| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 335365 | A. Building<br>B. Wing | 01/14/2025 |

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| Nyack Ridge Rehabilitation and Nursing Center | 476 Christian Herald Road<br>Valley Cottage, NY 10989 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686<br><br>Based on observation, interview, and record review conducted during the Recertification and abbreviated (NY00343179) survey from 1/6/2025 to 1/14/2025, the facility did not ensure the resident's right to a safe, clean, comfortable, and homelike environment. This was evident for 1 of 2 resident floors (3rd Floor) during observation of the environment. Specifically, the 3rd Floor was observed with foul, pervasive, and strong odor of urine and feces on multiple occasions; shower rooms with hanging ceiling tiles, stained wall and floor tiles, and stained worn shower chairs; there were multiple resident rooms with soiled and stained bathrooms, broken light fixtures, and dirty, spackled walls with mismatched paint; and, there was a floor dayroom with soiled bins of dolls and stuffed animals, marked floors, and scratched damaged walls.<br><br>The findings are:<br><br>The facility policy titled Quality of Life - Homelike Environment dated 6/2024 documented staff and management shall maximize characteristics of the facility including a clean, sanitary environment, adequate lighting, pleasant scents, and reduction of glare.<br><br>The facility policy titled Maintenance on Units dated 4/2024 documented maintenance issues must be reported immediately to the designated Maintenance Coordinator detailing a description of the issue, location, date, and time the report was made, and contact information for the reporting staff member. Cosmetic repairs are typically addressed within 5 business days. Regular audits will be conducted to identify areas for improvement.<br><br>From 1/06/2025 at 9:27 AM to 1/10/2025 at 4:45 PM, there were multiple observations of the 3rd floor with a strong, permeating, sometimes musty, stale odor of urine and feces. The smell was noticeable in the hallway near the Nursing Station upon entering the unit from the elevator. There was no singular identifiable source; however, the foul odor was strongest in the 3rd Floor Dayroom when residents gathered to eat dinner and did not dissipate after the meal was done.<br><br>The following was observed on the 3rd Floor in resident rooms and common areas from 1/6/2025 at 9:27 AM to 01/14/25 10:21 AM :<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - 3rd Floor Dayroom contained a bin of dolls and stuffed animals near the back of the room covered in dried brown and beige stains, black scuff marks on the linoleum floor, a puddle of urine on the floor during dinner, and walls with scrapes and scratches that caused chipped paint and damaged walls.<br><br>- room [ROOM NUMBER] had a 5-inch-wide area of wall, approximately 3 feet in length, across from 321B that was spackled and mismatched the paint in the room. There were scrapes and gauges into the wall near the head of 321B's bed. The floor mat next to 321B's bed was stained with brown and beige dried splotches throughout. Both closets near 321A's bed had missing and broken dresser drawers. The light fixture above the shared sink was missing its cover, had 1 exposed lightbulb lit, and had 1 lightbulb that had burnt out and was dark. The window screen was torn and had several areas of blue tape holding it together.<br><br>- The shared bathroom between room [ROOM NUMBER] and 323 had peeling, spackled pain that mismatched the pink walls. The tiled walls surrounding the toilet bowl were covered in a spray of dried black and brown droplets that ran down to the floor along with several pieces of dried brown matter stuck to the tiled wall. The raised toilet seat positioned above the toilet bowl was covered in yellow, brown, and black dried matter along the metal legs and the interior and edges of the seat.<br><br>- room [ROOM NUMBER] had large gauges and pieces taken out of the wall along the sharp edges of the doorways entering the room and the bathroom. The toilet bowl in the shared bathroom had feces and toilet paper that had not been flushed. The raised toilet seat positioned over the toilet bowl had brown stains along the rim running down the steel frame legs.<br><br>- room [ROOM NUMBER] had a shared bathroom with brown and black feces splattered and dried onto the toilet bowl seat, along the perimeter wall of the toilet bowl, and on the light switch near the door.<br><br>- The 3rd Floor Hallway 'B' Shower Room contained a shower chair with loose, faded, and torn mesh backing and a seatbelt strap heavily stained and soiled brown and rust colored stains along the edges of the seat and legs. Ceiling tiles were warped, hanging down in several locations, and stained brown in multiple areas. A plastic toilet bowl seat cover was thrown into the corner of the room on the floor. A large yellow trash bin was observed in the corner filled with garbage. The wall and floor tiles were stained in brown, yellow, and white soap scum.<br><br>- room [ROOM NUMBER] had a small black personal refrigerator on 329A's bedside dresser. The refrigerator had 3 partially consumed bottles of soda. There was no inspection date observed. The refrigerator had several dried brown stains and food crumbs inside and outside the fridge.<br><br>- room [ROOM NUMBER] had a bathroom with a soiled tub, multiple missing wall tiles, and a crack along the painted part of the wall.<br><br>- The 3rd Floor Hallway 'C' Shower Room had missing corroded caulking causing loose baseboards along the perimeter of the wall. The ceiling tiles were stained brown, warped, and falling off the ceiling in multiple places throughout the room.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - room [ROOM NUMBER] had scratches, spackle, and mismatched paint in multiple areas on the walls throughout the room. There were 2 large brown dried stains covering an area that spanned multiple ceiling tiles.<br><br>- room [ROOM NUMBER] had a window with a linear crack spanning from one corner to the opposite side of the windowpane.<br><br>On 1/08/2025 at 3:29 PM, Resident #79 was interviewed and stated the room appeared shabby and gloomy.<br><br>On 1/08/2025 at 3:37 PM, Certified Nurse Aide #40 was interviewed and stated room [ROOM NUMBER] looked shabby and stains on the walls and ceilings should have been reported to the front desk and Maintenance Department.<br><br>On 1/08/2025 at 3:43 PM, Registered Nurse #7 was interviewed and stated the 3rd Floor was designated as the facility's long-term dementia unit and the appearance was not good. There were some issues along the walls and ceilings in resident rooms, but it was difficult to address the rooms where residents did not want things to be moved or cleaned. Supervisors had access to an electronic ticket system on their mobile phones to alert the Maintenance Department to repair needs on the unit. Registered Nurse #7 stated they were focused on resident health and were not focused on environmental issues. Registered Nurse #7 stated the Maintenance and Housekeeping Departments should address environmental concerns.<br><br>On 1/10/2025 at 5:41 PM, Certified Nurse Aide #22 was interviewed and stated the 3rd Floor did have a Housekeeper assigned on the evening shift during dinner, but the unit might smell because residents just had dinner and many of them need to be toileted and/or changed. Certified Nurse Aide #22 stated they did smell the odor of urine throughout areas of the 3rd Floor.<br><br>On 1/10/2025 at 6:10 PM, Registered Nurse #25 was interviewed and stated they have worked in the facility for 2 years and they may not have a sensitive sense of smell any longer. Registered Nurse #25 also stated they were wearing a facemask which could affect their ability to notice the odor of urine on the unit. Some residents had stronger smelling urine than others which could affect how strong the smell was on the unit. Registered Nurse #25 acknowledged it was not appropriate for the residents to eat in the Floor Dayroom if there was a strong foul odor of urine or feces present.<br><br>On 1/13/2025 at 11:55 AM and 12:22 PM, the Director of Housekeeping was interviewed and stated the fecal matter in spraying the walls of resident shared bathrooms was not acceptable. The Director of Housekeeping stated they made rounds on the units weekly and observed whether rooms were dusted. Their rounds included looking in the residents' bathrooms. The Director of Housekeeping stated they told the Housekeeper on the unit to stay on top of cleaning resident bathrooms. The 3rd Floor did not have an exhaust. The unit air smelled worse when the nursing staff changed residents because the air was not circulated or filtered out. The Director of Housekeeping stated they did notice the urine odor throughout the unit and acknowledged that the smell became stronger and worse in the evening around dinner time. There was only verbal communication between staff on the units and the Housekeepers when something needed to be addressed. The environment on the 3rd Floor was not good.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/08/2025 at 4:04 PM and 1/13/2025 at 4:22 PM, the Director of Maintenance was interviewed and stated the 3rd Floor would be undergoing a process of repair and renovation. The facility recently repaired a roof leak above room [ROOM NUMBER]. The Director of Maintenance stated they were aware of the condition of the rooms on the 3rd Floor, and they would be addressed during future renovation of the unit. The Maintenance Department addressed repair needs upon staff report and request. The Director of Maintenance did not have any recent requests for repair from 3rd Floor staff. On 1/14/2025 at 10:17 AM, the Director of Housekeeping was present on the 3rd Floor during observation of the Hallway 'B' Shower Room and stated the shower chair in the room was unacceptable for use with residents. The facility just ordered new showers chairs for several of the showers and the Director of Housekeeping had no explanation for this shower chair not being switched out with a newer one.<br><br>On 1/14/2025 at 09:43 AM, the Administrator was interviewed and stated they made visual rounds on the 2nd and 3rd Floors daily. Repair concerns were discussed by the department heads in the morning meeting. The Administrator stated they were aware of the repair and environment concerns on the 3rd Floor and the facility was in the process of renovating the unit and making repairs.<br><br>10 NYCRR 415.5(h-i)(1-3)<br><br>49255 |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673<br><br>Based on interviews and record review conducted during the Recertification and abbreviated surveys (NY00335588, NY00358884) from 1/6/2025 to 1/14/2025, the facility did not ensure the completion of discharge summaries for 3 out of 3 residents (Resident #124, #247 and #245) reviewed for discharge. Specifically, 1) Resident #124's electronic medical record did not contain a discharge summary. 2) Resident #247 was severely cognitively impaired and discharge did not include adequate communication with the resident's family regarding injectable medications. 3) Resident #245's discharge summary and instructions were incomplete and did not included a recapitulation of the residents' stay.<br><br>The finding is:<br><br>The policy and procedure titled Discharge the Resident revised 7/2024, documented that when a resident is discharged to home, the facility must ensure that the resident and responsible parties receive teaching and discharge instructions. when discharge is anticipated, the facility must ensure that a transfer summary is completed.<br><br>1. Resident #124 had diagnoses of end stage renal disease, dependence on renal dialysis, hypertension, and bladder cancer. The Minimum Data Set (a resident assessment tool) dated 10/3/24 documented Resident #124 was cognitively intact and expressed interest in being consulted regarding all assessments about returning to the community.<br><br>The Comprehensive Care Plan for discharge, last updated 9/26/24, documented to assess available support system for safe discharge back into the community, to coordinate with primary care physician all necessary prescription prior to discharge, and to refer to a certified home care agency for skilled services necessary for continuity of care.<br><br>The Social Work Discharge Summary Note dated 10/31/2024, documented that a discussion took place with the resident regarding the notice of Medicare non coverage for 11/4/24, by the managed care provider. The Resident was scheduled to be discharged to the community on 11/5/24, with time pending as well as mode of transportation pending.<br><br>The Nursing Progress note dated 11/5/2024, documented at 10:30 AM education was provided regarding discharged instruction, medications, and transport. Additional materials for dressing were provided, and the resident packed belongings independently. discharged paperwork was signed.<br><br>The Social Work discharge note dated 11/5/2024 at 1:37 PM, documented the resident was discharged to the community via ambulette and left with all his belongings. No signs acute distress was noted. Home care services from the hospital were arranged, and the resident left with walker and cane along with follow- up information for new dialysis treatment.<br><br>Review of the electronic medical record revealed no documentation of a discharge summary.<br><br>(continued on next page) |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview conducted on 1/10/25 at 10:51 AM, the Director of Nursing stated the discharge summary for the resident had not been completed and the physician was responsible for completing the discharge summary.<br><br>During an interview conducted on 1/10/25 at 3:35 PM, the Director of Social Work stated the discharge of the resident was discussed, and dialysis arrangements with transportation were set up. They also stated the discharge summary should have been completed, as this was the responsibility of the medical team.<br><br>During an interview on 1/10/25 at 3:45 PM, Unit Manager #1 stated they were aware of the discharge and were unsure why the discharge summary was not completed. They stated the physician was responsible for completing the discharge summary.<br><br>During an interview on 1/13/25 at 11:42 AM, Physician #17 stated they were covering for another physician, the discharge summary was completed and was located in the hard chart. They suggested to contact the Director of Nursing to retrieve it.<br><br>During an interview on 1/13/25 at 12:20 PM, the Director of Nursing stated they were unable to locate a discharge summary for Resident #124.<br><br>2. Resident #247 was admitted with diagnoses of type 2 diabetes, depression, and generalized weakness.<br><br>The 3/1/24 admission Minimum Data Set documented Resident #247 was severely cognitively impaired and required extensive assist with transferring, bed mobility, toileting and eating. The resident received Insulin injections seven days a week.<br><br>The comprehensive Care Plan for Discharge, dated 2/27/24, documented to access available support system for safe discharge back into the community, to provide resident's significant other with teaching regarding discharge process and other necessary follow- up in the community.<br><br>Physician orders dated 2/20/24 documented the resident was prescribed Humalog U-100 insulin injections for diabetes, and Epogen injections every Monday, Wednesday, and Friday for anemia.<br><br>The physician's discharge summary dated 3/9/2024, documented that the fall precaution were discussed with the nurse and the resident would be discharged safely to their home. There were 3 boxes for the physician to check for the discharge plan, the first box was checked that stated I have informed the patient of his/her medical condition and my plan of care. The next box was checked that stated I do not feel the patient understands his/her medical condition nor my plan for treatment and care. The third box was not checked and stated I have informed the patients next of his/her medical condition and my plan of treatment and care.<br><br>Review of Resident #247's electronic health record revealed the resident was discharged home 3/9/24. There were no documented instructions or education provided to the resident representative regarding the proper use and administration of the injectable medications.<br><br>Review of the discharge scripts dated 3/9/2024, documented the prescriptions were submitted electronically to the local pharmacy.<br><br>(continued on next page) |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a phone interview on 1/7/2025 at 12:37 PM, the resident family member stated Resident #247 was sent home on Epogen and Humalog insulin both of which were injectable medications. The family member reported that no education was provided on how to administer the medications. They said attempts were made to contact the facility to obtain education, but no one responded to questions.<br><br>During a follow up phone interview with the resident's family on 1/13/25 at 12:19 PM they stated the resident was discharged on a Saturday and he was hospitalized on Sunday following a fall.<br><br>During an interview on 1/10/25 at 10:00 AM, Unit Manager #1 stated that the resident was discharged on a Saturday, no education was provided prior to the discharge, and they were responsible for both the discharge and the education. Registered Nurse #1 could not recall if the family contacted the facility requesting information on how to administer injections.<br><br>During an interview on 1/10/25 at 10:30 AM, the Director of Social Services stated the discharge occurred on a Saturday and the Nursing Supervisor was responsible for providing education, ordering medications, and ensuring the resident received the prescribed medications. The Director of Social Services stated that upon returning to work on Monday, staff realized the resident had been sent home with missing medications and no education was provided regarding injectable medications.<br><br>During an interview on 1/10/25 at 10:55 AM, the Director of Nursing stated that no documentation existed to confirm that the resident's family received education on the administration of injectable medications. They stated the nurse or nursing supervisor was responsible for providing education to the resident or family.<br><br>During an interview on 1/13/25 at 11:15 AM, Physician #16 stated that the responsibility for education should have been assigned to the nurse. The social workers should have ensured that education and discharge planning were completed as part of the process. They stated it was their understanding that everything proceeded as expected with the discharge.<br><br>During an interview conducted on 1/13/25 at 11:32 AM, the Administrator stated the discharge process was managed through social services. Any education particularly related to medications, was provided by the nursing department, and the physicians was responsible for completing discharge summaries.<br><br>40686<br><br>3) Resident #245 had diagnoses of cerebral infarction and anxiety disorder.<br><br>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #245 had mild cognitive impairment, required substantial to maximal assistance with toileting, showering, and dressing, partial to moderate assistance with transfers and ambulating 150 feet, received a diuretic, and did not want a referral to a Local Contact Agency for discharge planning.<br><br>Nursing Notes dated 11/1/2023 documented Resident #245 was prescribed and receiving antibiotic medication for a left armpit abscess. Resident #245 was noted struggling to complete activities of daily living and required increased assistance.<br><br>The Nursing Note dated 11/2/2023 documented Resident #245 experienced pain from their left arm abscess and struggled to complete tasks such as hygiene and dressing.<br><br>(continued on next page) |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Social Work Note dated 11/3/2023 documented a discharge planning telephone conference was held between Finance, the Administrator, and Resident #245's Representative to discuss discharge planning and financial options for long term care. The Resident Representative was provided with financial options to assist with Medicaid options and a referral to an assisted living facility. The Resident Representative was expected to follow up with Social Services to further discuss options for Resident #245.<br><br>The Physiatry Note dated 11/8/2023 documented Resident #245 was a fall risk and had 2 falls within the last 12 months.<br><br>The Social Work Note dated 11/9/2023 documented Resident #245 was unable to apply for Medicaid, and although the resident wanted to return to their home in the community, Resident #245's representative would explore assisted living facility placement. The lack of community support made a discharge home unsafe and unfeasible for the resident. The Director of Social Work documented Resident #245's discharge date was set for 11/17/2023.<br><br>The Medical Doctor Note dated 11/11/2023 documented Resident #245 was evaluated for discharge to an assisted living facility at the request of the Social Work Department.<br><br>The Social Work Note dated 11/14/2023 documented a referral was made to an assisted living facility for Resident #245 to be discharged from the facility on 11/17/2023.<br><br>The Social Work Note dated 11/16/2023 documented Resident #245's representative was able to secure a private aide and Resident #245 would be able to access their home using a back entrance that did not require Resident #245 to negotiate stairs. The Director of Social Work referred Resident #245 to a certified home healthcare agency and the wheelchair in Resident #245's room was their own.<br><br>A Notice of Transfer/discharge date d 11/16/2023 documented Resident #245 was ready for discharge to their home in the community because their health has improved sufficiently to allow a more immediate discharge and was being made in compliance with the resident's request. The Notice was signed by the Resident Representative on 11/18/2023.<br><br>The facility Discharge Instructions dated 11/18/2023 documented Resident #245 was discharged home on a regular diet, required assistance with all activities of daily living, a wheelchair for long distances and ambulation, had a homecare referral to a certified home healthcare agency, and was released with prescribed medication.<br><br>The Discharge Instructions did not document a follow up referral to a community physician, the family's acquisition of a private aide, fall, safety, aspiration precautions, or Occupational Therapy recommendations including a list of assistive devices for bathing or other self-care needs.<br><br>The Nursing Note dated 11/18/2023 documented Resident #245 was discharged home with their daughter and son at 10 AM. The resident left with all their belongings, medication list, and medications.<br><br>The Physician Orders as of 11/18/2023 documented Resident #245 was on aspiration, fall, and safety precautions, was out of bed to a standard wheelchair with gel-foam cushion and bilateral leg rests, was ordered a wound care consult on 10/30/2023 for a left armpit abscess, and did not document a discharge to community order.<br><br>(continued on next page) |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Social Work Note dated 11/20/2023 documented Resident #245 was discharged to the community via private car on 11/18/2023.<br><br>On 1/08/2025 at 12:18 PM, the Resident Representative was interviewed and stated Resident #245 did not receive an Admission Agreement from the facility upon admission. Resident #245 was admitted to the facility for physical therapy and the Resident Representative was unaware of the facility daily rates, how much of Resident #245's stay was covered by their insurance coverage, or the Medicaid application process. The Finance Office contacted the Resident Representative in 10/2023 and requested documentation to apply for Medicaid for Resident #245. The Resident Representative stated they provided all the requested documentation. The Resident Representative stated they were next contacted by the Finance Office in 11/2023 and informed that Resident #245 had to be discharged from the facility because the resident's insurance coverage ceased. The Resident Representative stated Resident #245's Medicaid application was pending when they received the call from the facility to discuss discharge planning for Resident #245. The facility provided bills to Resident #245 reflecting the facility's room and board rate without factoring in that Medicaid would be retroactive when approved and would cover the facility's expenses. The Resident Representative stated Resident #245 was not ready for discharge and the bills from the facility stressed the resident until they felt the resident was pushed out of the facility. The Resident Representative stated they were never provided with a Notice of Transfer/Discharge from the facility or provided with the opportunity to appeal the resident's discharge. Resident #245 was approved for Medicaid after being discharged and the facility was retroactively paid. Resident #245 required a lot of physical assistance at home in the community post-discharge and the Resident Representative stated they did not feel Resident #245 was prepared to return home at the time the facility initiated the discharge plan.<br><br>On 1/13/2025 at 12:12 PM, the Director of Social Work was interviewed and stated Resident #245's discharge planning began the day of admission. Resident #245 was admitted to the facility for short term rehabilitation but was unsure whether they would have a caretaker or be able to negotiate the stairs necessary to return to their home in the community. The Director of Social Work stated they discussed alternative placement with the Resident Representative and referred them to an assisted living facility. The Resident Representative informed the Director of Social Work they were able to find a family friend to be a 24-hour private aide and Resident #245 would not have to negotiate stairs to gain entry to the home. The Director of Social Work stated the plan for the family to privately hire a family friend was not included in Resident #245's Discharge Instructions. The interdisciplinary team members from each department were responsible for filling out the Discharge Instructions to communicate the post-discharge needs of the resident. The Nursing staff were responsible for reviewing the Discharge Instructions with the resident and ensuring they were filled out with all the necessary information. If the resident and/or Resident Representative were not in agreement with a discharge plan, a Notice of Transfer/Discharge would be issued at least 30 days prior to the resident's discharge date . Resident #245's Representative wanted the resident to be discharged to the community. The Director of Social Work stated they could not recall Resident #245's Medicaid eligibility at the time of their discharge home but did recall there was an issue with Resident #245's finances.<br><br>On 1/14/2025 at 12:19 PM, the Administrator was interviewed and stated they did not recall the specific issues surrounding Resident #245's discharge to the community, Medicaid eligibility, or their financial status. The Administrator stated there was a payment issue but was unable to provide any documented evidence detailing Resident #245's financial issue at the time they were discharged from the facility.<br><br>(continued on next page) |

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|---|---|---|---|
| | 335365 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Nyack Ridge Rehabilitation and Nursing Center | 476 Christian Herald Road<br>Valley Cottage, NY 10989 |

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

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10 NYCRR 415.11(d)(1)(2) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>51214<br><br>Based on interviews and record review during the Recertification and abbreviated (NY00339429) surveys from 1/6-1/14/2025, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 30 residents reviewed for quality of care (Resident #107). Specifically, Resident #107 did not receive their eye drops as ordered by the physician after and prior to their cataract surgeries.<br><br>Findings include:<br><br>Resident #107 had diagnoses including Dry Eye Syndrome, Edema (swelling) of unspecified eye, and Diabetic Cataracts. The Quarterly Minimum Data Set (assessment tool) dated 10/25/24 documented the resident had intact cognition, moderately impaired vision, and no behaviors.<br><br>A nursing note dated 4/1/24 at 1:13 PM, documented the resident would have cataract surgery on 4/10/24 on the right eye. Post operative orders included prednisolone drops 4 times a day for 4 weeks, then 3 times a day for 1 week, then 2 times a day for 1 week, then 1 time a day for 1 week. The first follow-up appointment was scheduled for 4/11/24.<br><br>The physician telephone order dated 4/1/24 documented prednisolone sodium phosphate eye drops to the right eye 4 times per day for 4 weeks post operative.<br><br>A nursing note dated 4/10/24 documented at 5:45 PM the resident returned from cataract surgery to the right eye, the physician was notified of resident's return and the resident was to follow-up with the ophthalmologist on 4/11/24.<br><br>Review of the April 2024 Medication Administration Record revealed the prednisolone eye drops were to be started on 4/10/24 at 5:00 PM, however the eye drops were documented as refused at 5:00 PM and 9:00 PM on 4/10/24.<br><br>A nursing progress note dated 4/11/24 at 6:26 PM, documented prednisolone 1% phosphate was not available, and the order was changed to phosphate acetate 1% drops.<br><br>A physician order dated 4/11/24 documented prednisolone acetate 1 % eye drops suspension, instill 1 drop in right eye 3 times per day for 1 week. Review of the April 2024 Medication Administration Record revealed prednisolone acetate eye drops to the right eye with a start date and time of 4/11/24 at 1:56 PM, however the first dose was documented as given on 4/12/24 at 9:00 AM.<br><br>A nursing progress note dated 4/12/24 at 3:04 PM, by the medication nurse, documented the resident was given all morning medications at 8:30 AM except for the eye drops that were due at 9:00 AM. Around 10:30 AM, the resident was upset that the eye drops had not been given, and they were administered at 10:30 AM with the Registered Nurse Supervisor present. At 12:30 PM, the resident refused to take the eye drop scheduled for 1 PM.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician order dated 4/12/24 documented ciprofloxacin 0.3 % eye drops, instill 1 drop in left eye 4 times per day for 3 days. Start ciprofloxacin in the left eye for 3 days before cataract surgery 4/21, 4/22, and 4/23/24.<br><br>Review of the April 2024 MAR revealed the ciprofloxacin eye drops for the left eye were started on 4/12/24 and not 3 days prior to left eye surgery scheduled for 4/24/24.<br><br>A nursing note dated 4/24/24 at 2:55 PM, documented Resident #107 returned from cataract surgery.<br><br>During an interview on 1/14/25 at 10:32 AM, Resident #107 stated that after their cataract surgeries they did not always get their drops as scheduled. They stated that after the first surgery they had to wait to receive the first drops but could not recall details.<br><br>During an interview on 01/14/25 at 11:19 AM with the Director of Nursing, the April 2024 medication administration record for Resident #107 was reviewed. They stated on 4/11/24 the pharmacy contacted the facility about an alternate for the prednisolone drops delaying the first administration. On 4/12/24 the resident refused eye drops because they were administered too close together. The Director of Nursing stated the physician orders should be followed. They recalled some difficulty with resident at this time surrounding the cataract surgery and thought they had written a plan for nursing staff regarding the administration of eye drops but was unable to provide documentation.<br><br>10NYCRR 415.12 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>49364<br><br>Based on interview and record review conducted during the Recertification and abbreviated surveys (NY00348193) from 01/06/25 to 01/14/25, the facility did not ensure that sufficient nursing staff was consistently provided to meet the needs of residents on all shifts. Specifically, 1) multiple residents reported during the Resident Council Group meeting that the facility was short staffed and did not have sufficient nursing staff to care for the residents, there was a lack of timely staff response to call bells, 2) several nursing staff members reported working double shifts on the weekends; and 3) analysis of the actual staffing schedule showed that on multiple occasions from December 6, 2024 through January 6 2025, the facility was below the minimum levels documented on the Facility Assessment.<br><br>Findings include:<br><br>The facility assessment titled Facility Review/ Input revised July 5, 2024, documented nursing staff ratios in long-term care and short-term care (subacute) units for the day shift 1 nurse for 20 residents, evening shift 1 nurse for 20 residents, and night shift 1 nurse for 32 residents. Long term care and short-term care (subacute) units for the day shift of direct care staff of 1 certified nurse aide for 8 residents, evening shift 1 certified nurse aide for 10 residents, and night shift 1 certified nurse aide for 15 residents.<br><br>The facility daily staffing sheets from December 6, 2024, through January 06, 2025, and the Facility Assessment for resident to staff ratios, revealed the facility was understaffed 30 of 30 days on all shifts 7 AM- 3 PM, 3 PM-11 PM, and 11 PM- 7 AM shift.<br><br>During an interview on 1/07/25 at 8:12 AM, Resident #249's family member stated they lost tract of how many times they found the resident's brief saturated with urine.<br><br>During a Resident Council Group meeting on 1/07/25 at 1:33 PM, with 16 residents in attendance, several residents stated the facility did not have sufficient nursing staff to care for them. Resident #15 state they rang their call bell, it was answered at the desk using the speaker to the room, they requested pain medication at 8 AM and no one came to their room until 11 AM.<br><br>During an interview on 1/10/25 at 8:30 AM, Resident #111's family member stated most times when they came to visit the resident, they found their bed linen saturated with urine and reported it to the nurse manager.<br><br>During an interview on 1/10/25 at 1:41 PM, Certified Nurse Aide #30 stated they worked overtime for the facility every other weekend and when the staff was out sick.<br><br>During an interview on 1/10/25 at 1:45 PM, Licensed Practical Nurse #35 stated they worked overtime on the weekends to help the facility when they were short staffed.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/14/25 at 8:46 AM, the Human Resources/ Staffing Coordinator stated the facility used 3 staffing agencies for nursing staff on an as needed basis to fill call outs and open shifts. They stated the nursing schedule was done at least before the start of the month. They stated any open shifts were offered to the nursing staff on duty first, then the staffing agencies for as needed staff coverage. They stated the certified nurse aides and nurses did 1 to 3 overtime shifts per week. They stated the facility was short staffed for the 7-3 shift, and the facility needed certified nurse aides, licensed practical nurses, and registered nurses on the 7 AM-3 PM shift. They stated the 3-11 and 11-7 shift did not have a staffing problem, only if there were canceled shifts and then had difficulty filling the open shifts.<br><br>During an interview on 1/14/25 at 9:48 AM, with the Director of Nursing stated the facility had staffing challenges, and they were having conversation with upper management. They stated they were working on recruitment and retention of the nursing staff.<br><br>10 NYCRR 415.13(a)(1) (i-iii) |