 1 bottle each of Timolol; Brimonidine; Atropine; Ketorolac, GenTeal and Alaway. During an interview on [DATE] at 11:23 AM, Licensed Practical Nurse #1 stated medication was labeled when it came from the pharmacy. The label on the eye drops fell off, but they knew which patient the eye drop belonged to. Licensed Practical Nurse #1 stated they did not write the expiration date on the bottles, the pharmacy wrote the expiration date. During an interview on [DATE] at 02:52 PM, Assistant Director of Nursing #1 stated all medications came labeled from the pharmacy. They stated the fill date was different from the open date. The nurse opening the medication should write the open and expiration dates on the medication. When labels fall off, for example on eye drops, it was the nurse's responsibility to re-apply the label or request another medication from the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:45 AM, Director of Nursing #1 stated upon opening a medication the nurse should label the medication with open and expiration dates. Each nurse received medication administration training upon hire. Medication administration training included checking medication expiration dates prior to administration. 10 New York Codes, Rules, and Regulations 415.18(d)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48413 Based on observation and interviews during the recertification survey, the facility did not ensure that food was stored, prepared, distributed, or served following professional standards for food service safety in 2 of 2 resident unit nutrition areas and the main kitchen. Specifically, the area of the main kitchen and resident kitchenettes were not clean. This is evidenced by: During the initial inspection in the main kitchen on 2/10/2025 at 11:05 AM, the following observations were made: The manual can open had a build-up of debris in the cutting area of the device The mixer had dirt and debris on and under the device. Dust and dirt were on top of two fire extinguishers in the main kitchen. During an inspection of the East nutrition area on 2/12/2025 at 12:48 PM, the following observations were made: Temperature logs for the refrigerator and freezer for February 6, 8, 9, 10, and 12/2025 were missing. There was dirt and grime on the top of the refrigerator/freezer unit. There was dirt, grime, and food particles on the freezer bottom and shelves. There was dirt, grime, and food particles on the refrigerator bottom and shelves. There was dirt and grime on the seals of the refrigerator and freezer. There was dirt, grime, and food particles within the microwave. There was dirt, grime, and food particles built up on the drawers under the microwave. During an inspection of the East nutrition area on 2/12/2025 at 12:58 PM, the following observations were made: Temperature logs for the refrigerator and freezer for February 9, 10, and 12 were missing. Dirt and grime on the top of the refrigerator/freezer unit. Dirt, grime, and food particles on the freezer bottom and shelves. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dirt, grime, and food particles on the refrigerator bottom and shelves. Dirt and grime on the seals of the refrigerator and freezer. Dirt, grime, and food particles within the microwave. Dirt, grime, and food particles built up on the drawers under the microwave. During the follow-up inspection in the main kitchen on 2/13/2025 at 11:45 PM the following observations were made: The walk-in refrigerator had a large pool of free-standing water on the floor. The storage area for clean pots, pans, and food containers had multiple containers stacked together that were not fully dried. Containers, pots, and trays were put away wet and contained moisture. The rolling toaster contained a large amount of debris under and behind the apparatus. Dirt and grime on the shelving unit above the grill cooking area. Final rinse pressure on the dishwasher was 13 pounds per square inch. The signage on the device had a recommendation of 20 pounds per square inch. During an interview on 2/13/2025 at 12:22 PM, Director of Food Services #1 stated that their staff were responsible for the cleaning of the equipment being used in the kitchen. They stated they would need to be more diligent in cleaning the equipment and kitchen areas. They stated that they were made aware of the water in the cooler this morning and engineering was working on a potential leak but unsure of what they found or the progress that had been made with it. They stated that the individual who was washing the pots, pans, and containers did not let them dry fully and put them away too soon as it took several hours to fully dry. They stated that they would have to educate the individuals washing the pans on the proper time for drying. Food Service Director #1 stated that the main dishwasher was out of service on Tuesday 2/11/2025 due to a malfunction. The Administrator was made aware, and the service company was called immediately to repair the machine. It was found that a sensor wire corroded away causing the malfunction. Food Service Director #1 stated that they had the service individuals look at the gauges for the dishwashing machine and it was found that the water pressure gauge was not working appropriately and had a faulty sensor. They stated that the service company ordered a new part and would be back to fix it as soon as the part came in. The service individual stated that the recommended pressure on the system was 20 pounds per square inch plus or minus 5 pounds. In observing the rinse pressure of the machine, Food Service Director #1 stated that the final rinse pressure was below the recommended amount. Food Service director #1 stated that the Environmental Services was responsible for the cleanliness of the nutrition areas, but the temperature logs were the responsibility of the dining ambassador. When asked about the missing dates of the temperature logs, Food Service Director #1 stated that people were not doing their jobs, and they would make sure they were completed daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/2025 at 11:45 AM, Environmental Services Director #1 stated that their staff were responsible for the overall cleaning in the nutrition areas. They stated that the cleanliness of the areas had been lacking. They stated that they were in the process of developing a duty list of responsibilities the environmental service individuals were to complete daily. In showing the areas of concern, Environmental Service Director #1 stated that the areas should have been cleaned and that was the reason they wanted to develop the lists. 10 New York Codes, Rules, and Regulations 415.14(h)

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48413 Based on record reviews, and interviews conducted during a recertification survey, the facility did not ensure that Quality Assessment and Assurance Committee consisted at a minimum of the Director of Nursing, Medical Director or designee, Administrator, and Infection Preventionist. The failure to meet to coordinate and evaluate the need for performance improvement projects had the potential to affect all residents of the facility. Specially, Director of Nursing was also the Infection Preventionist. This is evidenced by: A review of the facility's undated Quality Assurance and Performance Improvement Plan, revealed that the Quality Assurance and Performance Improvement Plan provides leadership through its committee. The Quality Assurance and Performance Improvement committee shall be comprised of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Registered Nurse Manager, Registered Nurse Supervisors, Chief Executive Officer, [NAME] President of Operation, and other ancillary department heads. The Administrator is the chairperson of the Quality Assurance and Performance Improvement committee and is responsible for ensuring that Quality Assurance and Performance Improvement are implemented throughout the facility. The Quality Assurance and Performance Improvement Committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees. The overall responsibility of the steering committee is to develop and modify the Quality Assurance and Performance Improvement, identify teams who will problem solve as well as set priorities for the Performance Improvement Projects. A Review of the Policy and Procedure titled Infection Prevention and Control created in November 1977 and revised in August 2024 documented under Mission/Goal of the Infection Control Program: Through oversight of the Quality Assessment and Assurance Committee, the Infection Prevention and Control Committee, shall oversee the implementation of infection control policies and practices, and help department heads and managers implement infection prevention and control measures within their departments: and, inquiries concerning infection control policies, procedures, and facility practices should be referred to the Infection Preventionist or Director of Nursing Services. During the entrance interview conducted on 02/10/2025 at 10:30 AM, Director of Nursing #1 stated they were the current Infection Preventionist as well as the Nurse Educator. They stated that many staff members have multiple roles due to staffing issues. During an interview on 2/19/2025 at 11:15 AM, Administrator #1 stated that they held meetings every month and it was the responsibility of the staff to sign in for the meetings. They stated they were unaware that the Infection Control Preventionist was their own role and could not be a dual role with the Director of Nursing. 10 New York Code of Rules and Regulations 415.27(b)(3)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48615 Based on observation and interviews during the recertification survey, the facility did not designate one or more individual(s) as Infection Preventionist (s) responsible for the facility's Infection Prevention Control Practices. Specifically, the facility did not have a specified designated individual as their Infection Control Preventionist, and the Director of Nursing had performed a dual role since May 10, 2023. This is evidenced by: A Review of the Policy and Procedure titled Infection Prevention and Control created in November 1977 and revised in August 2024 documented under Mission/Goal of the Infection Control Program: Through oversight of the Quality Assessment and Assurance Committee, the Infection Prevention and Control Committee, shall oversee the implementation of infection control policies and practices, and help department heads and managers implement infection prevention and control measures within their departments. Inquiries concerning infection control policies, procedures, and facility practices should be referred to the Infection Preventionist or Director of Nursing. The Infection Preventionist implements corrective action plans for infection control in affected problem areas with the assistance of the Chief Executive Officer, Medical Staff, Quality Assurance Performance Improvement Committee, and Nurse Executive. A review of the Infection Preventionist documentation of sufficient training documented that the Director of Nursing #1 completed their nursing home infection prevention training course on 05/10/2023. This was the day they assumed the role of the infection preventionist. A review of key personnel from May of 2023 documented that the designated Infection Preventionist listed for the facility was Director of Nursing #1. During the entrance interview conducted on 02/10/2025 at 10:30 AM, Director of Nursing #1 stated they were the current Infection Preventionist as well as the Nurse Educator. They stated that many staff members have multiple roles due to staffing issues. During an interview on 02/19/2025 at 11:15 AM, Administrator #1 stated that they were unaware that the Infection Control Preventionist was to have their own specific role and could not have a dual role with the Director of Nursing. 10 New York Code of Rules and Regulations 483.80 (b) (1)-(4) (c)