STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335365	A. Building 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 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.

(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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on observation, interview, and record review during the Recertification survey from 01/06/2025 through 01/14/2025, the facility did not ensure residents had the right to a dignified dining experience for 3 of 30 residents (Residents #48, #345, and # 30) reviewed for dignity while dining. Specifically, facility staff were observed standing over Residents #48, #345 and #30 while assisting the residents with their meals. The findings include: The facility policy titled Resident [NAME] of Rights revised date 4/2023, documented residents are treated with consideration, respect, and full recognition of their dignity and individually, including privacy in treatment in care of their personal needs. The facility policy titled Assistance with feeding updated 10/2024, documented the facility staff will serve resident trays and will help residents who require assistance with eating. Resident who cannot feed themselves will be fed with attention to safety, comfort, and dignity. Staff should not stand over residents while assisting them with meals. 1) Resident #48 was admitted to the facility with diagnoses including seizures, schizoaffective disorder, and dysphagia (difficulty swallowing). The 12/06/2024 admission Minimum Data Set (an assessment tool) documented Resident #48 had severely impaired cognition and required assistance from staff with their activities of daily living including eating. During an observation on 01/06/25 at 12:30 PM, Resident #48 was sitting at the table with their tablemates and Certified Nurse Aide # 28 was standing over the resident while feeding them their lunch meal. 2) Resident #345 was admitted to the facility with diagnoses including neurogenic bladder, muscle weakness, and malnutrition. The 12/12/24 Discharge Minimum Data Set Assessment (a resident assessment tool) documented the Resident #345 had severely impaired cognition, was dependent on staff for eating. (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 - Few	During an observation on 1/6/25 at 1:13 PM, Certified Nurse Aide #28 was observed standing over Resident #345 while assisting the resident with their meal. During an interview on 01/13/2024 at 10:57 AM, Certified Nurse Aide #28 stated they knew they should have been seated when feeding the residents. They stated they were multitasking, and the facility was short staffed. 40686 3) Resident #30 had diagnoses including vascular dementia, anxiety, and restlessness. The Minimum Data Set assessment dated [DATE] documented Resident #30 was severely cognitively impaired and required a helper's physical assistance when eating. During an observation on 1/06/2025 at 5:46 PM, Resident #30 was in their recliner in their room during dinner service. Certified Nurse Aide #22 placed Resident #30's meal tray on a overbed table and positioned the table next to Resident #30's recliner. Certified Nurse Aide #22 stood next to the overbed table, faced the door to the resident's room, and began spoonfeeding Resident #30 without making eye contact. Certified Nurse Aide #22 stopped feeding Resident #30 in the middle of their meal and stated they should have been sitting down to feed the resident. Certified Nurse Aide #22 then stated they were going to find a chair to sit next to Resident #30 and exited the room. During an interview on 1/14/2025 at 10:30 AM, Nurse Educator/ Infection Control Preventionist stated the staff should be sitting closely and facing the residents when assisting them with their meals to look for signs of aspiration, choking and that the resident is alert to swallow and chew their meals well. 10 NYCRR 415.3 (d)(1)(i) 49255

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the Recertification survey from 11/6/2025 to 1/14/2025, the facility did not ensure a resident was provided with notice of changes in Medicare coverage of items and services. This was evident for 1 (Resident #118) of 3 residents reviewed for skilled nursing facility beneficiary notification. Specifically, Resident #118 was provided a written Notice of Medicare Non-coverage and Advanced Beneficiary Notice of Non-coverage despite the resident's inability to understand the content of the notices. The findings are: The facility policy titled Notice of Covered and Non-Covered Services dated 2024 documented if changes in coverage are made to items and services covered by Medicare, residents are notified in writing as soon as possible. Resident #118 had diagnoses including dementia and psychotic disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #118's family participated in the assessment and was an information source for questions. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #118 was moderately cognitively impaired. A Notice of Medicare Non-Coverage dated 12/26/2024 documented Resident #118 began Medicare covered physical and occupational therapy on 10/2/2024 and their last covered day for these services was 12/30/2024. The Notice documented detailed instructions to appeal the change in Medicare coverage. Refused to sign was documented under Signature of Patient or Representative. An Advanced Beneficiary Notice of Non-coverage dated 12/26/2024 documented Resident #118 would have to pay out-of-pocket for care at a rate of $421.86 daily. The Notice listed options for Resident #118 to either continue or cease receiving skilled care, and whether to continue or stop billing Medicare for services. None of the options listed were chosen and Resident refused to sign was documented under Signature of Patient or Representative. The Social Work Note dated 12/26/2024 documented Resident #118 and their daughter were made aware that Medicare coverage would cease on 12/30/2024 and Resident #118 had until 12/29/2024 to appeal this decision. Resident #118 and the daughter would not appeal Medicare's decision. On 1/06/2025 at 9:41 AM, Resident #118 was observed seated in a wheelchair at the doorway to their room. Resident #118 repetitiously and persistently asked out loud to all passersby, Where do I go? What do I do? Attempts to engage Resident #118 in dialogue were unsuccessful with Resident #118's attention, concentration, and thought process remained disorganized. Resident #118 was not oriented to place or time. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/2025 at 11:13 AM, the Social Work Assistant was interviewed and stated they were responsible for providing the Notice of Medicare Non-Coverage and Advanced Beneficiary Notice of Non-coverage to residents when there were changes in Medicare coverage for their skilled services and confirmed that they provided both notices to Resident #118 on 12/26/2024. Resident #118 was confused and became upset when informed physical and occupational therapy was ending. The Social Work Assistant stated the Resident #118 then refused to sign the notices of non-coverage. Resident #118 was moderately cognitively impaired. The Social Work Assistant stated they usually contacted and explained the notices of non-coverage to the family or representative of residents as cognitively impaired as Resident #118 because the resident would not be able to understand or make choices regarding the change in their Medicare insurance. Resident #118 would not be able to make the phone call necessary to request an appeal of the notice of non-coverage. The Social Work Assistant stated they were unable to reach Resident #118's daughter via telephone and the Social Work Progress note dated 12/26/2024 documented incorrect information. The Social Work Assistant stated they never spoke directly to Resident #118's daughter regarding the change in the resident's Medicare coverage and needed to revise the Social Work Note to reflect that they left Resident #188's daughter a voicemail message. The Notice of Medicare Non-Coverage and Advanced Beneficiary Protection Notice were not mailed to Resident #118's daughter to ensure they were provided with the notices in writing. On 1/13/2025 at 11:48 AM, the Director of Social Work was interviewed and stated Resident #118 was moderately cognitively impaired, the Medicare non-coverage notices should not have been presented to the resident for signature, and the notices should have been sent to Resident #118's daughter instead. Resident #118 would not be able to understand and navigate the content of the notices. The Social Work Department usually mailed out the notices and kept a copy of the stamped envelope as evidence. The facility did not use certified mail to confirm notices were delivered to the intended recipient. 10 NYCRR 415.3(d-f)

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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** 40686 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. The findings are: 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. 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. 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. 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 : - 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. - 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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. - 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. - 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. - 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. - 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. - room [ROOM NUMBER] had a bathroom with a soiled tub, multiple missing wall tiles, and a crack along the painted part of the wall. - 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. - 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. - room [ROOM NUMBER] had a window with a linear crack spanning from one corner to the opposite side of the windowpane. On 1/08/2025 at 3:29 PM, Resident #79 was interviewed and stated the room appeared shabby and gloomy. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.5(h-i)(1-3) 49255

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51214 Based on interviews and record review during the Recertification Survey from 1/6-1/14/2025, the facility did not ensure that residents were aware of the grievance process or that they were notified of their right to, and process of, filing a grievance with the facility or independent entities through postings in prominent locations throughout the facility. Specifically, 16 of 16 residents in attendance at the Resident Council meeting were not aware of the grievance filing process. In addition, signage for the grievance process, ombudsman contact information, and Complaint hotline was not found throughout the facility for resident view. The Facility Grievance Policy last reviewed 10/2021 documented that the facility will provide a mechanism for filing a grievance. Residents will be informed orally and in writing of their right to make complaints. Resident Council will review the grievance process at Resident Council on an annual basis and as needed. Grievance may be given to any staff member who will forward it to the Grievance Official. Resident Council minutes for October, November, and December 2024 were reviewed and showed no evidence of review of the grievance process with its members. During the Resident Council meeting on 01/07/25 at 1:33 PM, 16 of 16 residents in attendance stated they did not know how to file a grievance. During an observation on 1/8/25 at 9:00 AM, on Unit 2 the Ombudsman information was observed posted on the unit information board in Spanish only. There was no other information posted on the Grievance process, the Complaint Hotline, or how to find the New York State Survey results. During an observation on 1/8/25 at 9:05 AM, on Unit 3 the Ombudsman information was observed posted on the unit information board in Spanish only. There was no information posted on the Grievance process. During an interview on 01/08/25 at 11:34 AM, Registered Nurse #37 stated that if a resident had a complaint, they would inform the Supervisor/Unit Manager and the Social Worker, then document it in the progress notes. They were not aware of any form for residents to complete for grievances. During an interview on 01/08/25 at 11:37 AM, Licensed Practical Nurse #10 stated they would inform the Supervisor if there were a complaint. They stated they may report it to the specific department as well, for example laundry or maintenance. They were not aware of any forms that the residents completed for grievances. During an interview on 01/08/25 at 11:54 AM, Certified Nurse Aide #5 stated if a resident had a complaint, they would report it to a nurse or supervisor. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 11:56 AM, Nurse Manager #1 stated they would contact the department responsible for handling the complaint, for example laundry or maintenance. If the issue was not resolved quickly, they would complete a grievance form and give it to Social Services. They stated that grievance forms could be distributed to residents by any staff member and were at the nurses station. They stated Supervisors typically completed the form with the residents. During an interview on 01/08/25 at 4:03 PM, the Director of Social Services stated that they were the Grievance Officer. They stated that the floor staff reported a lot of grievances verbally, however grievance forms were on each unit in the social service binder. They stated staff would notify the supervisor if there was a grievance and then the supervisor would complete the grievance form with the resident. They stated residents were not told individually about the grievance process so they might not know about the form or process specifically. They stated they were confident that the residents knew who to speak to if they had a complaint. The Director of Social Services stated they would update the information boards to include the Grievance Process, Ombudsman, Complaint Hotline information, and where to find the New York State Survey results, as they should be on each unit and throughout the facility. 10NYCRR 415.3(d)(1)(i)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the Recertification survey from 1/6/2025 to 1/14/2025, the facility did not ensure a resident was free from physical restraints imposed for convenience and not required to treat the resident's medical symptoms. This was evident for 1 (Resident #25) of 3 residents reviewed for falls. Specifically, Resident #25 was observed with a concave mattress in place to reduce the resident's fall risk by preventing the resident from getting out of bed. The findings are: The facility policy titled Use of Restraints dated 11/2024 documented physical restraints are defined as devices or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, and which restricts freedom of movement. Restraints may only be used when the resident has a specific medical symptom that cannot be addressed by another less restrictive interventions and treats a medical symptom and protects the resident's safety and helps the resident attain their highest physical wellbeing. Resident #25 had diagnoses of schizophrenia, bipolar disorder, and chronic obstructive pulmonary disease. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #25 had a significant change in condition, mild cognitive impairment, no behavior, no restraint use, 1 fall with no injury since last assessment, weighed 115 pounds with no significant weight loss or gain, was edentulous, 2 unstageable pressure injuries present upon admission/reentry to facility, used a pressure reducing device for the chair and bed, received pressure ulcer care, required partial to moderate assistance with eating, and was totally dependent on assistance of 1 to 2 people for transfers from bed to chair. The Comprehensive Care Plan related to cognitive deficits initiated 11/29/2022 and last reviewed 11/15/2024 documented Resident #25 had altered mental status and should be given instruction one at a time, approached warmly, offered simple choices, and engaged in appropriate conversation. The Comprehensive Care Plan related to high risk for falls initiated 10/4/2022 documented Resident #25 had 8 falls since 1/2024 - 6 falls from the wheelchair, 1 fall while being transferred, and 1 fall from the bed. Interventions to prevent falls included maintaining the bed at the lowest position, providing education on safety, reality orientation, rehab referral, anticipating resident's needs, referral to psychiatry, maintaining a clutter-free environment, medical workup, referral to social service, referral to physical and occupational therapy for wheelchair positioning and evaluation of current bed. An air mattress with wings (concave mattress) was requested on 11/3/2024. The Comprehensive Care Plan related to seizure disorder (epilepsy) documented Resident #25 did not have any seizure activity from 12/5/2022 through last review dated 10/29/2024. There was no documented evidence of a Physician's Order for Resident #25 to have a concave mattress. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Work Note dated 12/14/2024 documented Resident #25 had a Brief Interview for Mental Status score of 5, indicating severe cognitive impairment. The Certified Nursing Assistant Accountability Record for January 2025 documented Resident #25 was a fall risk. On 1/06/2025 at 11:00 AM and 1/08/2025 at 11:53 AM, Resident #25 was observed asleep in their bed. Resident #25 was observed surrounded by the raised perimeter of a concave mattress. Resident #25 was again observed in bed with a concave mattress in use on 1/10/2025 at 5:25 PM. On 1/10/2025 at 5:41 PM, Certified Nursing Assistant #24 was interviewed and stated, even though they did not know what kind of mattress Resident #25 currently had, Certified Nursing Assistant #25 was happy the concave mattress was there because Resident #25 no longer attempted to get out of the bed. Certified Nursing Assistant #24 stated Resident #25 previously was able to swing their legs over the side of the bed and was at risk for falls before the concave mattress was used. On 1/10/2025 at 6:10 PM, Registered Nurse #25, the evening supervisor for both floors, stated preventing falls included visual checks by staff and their bed should be in the lowest position. The Certified Nursing Assistant was responsible for ensuring Resident #25's needs were met because unmet needs placed the resident at higher risk for falls. The facility did not use restraints as a fall-prevention intervention. Resident #25 had a concave mattress to prevent them from falling. The concave mattress was a safety precaution. The resident and their family needed to consent for the concave mattress and an interdisciplinary team decided when a concave mattress was a necessary intervention. Registered Nurse #25 stated there were 2 other residents in the facility with concave mattresses in place to prevent falls. The concave mattress was effective because Resident #25 liked to lean on their side, and it prevented the resident from falling on the floor. On 1/14/2025 at 12:47 PM, the Director of Nursing was interviewed and stated the concave mattress was not a restraint and was used to make residents aware of their bed boundaries and was used for residents who frequently fell . The interdisciplinary team discussed fall incidents, and the nursing staff decided when a concave mattress was necessary. Nursing recommended and implemented fall-prevention interventions for residents who frequently fell . 10 NYCRR 415.4(a) (2-7)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 44673 Based on record reviews and interviews conducted during the Recertification Survey from 1/6/25 to 1/14/25, the facility did not ensure that all completed resident assessments were submitted and transmitted into the Quality Improvement Evaluation Assessment Submission and Processing in a timely manner. Specifically, 11 (Resident #43, Resident #51, Resident #88, Resident #90, Resident #104, Resident #108, Resident #120, Resident #124, Resident #129 and Resident# 131) of 30 Minimum Data Set assessments submissions, reviewed were not submitted to the Centers for Medicaid and Medicare Services within 14 days of completion. The findings are: The facility's policy and procedure titled Minimum Data Set 3.0 Submission revised 1/2024 documented that each department was expected to complete their assigned responsibilities no later than 14 days from Assessment Reference date set by the facility Minimum Data Set Coordinator or designee for compliance with regulatory guidelines. Review of the submissions revealed: - Resident #51's quarterly Minimum Data Set 3.0, with assessment reference date of 11/1/24 and completion date of 11/14/24, was submitted on 1/5/25. - Resident #88's quarterly Minimum Data Set 3.0, with assessment reference date of 11/8/24 and completion date of 11/21/24, was submitted on 1/5/25. - Resident #90's discharge Minimum Data Set 3.0, with assessment reference date of 11/6/24 and completion date of 11/19/24, was submitted on 1/5/25. - Resident #99's entry track record Minimum Data Set 3.0, with assessment reference date of 11/18/24 and completion date of 11/22/2024, was submitted on 1/5/25. - Resident #104's quarterly Minimum Data Set 3.0, with assessment reference date of 11/8/24 and completion date of 11/21/24, was submitted on 1/5/25. - Resident #108's quarterly Minimum Data Set 3.0, with assessment reference date of 11/8/24 and completion date of 11/21/24, was submitted on 1/5/25. - Resident #120's quarterly Minimum Data Set 3.0, with assessment reference date of 11/1/24 and completion date of 11/14/24, was submitted on 1/5/25. - Resident #124's discharge Minimum Data Set 3.0, with assessment reference date of 11/5/24 and completion date of 11/18/24, was submitted on 1/5/25. - Resident #129's discharge Minimum Data Set 3.0, with assessment reference date of 11/4/24 and completion date of 11/15/24, was submitted on 1/5/25. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	- Resident #131's discharge Minimum Data Set 3.0, with assessment reference date of 11/9/24 and completion date of 11/21/24, was submitted as of 1/5/25. During an interview on 1/13/25 at 3:00 PM, the Minimum Data Set Coordinator stated that this was the first occurrence of this issue. The Minimum Data Set Coordinator further stated that the reason for the delay in submission of this batch of assessments was unknown. The Minimum Data Set Coordinator acknowledge responsibility for ensuring timely submission. During an interview on 1/14/25 at 10:55 AM, the Director of Nursing stated they were unaware of the delay in submitting the assessments. The Director of Nursing stated that the Minimum Data Set Coordinator was responsible for submitting the assessments. 10 NYCRR 415.11

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50816 Based on record review and interviews during the Recertification survey from 1/6/2025 to 1/14/2025, the facility did not ensure that a complete preadmission screening for individuals with a mental disorder was conducted. This was evident for 1 of 30 residents (Resident #86) reviewed for Preadmission Screening and Resident Review (PASRR). Specifically, the SCREEN DOH 695 form was incomplete and a determination of a resident's need for Level II services had not been documented. Answers to items 27, 28, 29 and 30 were not documented. The findings are: Resident # 86 was admitted from acute care hospital with diagnoses and conditions including but not limited to bipolar disorder, schizoaffective disorder and parkinsonism. The Policy on Resident Assessment -Coordination with PASRR Program dated 4/2024 documented the facility coordinates assessment with the preadmission screening and resident review (PASRR) program to ensure that individuals with serious mental illness and or individuals with intellectual disability/developmental disability, who apply or reside in Medicaid certified beds in a nursing home regardless of payor. During review of the SCREEN Form DOH-695 completed for Resident #86 dated 01/06/2023, the section Level 1 Review for Possible Mental Illness (MI), included Item #23 Does this person have a serious mental illness? Item #23 was checked YES. The guideline on the SCREEN form documented that if item 23 or any of item 24-26 were marked YES, proceed to Categorical Determination (items 27-30). Items 27-30 on the SCREEN form were not completed. During an interview on 01/08/25 at 01:41 PM, the Director of Social Services stated that they reviewed the screens for all residents prior to admission to the facility. During the interview, the Director of Social Services reviewed the Screen form for Resident #86 and stated questions #27, 28, 29 and 30 were not answered and they did not know why. The Director of Social Services stated they missed reviewing the PASRR SCREEN of Resident # 86 for Items 27, 28, 29 and 30 as they should have been answered. During an interview on 01/13/2025 at 11:43 AM, the Director of Nursing stated the Social Worker was in charge of reviewing the SCREEN before a decision was made to accept the resident. They stated that the SCREEN form for Resident #86, was not complete and should have been reviewed by the Social Worker. 10 NYCRR 415.11(e)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673 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. The finding is: 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. 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. 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. 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. 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. 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. Review of the electronic medical record revealed no documentation of a discharge summary. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. 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. 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. 2. Resident #247 was admitted with diagnoses of type 2 diabetes, depression, and generalized weakness. 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. 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. 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. 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. 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. Review of the discharge scripts dated 3/9/2024, documented the prescriptions were submitted electronically to the local pharmacy. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. 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. 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. 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. 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. 40686 3) Resident #245 had diagnoses of cerebral infarction and anxiety disorder. 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. 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. 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. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm 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. The Physiatry Note dated 11/8/2023 documented Resident #245 was a fall risk and had 2 falls within the last 12 months. 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. 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. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview and record review conducted during a Recertification survey from 1/6/2025 to 1/14/2025, the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote wound healing and prevent new ulcers from developing for 1 of 5 residents (Resident #25) reviewed for Pressure Ulcers. Specifically, Resident #25 did not receive pressure relieving devices to promote pressure ulcer healing in accordance with the Physician Order. The findings are: The facility policy titled Pressure Injury Assessment, Management, and Intervention dated 7/5/2024 documented pressure injury interventions included meticulous skin care, relieving pressure using positioning pillows, nutritional support, and care planning. Resident #25 had diagnoses of schizophrenia, pressure injuries, and chronic obstructive pulmonary disease. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #25 had a significant change in condition, mild cognitive impairment, 2 unstageable pressure injuries present upon admission/reentry to facility, used a pressure reducing device for the chair and bed, received pressure ulcer care, required partial to moderate assistance with eating, and was totally dependent on assistance of 1 to 2 people for transfers from bed to chair. The Comprehensive Care Plan related to skin integrity initiated 11/18/2024 documented Resident #25 had a deep tissue injury to their right and left heel from admission on 10/28/2024. Care plan note dated 12/18/2024 documented Resident #25's right heel wound was reclassified as a Stage 3 injury measuring 2 X 2 X .2 centimeter with moderate drainage and left heel wound measured 1.5 X 1 X 0 centimeter and had no drainage on 12/12/2024. Physician's Orders documented orders starting 11/3/2024 to place a pillow daily and as needed to offload Resident #25's bilateral heels. On 11/12/2024, orders were placed for skin prep to Resident #25's left heel daily and as needed. Treatment orders were initiated 11/27/2024 for Santyl ointment to Resident #25's right heel daily and as needed. On 1/3/2025, Resident #25's right heel was ordered to be cleansed with normal saline, treated with Silvadene 1% topical cream, and covered with dry protective dressing daily and as needed to address deep tissue damage. On 1/10/2025, an order was placed for Resident #25's left to be cleansed with normal saline, treated with Medi- Honey 100% topical paste, and covered with sterile gauze protective dressing daily and as needed to address pressure-induced deep tissue damage. The Wound Nurse Note dated 11/2/2024 documented Resident #25 had deep tissue injuries to bilateral heels that were fluid-filled and present upon readmission to the facility. Resident #25 refused to wear heel booties, and a pillow was placed under their legs instead to offload their heels. The Nurse Practitioner Note dated 12/4/2024 documented Resident #25 was confused, exhibited generalized weakness, declined in mobility, and needed assistance. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Nurse Note dated 12/12/2024 documented Resident #25's right heel deep tissue injury was reclassified as a Stage 3 pressure ulcer treated with Santyl ointment daily and as needed. Resident #25's left heel deep tissue injury received daily application of skin prep. Pillow placed under both legs for heel off-loading and air mattress was in place. The Certified Nursing Assistant Accountability Record for January 2025 documented Resident #25 required skin checks every shift to monitor pressure areas. On 1/06/2025 at 11:00 AM and 1/08/2025 at 11:53 AM, Resident #25 was observed asleep in their bed. Resident #25 did not have a pillow offloading their heels. On 1/10/2025 at 5:25 PM, Resident #25 was observed alert in bed with their meal tray in front of them. No offloading pillow was observed under Resident #25's legs. On 1/10/2025 at 5:41 PM, Certified Nursing Assistant #24 was interviewed and stated Resident #25 was readmitted from the hospital with bandages on their heels. Certified Nursing Assistant #25 stated they did not know about where to check for instructions on how to care for residents and relied on the nurses to give them verbal report on resident devices a resident needed. On 1/13/2025 at 3:22 PM, Licensed Practical Nurse #21 was interviewed and stated Resident #25 had bilateral heel pressure ulcers and had a Physician Order to offload bilateral heels with a pillow. There should be a pillow under Resident #25's legs at all times while the resident was in bed. On 1/13/2025 at 3:38 PM, the Wound Care Nurse entered Resident #25's room to provide wound care and observed Resident #25 without a pillow under their legs. The Wound Care Nurse stated Resident #25 should have a pillow under their legs to offload both their heels. The Wound Care Nurse checked Resident #25's surrounding area and closet and was unable to find a pillow. The Wound Care Nurse left the room and returned and stated they requested for nursing staff on the unit to find a pillow for Resident #25 to offload their heels. 10 NYCRR 415.12(c)(1-2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 1/6/2025 to 1/14/2025, the facility did not ensure a resident remained free of accident hazards. This was evident for 1 (Resident #44) of 5 residents reviewed for accidents. Specifically, Resident #44 was fed a mechanically altered diet by unqualified and unsupervised staff. The findings are: The facility policy titled Activities of Daily Living dated 4/2024 documented appropriate care and services will be provided for residents including support and assistance with dining. The facility policy titled Nutritional assessment dated ,d+[DATE] documented as part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process to help define meaningful interventions for a resident at risk for or with impaired nutrition. The facility Job Description for Transport Aide documented the Transportation Aide was responsible for the safe and timely transportation of residents to and from appointments and other destinations, and able to perform duties not only limited to transportation as guided by the Supervisor/Manager. There was no documented evidence the Transportation Aide received the necessary training or was responsible for feeding residents. The facility Job Description for Licensed Practical Nurse documented the Licensed Practical Nurse, when designated as Charge Nurse, assures oversight of meal delivery and consumption. Resident #44 had diagnoses including dementia, seizures, and vomiting. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #44 was severely cognitively impaired, was totally dependent on staff for eating, did not have a swallowing disorder, and was on a mechanically altered diet. The Comprehensive Care Plan related to nutritional status initiated 10/12/2022, and last updated 11/25/2024, documented Resident #44 was at risk for malnutrition and received a mechanically altered diet. Nursing, Dietary, and Medical staff were responsible for providing Resident #44 assistance with meals. Care plan note dated 10/23/2024 documented Resident #44 weighed 140.6 pounds. On 11/25/2024, the care plan notes documented Resident #44 weighed 132.6 pounds, amounting to a 5.69% weight loss in 1 month. The Comprehensive Care Plan related to activities of daily living initiated 10/15/2022, and last reviewed 5/2/2024, documented Resident #44 required limited assistance of 1 person for eating. On 3/3/2024, the care plan documented Resident #44 was able to feed themselves with supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Speech Therapy Evaluation dated 8/13/2024 documented Resident #44 was diagnosed with dysphagia (difficulty swallowing), had difficulty tolerating a chopped diet, and was downgraded to ground solids. Resident #44 required close supervision for oral intake and caregivers would feed Resident #44 using safe meal management strategies. The Medical Doctor Orders dated 12/16/2024 documented Resident #44 was on aspiration precautions and required 1-to-1 assist with meals. On 1/10/2025, Resident #44 was ordered a pureed diet with thin liquids and ground sandwiches with no crusts. The Certified Nursing Assistant Tasks as of 1/13/2025 documented Resident #44 was on aspiration precautions and a chopped diet with thin liquids. There was no documented evidence Resident #44's assigned Certified Nursing Assistant was aware the resident's meals were downgraded to pureed consistency and the resident needed 1-to-1 feeding assistance with meals. On 1/06/2025 at 4:59 PM, the 3rd Floor Dayroom was observed with several residents already served their dinner meal. Resident #44 was seated at a table alone with a tray in front of them. Transporter #23 , Certified Nursing Assistant #44, and Certified Nursing Assistant #45, were in the dayroom serving residents their trays. There were 2 residents being fed by the Certified Nursing Assistants, 10 residents that had been served their trays, and 3 residents actively eating. Resident #44 sat in their recliner and looked at their food. There was no Licensed Practical Nurse or Registered Nurse supervising the 3rd Floor Dayroom while residents ate. The suction machine was against the wall, covered, and unplugged. Transporter #23 sat down next to Resident #44, uncovered the resident's meal tray, and began to setup their liquid nourishments and utensils. Transporter #23 was observed placing a fortified milkshake carton with a straw up to Resident #44's mouth. Transporter #23 placed the shake back onto Resident #44's tray and used a spoon to scoop up mashed potatoes. Transporter #23 inserted the spoon into Resident #44's mouth and removed the spoon with approximately half of the mashed potatoes remaining on the spoon. Transporter #23 performed the same actions with the pureed vegetables on Resident #44's tray. There was no documented evidence Transporter #23 received the required feeding assistance training and Resident #44 received adequate supervision by licensed nursing staff to prevent aspiration during mealtime. On 1/13/2025 at 2:31 PM, Transporter #23 was interviewed and stated they were hired by the facility approximately 4 months ago and their job responsibilities as a transporter included transporting residents to and from different areas of the facility and to and from clinic appointments outside of the facility and did not include feeding residents. Transporter #23 stated they did not possess the credentials to be a Certified Nursing Assistant or paid feeding assistant training requirements to feed residents with swallowing impairments who require mechanically altered diets. Transporter #23 stated they fed Resident #44 during dinner on 1/6/2025 because they were alone in the 3rd Floor Dayroom and there were no other nursing staff available or present to provide the resident with eating assistance. Feeding Resident #44 without the required training and certification placed the resident at risk for aspiration because they received a pureed diet. Transporter #23 confirmed residents were eating for the first 30 minutes of their meal without the presence or supervision of a Licensed Practical Nurse or Registered Nurse. After the incident, Transporter #23 stated they received a verbal warning from the Inservice Coordinator. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 at 12:21 PM, the Director of Nursing was interviewed and stated the Registered Nurse Managers were responsible for filling out and updating the Certified Nursing Assistant Task sheets on the units and overseeing the Certified Nursing Assistants to ensure they assist residents with activities of daily living. The Registered Nurse Manager was also responsible for supervising the Floor Dayroom during resident meals. Transporter #23 should not have fed Resident #44 on 1/6/2025 and received inservice from the Inservice Coordinator. The Registered Nurse Manager on the 1/6/2025 day shift was scheduled to stay a few hours longer than their normal shift to supervise dinner on the 3rd Floor. The Registered Nurse Manager left the facility without informing anyone and subsequently resigned. 10 NYCRR 415.12(h)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the Recertification survey from 1/6/2025 to 1/14/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status. This was evident for 2 (Resident #80 and #25) of 8 residents reviewed for Nutrition. Specifically, 1) interventions were not identified, implemented, monitored, and modified to prevent and address Resident #80's significant weight loss, and 2) interventions were not identified, implemented, monitored, and modified to prevent and address Resident #25's significant weight loss. The findings are: The facility policy titled Nutritional assessment dated ,d+[DATE] documented the nutritional assessment includes gathering data to help define meaningful interventions for a resident at risk for impaired nutrition. The multidisciplinary team will identify the resident's usual body weight, current body weight, description of intake and appetite, preferences, medication regimen, clinical conditions, and cognitive or functional decline. 1) Resident #80 had diagnoses of dementia and osteoarthritis. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #80 was severely cognitively impaired, required supervision or touching assistance with eating, did not display signs and symptoms of a swallowing disorder, and had no dental issues. Resident #80 weighed 88 pounds at the time of the assessment and had a significant weight loss of 5% or more in 1 month or 10% or more in 6 months. Resident #80 was not on a physician-prescribed weight loss and received a mechanically altered diet consistency. The Comprehensive Care Plan related to cognitive deficits and dementia initiated 10/19/2022 and last reviewed 12/13/2024 documented Resident #80 required one instruction at a time. The Comprehensive Care Plan related to nutritional status initiated 11/1/2022 documented the following interventions to address Resident #90's risk for weight loss and malnutrition as of 11/28/2022: weight per Physician Order, 8-ounce double strength supplement three times daily in between meals, magic cup twice daily, milkshake three times daily with meal, and sandwich with lunch and dinner, monitor food and fluid intake, and provide assistance with meals. The Comprehensive Care Plan related to activities of daily living initiated 12/19/2022 and last reviewed 4/15/2024 documented Resident #80 required setup help only and limited assistance with eating. Physician's Orders documented Resident #80 was ordered 8-ounce double strength supplement three times daily in between meals as of 2/12/2024, regular chopped consistency diet as of 4/10/2024, and vital signs (including weights) monthly. The Dietary Note dated 7/14/2024 documented Resident #80 weighed 104.6 pounds and was consuming their meals in the Reflection Group. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Note dated 9/30/2024 documented Resident #80 weighed 89.6 pounds. The resident's meal intake was reported as good and to continue plan of care. The Clinical Monitoring Report documented Resident #80 weighed 94.8 pounds on 10/17/2024. The Dietary Note dated 12/24/2024 documented Resident #80 was receiving chopped consistency diet and 8-ounce double strength supplement three times daily in between meals. Resident #80's weight was slightly down and weighed 88.2 pounds as of 12/6/2024. Continue plan of care. The Medical Doctor Note dated 12/28/2024 documented Resident #80's weight had been stable for the last 4 months. The Nurse Practitioner Note dated 1/4/2025 documented Resident #80 had a fair appetite and required much encouragement to eat. The Clinical Monitoring Report documented Resident #80 weighed 88.4 pounds on 1/7/2025. The Certified Nursing Assistant Accountability Record for January 2025 documented Resident #80 had poor intake and was a feeder that needed assistance with eating. The record only documented Resident #80's meal consumption percentage on 9 out of 27 opportunities between 1/1/2025 and 1/9/2025. There was no documented evidence Resident #80's nutrition care plan was reassessed by the interdisciplinary team to develop alternate or additional interventions to address Resident #80's significant weight loss of 15.68 % from 7/14/2024 to 1/7/2025. There was no documented evidence Resident #80's plan of care adequately determined the number of calories, ideal body weight, and ensured adequate monitoring to ensure accurate and complete food intake and frequent weights were recorded. During an observation on 1/6/2025 at 12:01 PM, Resident #80 was served their lunch tray and stared quietly at the food without grabbing any of the utensils on their tray to start to eat. Resident #80 appeared confused. Staff continued to hand out meal trays and feed other residents while Resident #80 sat with their tray. During an observation on 1/06/2025 at 5:28 PM, Resident #80 was seated at a table in the 3rd Floor Dayroom with their dinner tray in front of them. Resident #80 sat and stared confused at the meal on the plate and dipped their spoon into a 4-ounce container of ice cream. Resident #80 tasted the ice cream and did not eat any of the other items on the tray. Staff did not encourage Resident #80 to eat. Staff did not interact with Resident #80 during the meal service or provided physical assistance to cue Resident #80 on eating mechanics. During an observation on 1/08/2025 at 11:48 AM, Resident #80 was served lunch in the 3rd Floor Dayroom. Resident #80 sat at the table, staring at their meal and did not attempt to pick up utensils or eat any food on their tray. There were no observations of staff interventions to encourage or physically assist Resident #80 with consuming their meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/10/2025 at 5:02 PM, Resident #80 was placed at a table in the 3rd Floor Dayroom alone without any other residents and a meal tray containing mashed potatoes with gravy, cheese blintzes, and berry sauce was placed in front of them. Resident #80 stared at their tray, fidgeted with their utensils and straw, and appeared confused by the items in front of them. Resident #80 shrugged their shoulders, got up from the table, and began to wander throughout the dayroom while other residents were served their dinner. After several minutes, Licensed Practical Nurse #21 redirected Resident #80 to sit back down in front of their meal tray. Licensed Practical Nurse #21 began spoon-feeding Resident #80 after verbal encouragement was ineffective. On 1/13/2025 at 3:28 PM, Licensed Practical Nurse #21 was interviewed and stated Resident #80 required staff to physically assist them with eating. Resident #80 needed supervision during meals and needed to be spoon-fed by staff. Licensed Practical Nurse #21 stated they instructed Certified Nursing Assistants to feed Resident #80 if they were busy. Licensed Practical Nurse #21 stated they did not record Resident #80's percentage of meal consumption when they fed the resident and did not know where meal consumption records were documented. If a resident has been identified as a poor eater, the staff were instructed to feed them. The Dietician visited the unit in the morning and verbally communicated special instructions to the Nursing staff to address residents with significant weight loss. Resident #80 received Ensure supplements in between meals because they had poor meal consumption. On 1/14/2025 at 9:41 AM, the Dietician was interviewed and stated Resident #80 had a significant weight loss in 3/2024 and was ordered to receive nutritional supplements. Resident #80 was severely cognitively impaired and ate in the Reflection Group in the 3rd Floor Dayroom to ensure they were fed by staff and complete their meal. The Certified Nursing Assistants were supposed to provide Resident #80 with physical assistance to eat and encouragement to finish their meal. The Dietician state they visited the 3rd Floor Dayroom during mealtimes and did not notice the strong odor of urine and feces that permeated the room while residents ate. The Dietician stated that foul odors during mealtimes would not be a conducive environment for resident appetites and meal consumption. The Dietician stated Resident #80 was a tiny resident and they were not able to get Resident #80 to gain weight. 2) Resident #25 had diagnoses of schizophrenia, bipolar disorder, and chronic obstructive pulmonary disease. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #25 had a significant change in condition, mild cognitive impairment, weighed 115 pounds with no significant weight loss or gain, was edentulous. and required partial to moderate assistance with eating. The Comprehensive Care Plan related to cognitive deficits initiated 11/29/2022 and last reviewed 11/15/2024 documented Resident #25 had altered mental status and should be given instruction one at a time, approached warmly, offered simple choices, and engaged in appropriate conversation. The Comprehensive Care Plan related to nutritional status initiated 11/21/2022 and last reviewed 10/15/2024 documented Resident #25 received a mechanically altered diet and was at risk for malnutrition and weight loss due to a history of weight loss. Interventions, last updated 11/21/2022, documented Resident #25 be offered snacks between meals, assessed for weight loss, provided food preferences, a provided nutritional supplements such as 8-ounce double strength supplement three times daily in between meals and liquid protein twice daily. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Orders dated 10/31/2024 documented Resident #25 received 8-ounce double strength supplements three times daily in between meals and liquid protein supplement twice daily. The Mini Nutritional assessment dated [DATE] documented Resident #25 should receive double strength supplements because the resident was malnourished. The Clinical Monitoring Report documented Resident #25 weighed 113 pounds on 10/10/2024 and 10/15/2024 and weighed 114.8 pounds on 11/5/2024. The Nurse Practitioner Note dated 12/4/2024 documented Resident #25 was confused, exhibited generalized weakness, declined in mobility, and needed assistance. On 12/6/2024, the Clinical Monitoring Report documented Resident #25 weighed 97.4 pounds. The Nurse Practitioner Note dated 12/8/2024 documented Resident #25 had a significant weight loss from the previous month and required dietary management, nutritionist follow-up, and close monitoring. The Nurse Practitioner Note dated 12/29/2024 documented Resident #25 had a significant weight loss from the previous month and required dietary management, close follow-up with a nutritionist, and close monitoring. On 1/3/2025, the Clinical Monitoring Report documented Resident #25 weighed 98.6 pounds for a total significant weight loss of 14.11% between 11/5/2024 and 1/3/2025. The Certified Nursing Assistant Accountability Record for January 2025 documented Resident #25 required a soft/cut-up diet. There was no documented evidence Resident #25's nutritional approach, diet, preferences, and weights were reviewed upon significant weight loss between 11/5/2024 and 1/3/2025. There was no documented evidence the Dietician addressed Resident #25's nutrition care plan after 10/31/2024. On 1/06/2025 at 11:00 AM and 1/08/2025 at 11:53 AM, Resident #25 was observed asleep in their bed. On 1/10/2025 at 5:25 PM, Resident #25 was alert in bed with their meal tray in front of them. Resident #25 stated they were not happy with the meal and that it was more like dessert than dinner. The soup, diet cola, and coffee documented on Resident #25's meal ticket was not observed on the present meal tray. Certified Nursing Assistant #22 was asked to assist Resident #25 with their request for coffee. Certified Nursing Assistant #22 brought Resident #25 a cup of coffee and observed Resident #25 had eaten approximately 10% of their meal. Certified Nursing Assistant #22 asked Resident #25, Are you done? Resident #25 was not offered an alternative to the main dinner meal. Resident #25 stated they were unable to request an alternate to the main meal if they were unhappy with what was served. Resident #25 stated their preferences and requests were not honored, and they stopped asking staff for anything else to eat if they did not like the meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/2025 at 5:41 PM, Certified Nursing Assistant #24 was interviewed and stated Resident #25 was weak after being readmitted from the hospital and required assistance with eating their meals. At this time, Resident #25 no longer required physical assistance with meals. Certified Nursing Assistant #24 stated they recorded Resident #25's input and output in a logbook at the nursing station. Resident #25 had no difficulties with swallowing and the kitchen put all the menu items on the tray that the resident needed. Certified Nursing Assistant #24 stated they checked the name on the tray ticket when they delivered trays to residents and did not check the menu items to ensure residents received all the items listed on the meal ticket. Certified Nursing Assistant #24 stated Resident #24 received whole blintzes for dinner and was on a chopped diet, but the Dietician told the nursing staff that blintzes were soft enough for residents on different diet consistencies and did not need to be chopped or ground up. Resident #25 had a problem with chewing and their teeth, so the kitchen usually sent the resident mashed potatoes. On 1/14/2025 at 9:26 AM, the Dietician was interviewed and stated Resident #25 recently had a weight loss, but their weight was now stable. The Dietician stated they visited Resident #25 during lunch and provided the resident with a sandwich because the resident did not like their meal. The Dietician stated they were responsible for reviewing and revising the nutrition care plan quarterly and when there were changes in the resident's weight or condition. Residents were weighed monthly unless there was a weight loss, and they required closer monitoring with weekly weights. The Dietician stated they placed Resident #25 on weekly weight monitoring as of 1/6/2025. Resident #25 had a weight loss on 12/10/2024 and weighed 98.2 pounds. The Dietician stated they made rounds and visited with residents who had weight loss during mealtime, checked their preferences, and updated their tickets in the kitchen to reflect their preferences. The Dietician stated they also referred residents to the Medical Doctor and asked for labs to be done if a resident was experiencing weight loss. 10 NYCRR 415.12(j)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51214 Based on observation, interview, and record review conducted during the Recertification Survey from 1/6-1/14/2025, the facility did not ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for 2 of 3 residents (Resident #46 and Resident #107) reviewed for Respiratory Care. Specifically, 1) Resident #46 was provided oxygen 3 liters via nasal cannula with a physician order for 2 liters; and 2) Resident #107 was provided oxygen 3 liters via nasal cannula with a physician order for oxygen 2 liters. In addition, the nasal cannula and humidified water bottle for Resident #107 was not dated. The Findings include: The Facility Policy titled Oxygen Administration updated July 2024 documented that the purpose is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 1) Resident #107 had diagnoses including, hypertension (high blood pressure), wheezing, and cough. The Quarterly Minimum Data Set (assessment tool) dated 10/25/24 documented Resident #107 was cognitively intact, had shortness of breath when lying flat, and used oxygen. A Physician order renewed 10/29/24 documented to change nebulizer mask and oxygen tubing every Sunday on the 11 PM -7 AM shift. The Comprehensive Care Plan note dated 11/9/24 documented the resident continued on oxygen. The December 2024 Medication Administration Record had no documented evidence that tubing was changed since 12/8/24. A Physician order renewed 12/26/24 documented oxygen 2 liters via nasal cannula. During an observation on 1/06/25 at 9:58 AM, Resident #107 had oxygen 3 liters in use via nasal cannula. No date noted on nasal cannula tubing or water bottle for humidification. During observations on 1/07/25 at 12:13 PM, and 1/8/25 at 1:54 PM, Resident #107 was observed with oxygen 2 liters in use via nasal cannula, no date on nasal cannula tubing or water bottle for humidification. During an interview on 01/08/25 at 1:54 PM, Licensed Practical Nurse #10 stated the resident was on oxygen 2 liters via nasal cannula. They stated the nasal cannula tubing for Resident #107 was not dated and should have been changed and dated weekly. They stated they did not think the water bottles for humidification were dated because they were changed frequently. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/08/25 at 2:04 PM, the Assistant Director of Nursing stated that both the humidifying water bottles for the oxygen concentrators and the nasal cannula tubing should be dated when changed weekly. During an observation on 01/14/25 at 10:50 AM Resident #107 was observed with oxygen 2.5 liters in use via nasal cannula. 50816 2) Resident #46 had diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and Bipolar Disorder. The Physician Orders dated 10/8/2024 documented oxygen 2 Liters per nasal cannula as needed during ambulation and when in wheelchair every day at 7 AM - 3 PM; and Oxygen therapy at 2 liters per minute per nasal cannula when in bed until in the morning. The Quarterly Minimum Data Set (MDS; a resident assessment tool) of 12/06/2024 documented resident is cognitively intact and is on oxygen therapy. The Care plan on Respiratory disorder dated 12/27/2024 documented resident will have adequate gas exchange as manifested by oxygen saturation level greater than 90 %. Interventions included oxygen therapy as per physician order. During observations on 1/06/2025 at 10:25 AM, 11:53 AM and 2:59 PM Resident #46 was observed receiving oxygen therapy. The oxygen concentrator was observed at 3 Liters per minute. On 01/08/25 at 11:22 AM the resident was observed in bed receiving oxygen therapy and the oxygen concentrator was at 3 Liters per minute. During an interview on 1/08/25 at 11:30 AM, Licensed Practical Nurse #9 stated they checked the resident's order for oxygen therapy in the medical record. The Physician's order dated 10/8/24 documented oxygen therapy 2 Liters per minute per nasal cannula, when in bed until in the morning. The Physician's order dated 10/8/24 documented oxygen 2 Liters per nasal cannula during ambulation and when in wheelchair. Licensed Practical Nurse #9 checked the Treatment Administration Record and Medication Administration Record and stated that there was no documentation of oxygen therapy in both Treatment Administration Record and Medication Administration Record. They stated Oxygen therapy was supposed to be documented in the Treatment Administration Record. During an observation and interview on 1/08/25 at 11:51 AM, Licensed Practical Nurse #9 checked the flow regulator of the oxygen concentrator. Licensed Practical Nurse #9 stated the regulator was at 3 Liters. Licensed Practical Nurse #9 adjusted the regulator to 2 Liters. During an interview on 1/13/25 at 11:36 AM, the Director of Nursing stated that oxygen therapy was documented by nurses every shift on the Treatment Administration Record. During the interview, the Director of Nursing checked the resident's Treatment Administration Record and stated there was no documentation of oxygen therapy from October 2024 to January 13, 2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12(k)(7)

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F 0725 Level of Harm - Minimal harm or potential for actual harm 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. 49364 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. Findings include: 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm 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. 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. 10 NYCRR 415.13(a)(1) (i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49364 Based on interviews and review of the facility's records during the Recertification survey from 1/6/2025 through 1/14/2025, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months. Specifically, six of six randomly selected Certified Nurse Aides (#29, #30, #31, #32, #33, and #34) did not have a performance review documented at least once every 12 months. Findings include: Review of records provided by the facility on 1/7/2025 revealed Certified Nurse Aides #29, #30, #31, #32, #33, and #34 had been working at the facility for more than one year, their hire dates ranged from 2000 through 2018. During an interview on 1/7/2025 at 5:07 PM, the Human Resources/ Staffing Coordinator stated the Certified Nurse Aides' performance evaluations were not completed and they had a recent discussion with the Director of Nursing. During an interview on 1/08/25 at 11:00 AM, the Nurse Educator stated they conducted the mandatory in-services for the staff on the units and in the classroom. They stated the annual performance evaluations for Certified Nurse Aides were not done. They stated they had been in discussion with the Director of Nursing pertaining to the performance's evaluation. During an interview on 1/10/2025 at 1:41 PM, Certified Nurse Aide #30 stated they had worked at the facility since 2007 and the last time they had a performance evaluation was 2012. During an interview on 1/13/25 at 11:59 AM, with the Director of Nursing stated they recently had a discussion with Human Resources and the Nurse Educator related to the performance evaluations for the Certified Nurse Aides. They stated performance evaluations had not been done for a couple of years and some were done sporadically. They stated going forward they would be implementing the nursing staff performance evaluations again. 10 NYCRR 415.26 (c) (2) (iii)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conduced during the Recertification survey from 1/6/2025 to 1/14/2025, the facility did not ensure a resident diagnosed with dementia, received the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. This was evident for 1 (Resident #30) of 2 residents reviewed for Dementia Care and 1 (Resident #122) of 1 resident(s) reviewed for Activities. Specifically, 1) treatment of Resident #30's dementia and related behaviors did not include a person-centered individualized approach or meaningful activities to address the resident's customary routines and preferences, and 2) there was no evidence Resident #122's plan of care included meaningful activities that enhanced the resident's wellbeing. The findings are: The facility policy titled Dementia Care of Resident dated 2/2024 documented restlessness in people with dementia gets worse at the end of the day. Increase daytime activities, discourage inactivity and napping, turn on lights and minimize shadows to diminish confusion, and be aware that sleeping pills may solve one problem but cause more confusion the next day. The facility policy titled Reflection Group dated 9/2023 documented Nursing, Activities, and Social Service recommended residents for the reflection program based on cognitive deficits, ability to benefit from structured groups, and history of behaviors. Activities must be facilitated by dedicated staff who have been educated in caring for residents with cognitive deficits and familiar with dementia care practices. Activities include arts and crafts, light physical exercise, reminiscence therapy, games, and sensory stimulation. Activity planning should include input from residents and families. 1) Resident #30 had diagnoses of unspecified dementia and anxiety disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #30 was severely cognitively impaired, did not display any mood or behavior symptoms, found it very important to listen to music, be around animals, go outside for fresh air, and participate in religious services. Resident #30 also found it somewhat important to participate in their favorite activities and do things with groups of people. The Comprehensive Care Plan related to cognitive deficits initiated 10/28/2022 and last reviewed by the Director of Social Work on 11/7/2024 documented Resident #390 had altered thought process related to dementia and interventions included therapeutic activities. The Comprehensive Care Plan related to psychosocial wellbeing/inability to cope initiated 10/28/2022 and last reviewed by the Director of Social Work on 11/7/2024 documented Resident #30 was unable to cope with life's demands and aging process and had periods of restless behavior. Interventions included engaging Resident #30 in recreational activities after identifying their daily routines prior to admission. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan related to behavior symptoms initiated 11/12/2022 and last reviewed 11/22/2024 documented Resident #30 had a diagnosis of dementia without behavioral disturbance and exhibited restless behavior. Crawling, screaming, and physical agitation. Interventions included providing Resident #30 with a private room, social service evaluation, knee pads to bilateral knees to address behavior of crawling on the floor, and identifying a pattern of behavior. The Activities Note dated 11/2/2024 documented Resident #30 refused to attend group program. Staff offered music therapy, sensory hour, and ice cream day. The Weekly Behavior Note dated 12/20/2024 documented Resident #30 did not display any behaviors. The Weekly Behavior Note dared 12/27/2024 documented Resident #30 screamed occasionally from their room. The Weekly Behavior Note dated 1/2/2025 documented no behavior was exhibited by Resident #30. The Physician's Orders initiated 11/28/2022 and renewed 12/25/2024 documented Resident #30 was ordered bilateral knee pads in the morning to be removed at bedtime because the resident was crawling on the floor. Starting 11/27/2024 and renewed 12/25/2024, Resident #30 was ordered to be out of bed to a high-back reclining wheelchair with a cushion and bilateral leg rests. Resident #30 was ordered to receive donepezil 10mg every evening for unspecified dementia, trazodone 50 mg at bedtime for major depressive disorder, memantine 20 mg at bedtime for vascular dementia, quetiapine 12.5 mg twice daily for anxiety disorder, and escitalopram 20 mg daily for depressive episodes. The Medical Doctor Note dated 12/24/2024 documented Resident #30 had no new complaints and tolerated their medication well. Resident #30 had a history of dementia, received trazodone, Namenda, donepezil, quetiapine, and sertraline, and was followed by Psychiatry. The Psychiatry Consult dated 12/29/2024 documented Resident #30 was stable with no signs of psychiatric decompensation and a recommendation to decrease the frequency of Resident #30's quetiapine 12.5 mg from twice daily to once daily at bedtime. The Social Work Note dated 1/4/2025 documented Resident #30 had a Psychiatry Consult and it was recommended for frequency of quetiapine 12.5 mg to be decreased to once daily at bedtime. The Medication Regimen Review dated 1/6/2025 documented consider tapering Resident #30's quetiapine from twice daily to once daily as per Psychiatry Consult recommendation. On 1/06/2025 at 9:30 AM, Resident #30 was observed with the upper half of their body in their bed and the lower half of their body hanging off the bed and onto a floor mattress at bedside. Resident #30's window screen was torn and the lighting above the sink in the room was dim and produced glare because 1 light socket did not have a lightbulb, and the light fixture cover was missing. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/2025 at 11:13 AM, Transporter #23 was observed in the 3rd Floor Dayroom with 15 residents. Transporter #23 engaged residents by playing music from the television and telling them to lift their arms up and down repeatedly. At 11:14 AM, Transporter #43 entered the room and Transporter #23 ended their engaging interaction with the residents. Music continued playing from the television and 2 of the residents began to wander away from the group. Another resident asked, what are we doing? Where should we go? Another resident in a wheelchair began grabbing at the resident in the chair next to them and the resident in the chair became agitated and began yelling. Transporter #23 and #43 separated and provided 1-to-1 supervision to the resident who began yelling. A white erase-board on the wall documented 11:30 AM - Exercise in marker and a printed sign documented Resident Council - 12/30. On 1/06/2025 at 11:25 AM, Resident #30 was observed fully on their floormat at bedside with a bedsheet tangled around their midsection and their sweatshirt pulled up around their neck, exposing their upper body. Resident #30 had their eyes closed and appeared to be asleep but yelled Ow! and other intelligible words intermittently. On 1/06/2025 at 12:25 PM, Resident #30 was fully in their bed with their sweatshirt pulled back down covering them appropriately. Resident #30 appeared to be asleep with their eyes still closed but moaned and called out loudly intermittently. On 1/06/2025 at 5:32 PM, Resident #30 was observed in their room, out of bed to a recliner with their knees pulled up to their chest in a fetal position. The resident's eyes were closed and, approximately every 30-60 seconds, Resident #30 tensed their body, thrashed in the recliner, and screamed Oh God, help me! or Mommy, please help! There was no television, music, or any other activity ongoing for Resident #30 while they were alone in their room. On 1/10/2025 at 4:45 PM, Resident #30 was observed in the 3rd Floor Dayroom in their recliner. Resident #30's knees were pulled up into a fetal position, their left arm and shoulder were pulled out of their sweatshirt, and their upper body was awkwardly leaning so their upper body rested on the armrest of the recliner. Dinner service began and Resident #30 seemed unaware of their surroundings, howling or screaming loudly while other residents ate and causing other residents in the dining room to tell Resident #30 to shut up. There were no observations of Resident #30 with bilateral knee pads in accordance with Physician's Orders to prevent injury when crawling on the floor. There was no documented evidence Resident #30 was provided with meaningful activities reflective of their customary routines, interests, and preferences to enhance Resident #30's wellbeing. There was no documented evidence person-centered, individualized, nonpharmacological interventions were developed and implemented to address Resident #30's diagnosis of dementia and related behaviors. There was no documented evidence Resident #30 had a gradual dose reduction of their quetiapine in accordance with Psychiatry recommendations. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/2025 at 11:55 AM, the Director of Social Work was interviewed and stated they were not aware of the interventions used by the nursing staff to redirect and engage Resident #30 when they exhibited dementia-related behaviors. Resident #30's behaviors have improved. Resident #30 should be dressed appropriately if in their recliner in a public setting like the Floor Dayroom. The Director of Social Work stated they were involved in ensuring Psychiatry consult recommendations were reviewed and addressed. They communicated to the Medical Doctors when they received a final list of recommendations from the Psychiatry nurse Practitioner. The Nursing staff were responsible for informing the Medical Doctors and getting consent from the resident's family prior to making changes to a resident's medication regime. Antipsychotic medications were not prescribed to treat a dementia-related behaviors. The interdisciplinary team addressed behaviors with non-pharmacological interventions like the 3rd Floor Reflection Group. On 1/13/2025 at 3:17 PM, Licensed Practical Nurse #21 was interviewed and stated they were working a double shift because the unit was short-staffed, and they were feeling tired. Licensed Practical Nurse #21 stated they were provided dementia inservice and training a few weeks ago. Resident #30 required total staff assistance with all activities of daily living and had bilateral floormats at bedside because of episodic crawling behavior. Licensed Practical Nurse #21 stated they were unaware of any Physician Order for Resident #30 to have bilateral knee pads during the day. On 1/14/2025 at 9:56 AM, the Psychiatry Nurse Practitioner was interviewed and stated they were not responsible for prescribing medications and only made recommendations for medication changes to the Medical Doctors. The Psychiatry Nurse Practitioner stated they completed their consults on one day and wrote their notes and recommendations after leaving the facility. They provided a list of treatment/medication recommendations to the Director of Social Work with the understanding that the Director of Social Work would communicate the recommended changes to the Medical Doctors. The Psychiatry Nurse Practitioner stated their consult notes were also available for review in the facility's electronic medical record. Resident #30 was evaluated 12/29/2024 and the Psychiatrist Nurse Practitioner stated they recommended a gradual dose reduction of Resident #30's quetiapine from 12.5 mg twice daily to once daily. The Medical Doctors would contact the Psychiatry Nurse Practitioner to communicate with them if they disagreed with their recommendations. The Psychiatry Nurse Practitioner stated the primary care physician for Resident #30, Medical Doctor #1, had no communication with them following their consult and the Psychiatry Nurse Practitioner was unaware whether Medical Doctor #1 agreed or disagreed with their recommendations. 1/14/2025 at 11:09 AM, Registered Nurse #1 was interviewed and stated the Nurse Managers were responsible for reviewing psychiatry Consults and communicating any recommendations to the Medical Doctors. The Director of Social Work was also responsible for communicating Psychiatry recommendations to the Medical Doctors because the Director of Social Work received a list of recommendations directly from the Psychiatry Nurse practitioner following their facility visit. Nursing staff were also responsible for documenting review of the consult and communication with the Medical Doctor in a Progress Note. If the Medical Doctor disagreed with the recommendation, the Medical Doctor was responsible for documenting their decision and rationale in a Progress Note. After reviewing Resident #30's medical record, Registered Nurse #1 stated they did not see any documentation reflecting Nursing staff review of the Psychiatry consult and recommendations, communication between Nursing staff and Medical Doctor #1 that a gradual dose reduction was recommended, Medical Doctor #1's acknowledgement of Psychiatry recommendations, or a gradual dose reduction of Resident #30's quetiapine medication on the Physician's Orders. The Nurse Manager should have informed Medical Doctor #1 of the Psychiatry Consult. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 at 11:54 AM, Medical Doctor #1 was interviewed and stated they last evaluated Resident #30 on 12/24/2024 and the resident was in stable condition. Medical Doctor #1 stated the Nursing staff made them aware when there were recommendations from consulting physicians. Medical Doctor #1 stated they were unaware Resident #30 had a Psychiatry Consult on 12/29/2024 and was not informed by facility staff of consult recommendations to perform a gradual dose reduction of Resident #30's quetiapine. Medical Doctor #1 stated Resident #30 previously failed a gradual dose reduction but could not recall when the attempted dose reduction occurred. Medical Doctor #1 stated gradual dose reductions were implemented to place elderly residents with dementia on the lowest possible dose of antipsychotic medication, if any, because these medications can result in extrapyramidal side effects, lethargy, and falls. 2) Resident #122 had diagnoses of unspecified dementia without behavioral disturbance and depression. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #122 was severely cognitively impaired and found it very important to listen to music, have books, newspapers, and magazines, do things with groups of people, participate in religious services, and do their favorite activities. The assessment dated [DATE] documented Resident #122 had highly impaired vision and was severely cognitively impaired. The Comprehensive Care Plan related to activities initiated 11/16/2023 and last reviewed 12/14/2024 documented Resident #122 was offered 1-to-1 room visits and engaged in independent activities. Interventions included providing Resident #122 with a monthly calendar, respecting the resident's right to refuse recreation programs, and providing emotional support. The Comprehensive Care Plan related to cognitive deficits initiated 11/18/2023 and last reviewed 12/19/2024 documented Resident #122 was severely cognitively impaired. Interventions to maintain Resident #122's reasoning skills included therapeutic activities, engaging in social conversation, and approaching the resident warmly and positively. The Comprehensive Care Plan related to psychosocial wellbeing initiated 11/18/2023 and last reviewed 12/19/2024 documented Resident #122 established their own goals and interventions to ensure they were actively involved in activities included encouraging Resident #122 to express their feelings, being supportive their feelings, identifying strengths, and assisting Resident #122 with identifying likes and dislikes related to therapeutic recreation. The Activities Note dated 12/14/2024 documented Resident #122 received 1-to-1 room visits, hand massages, music therapy, and enjoyed watching television. Physician's Orders renewed 12/16/2024 documented Resident #122 was ordered to receive sertraline 150 mg at bedtime for depression starting 11/9/2023, mirtazapine 15 mg at bedtime for depression starting 2/5/2024, and olanzapine 10mg at bedtime for unspecified behavior disorder starting 10/30/2024. The Psychiatry Consult dated 12/27/2024 documented Resident #122 was stable with no signs of psychiatric decompensation and recommended olanzapine be decreased from 10mg to 7.5 mg daily at bedtime. The Certified Nursing Assistant Accountability Record for 1/2025 documented Resident #122 was at high risk for falls. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/06/2025 at 11:05 AM, Resident #122 was observed in their recliner in their room, with their back to their television. The television was off and there was no music playing. Resident #122 was alert but not responsive to verbal stimuli and stared at the floor in front of them while moving their mouth in a chewing motion. On 1/07/2025 at 12:52 PM, Resident #122 was observed in a recliner in their room. Resident #122 was alert, not responsive to verbal stimuli, stared at the floor, and was turned away from the television. On 1/08/2025 at 11:52 AM, Resident #122 was observed in their recliner alone in their room with their eyes closed and television on and facing away from Resident #122's line of sight. On 1/13/2025 at 11:55 AM, the Director of Social Work was interviewed and stated they made rounds on the 3rd Floor daily and stationed themselves on the unit to observe the daily routine and get a sense of the environment. The Reflection Group was created to address residents with dementia and cognitive impairments who require more 1-to-1 supervision. The interdisciplinary team determined who was eligible to join the group based on the resident's cognitive assessment scores. The Reflection Group was in the 3rd Floor Dayroom. The Director of Social Work stated they were not familiar with the Reflection Group's daily activities and schedules, and the Director of Recreation was more involved with the coordination of group. The Director of Social Work stated the main goal of the Reflection Group was to provide a combination of redirection, activities, and nursing supervision to keep residents with dementia engaged. The Director of Social Work stated they were responsible for developing, reviewing, and revising care plans related to resident cognitive status. The Director of Social Work stated the care plans were individualized and included all the appropriate interventions required by that resident to address their cognitive impairments. The Director of Social Work stated the cognitive loss care plan was not necessarily a dementia care plan, and they did not know who was responsible for developing dementia care plans. On 1/13/2025 at 2:31 PM, Transporter #23 was interviewed and stated their job responsibilities included transporting residents from their rooms to the floor dayroom or from the facility to outside clinic appointments. The Director of Recreation provided the Transporters with a schedule of Reflection Group attendees and activities. Transporter #23 stated they did not receive Recreation Aide training, and their job responsibilities did not include facilitating Reflection Group activity programs. Transporter #23 stated they were told by the Director of Recreation that there were some activities that they could help with when no other Recreation staff were available. Transporter #23 stated they helped cover Recreation staff on the 3rd Floor once 1 to 2 times weekly. The Reflection Group started each day in the morning at approximately 10 AM. The same residents from the Reflection Group stayed seated at the same tables in the Floor Dayroom for lunch served between 11:30 AM and 12 PM. Transporter #23 stated they received inservice and training on dementia care but was unable to specify when or provide examples of topics covered. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 at 10:12 AM, Recreation Leader #26 was interviewed and stated they were often assigned to work on the 3rd Floor and started their day by making rounds on the unit. Recreation Leader #26 stated they could not recall a facility-wide dementia care inservice but provided daily reminders to the other Recreation staff to be mindful of residents with dementia. The Reflection Group for residents with dementia had a separate activities calendar and special activities that were different from activities available to the other 3rd Floor residents. Recreation Leader #26 stated the Director of Recreation was out on leave and the Recreation Department was short-staffed. The Recreation Department was unable to assign a Recreation Leader to the 3rd Floor or the Reflection Group and the Transporters and Certified Nursing Assistants were asked to help give residents activities. On 1/14/2025 at 12:21 PM, the Director of Nursing was interviewed and stated the Inservice Coordinator was on sick leave and the Director of Nursing was unable to locate the facility's annual dementia care inservice. The Director of Nursing stated they were responsible for maintenance of and availability of inservice records despite the Inservice Coordinators absence. The Reflection Group was the combined responsibility of the Recreation and Nursing Departments and was a specialized area with structured activities for cognitively impaired residents. Transporters and Certified Nursing Assistants were not responsible for providing activities to residents; however, the Director of Nursing stated they would rather have residents entertained than waiting for a Recreation Leader to arrive. The Director of Nursing stated they were not involved in and could not comment on Recreation schedules and assignments. The Director of Nursing stated they visited the Reflection Groups on previous occasions and the Charge Nurse was responsible for ensuring the Certified Nursing Assistants provided activity of daily living care to the Reflection group attendees. Nurse Managers were also responsible for informing the Medical Doctors within 24 hours of a resident's Psychiatry Consult and Psychiatry recommendations, if any. 10 NYCRR 415.12

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51214 Based on observations and interviews conducted during a Recertification survey from ,d+[DATE]-[DATE], the facility did not ensure drugs and biologicals were maintained in accordance with currently accepted professional standards, labeling, expiration date, and storage of medication at proper temperatures. Specifically, expired feedings, supplies, and test kits, open unlabeled medications, and a medication storage refrigerator temperature above the acceptable range, were found in one of one medication storage rooms (Second Floor Unit) examined for medication storage. The findings are: The Facility Policy titled Storage of Medication updated ,d+[DATE] documented that drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During observations on [DATE] at 1:38 PM in the second floor unit medication storage room, the following was found; one unlabeled tube of bacitracin zinc ointment and an open unlabeled flush bag, three bags of Nutren 2.0 feeding with an expiration date of [DATE], two Pleurx Drainage Kits with expiration dates of [DATE] and [DATE], two boxes of COVID 19 Antigen Self Tests with expiration dates of [DATE], and one disposable sampling kit with an expiration date of [DATE]. The medication storage refrigerator read 50 degrees Fahrenheit. The last recorded temperature check was on [DATE]. During an interview on [DATE] at 1:38 PM, Licensed Practical Nurse #9 stated that all of the nurses should be checking the medication storage room on the unit. The expired and unlabeled medications, feedings, and supplies should not have been in the storage room and needed to be disposed. They also stated that the refrigerator temperature was out of range and they would contact Maintenance for repair. During an interview on [DATE] at 9:52 AM, Nurse Manager #1 stated the nurses were responsible for their floor and should have been checking the medication storage room every shift. Feedings, medications and equipment should be checked routinely by nursing and should be removed from the room if expired. Medications without labels should not have been in the room and should have been disposed of. Refrigerator temperatures were checked every shift and if it out of range nursing should report it to maintenance. 10 NYCRR 415.18(e)(,d+[DATE])

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observations and interviews conducted during the Recertification survey from [DATE] to [DATE], the facility did not ensure that food was stored and prepared in accordance with professional standards for food safety practice. Specifically, 1) Opened and undated food was stored in refrigerators, freezer, and the dry storage room. 2) Employee stored personal food in the freezer and kitchen reach-in refrigerator that was not designated for employee food storage. 3) Expired food items were observed in the emergency food supply and reach in refrigerator. 4) Hot food was held below 135 degrees Fahrenheit the steam table and cold turkey was at 51 degrees Fahrenheit. Findings include: The facility policy Refrigerators and Freezers updated December, 2024 documented all food shall be appropriately dated to ensure proper rotation by expiration dates. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. The facility policy Food Preparation and Service updated December, 2024 documented the danger zone for food temperatures is between 41 F and 135 F. The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff. The following internal cooking temperature/time for fish is reached to kill or sufficiently inactivate pathogenic microorganisms is 145-degree Fahrenheit/15 minutes. During an initial tour of the kitchen on [DATE] at 09:14 AM conducted with Food Service Director the following were observed: 1. In the walk-in refrigerator, there was a tray of undated applesauce cups. In the freezer there was an opened and undated box of frozen hamburger patties, with a few frozen patties laying on the floor. The boxes of cream pie and sweet potato pie were opened to air. Also open was an undated bag of chicken breast, an undated bag of breakfast sausage, a bag of French fries, and boxes of frozen cookies. Observation of the dry storage room revealed opened and undated bags of egg noodles, ziti pasta, cream of wheat, and vanilla pudding mix. At the time of observation, the Director of Food Service removed all undated items and stated that once the food was opened it needed to be dated. They could not explain the presence of undated food in the dry storage room. 2. Observation of the walk-in freezer floor revealed frozen turkey stored on the floor. The Director of Food Service stated that the turkey belonged to an employee. During the initial inspection of the reach-in refrigerator the employee's food box was observed. The Director of Food Service removed the employee's food box and turkey, and stated that the freezer as well as reach-in refrigerator were not designated for employees' food storage. The Director of Food Service stated that all employees would be re-educated about the use of kitchen refrigerators. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation of reach-in refrigerator on [DATE] AM at 9:38 AM revealed a bottle of opened [NAME] applesauce with expiration date of [DATE]. Observation of emergency food supply area accompanied by Director of Food Service revealed a box of nectar thick liquid with expiration date [DATE], boxes of corn flakes with expiration date [DATE], a box of vanilla pudding cans (6 cans) with expiration date [DATE], a box of oatmeal variety pack with expiration date [DATE], a box of Instant oatmeal variety flavor with expiration date [DATE], cans of corn beef hash with expiration date [DATE]. During an interview with Food Services Director on [DATE] at 10:02 AM, they stated that they restocked emergency food supplies often, most recently ,d+[DATE] weeks ago, but did not have time to check expiration dates. The Food Services Director collected all expired items and stated that they would be discarded immediately. 4. During observation and temperature check on tray line on [DATE] at 11:37 AM the following was identified: Fried fish temperature on a steam table taken by [NAME] showed 114 degrees Fahrenheit. During an interview with [NAME] on [DATE] at 11:39 AM, they stated the fish pieces were very thin and that the fish had cooled down from pulling it out of the oven and placing it on the steam table. During observation and temperature check on tray line on [DATE] at 12:00 PM, cold cut turkey sandwich temperature taken by Food Service Director was 51 degrees Fahrenheit. The Food Service Director stated that cold food shall be maintained at a temperature of 41-degree Fahrenheit or below and all cold cut sandwiches brought to tray line straight from the refrigerator. The Food Service Director could not explain why the temperature inside of cold cut turkey was 51 degrees Fahrenheit. 10 NYCRR 415.14 (h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50816 Based on observation, record review and interviews conducted during a Recertification survey on 1/6/2025 to 1/14/2025 the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. This was evident for 2 (Resident #69 and #25) of 5 residents reviewed for pressure injuries and 1 of 2 residents (Resident #121) reviewed for urinary tract infections. Specifically, 1) Resident #69 was on enhanced barrier precautions and a certified nurse aide was observed providing care without proper personal protective equipment; 2) Resident #121 had a history of urinary tract infections and their catheter bag was observed lying directly on the floor; and 3) the Wound Care Nurse did not perform handwashing or don a gown while performing wound care on Resident #25. Findings include: 1) Resident #69 was admitted with diagnoses including Diabetes Mellitus, Nutritional Anemia, and a Stage 3 pressure ulcer. The Minimum Data Set (an assessment tool) Annual assessment dated [DATE] documented the resident had moderate cognitive impairment, was frequently incontinent of urine and bowel, had a feeding tube, a Stage 3 pressure ulcer and was totally dependent on staff for all cares. The 12/31/24 Physician order documented Enhanced Barrier Precautions for wound and G-Tube. Observations on 1/6/2025 at 10:45 AM, 11:06 AM and 3:02 PM revealed there was no enhance barrier precaution sign outside Resident #69's door. On 01/07/25 at 9:59 AM Enhanced Barrier Precaution sign, Personal Protective Equipment (PPE) donning/doffing signs was noted outside resident #69 door. When asked by surveyor, Staff #9 stated the Enhanced Barrier Precaution sign was not there yesterday, they did not see it yesterday. Staff #9 stated they did not know who placed the sign. During an Interview on 1/10/25 at 1:08 PM, the Infection Control Preventionist stated Enhance Barrier Precautions were indicated for residents with wounds, catheter and Gastrostomy tubes. Resident #69 had Physician order for Enhanced Barrier Precaution on 12/31/2024 and there was not a sign for Enhanced Barrier Precaution outside Resident #69 room until 1/7/25. They stated they were responsible in making sure that staff was aware of the type of Personal Protective Equipment (PPE) to be used during care of residents on Enhanced Barrier Precautions. On 1/13/25 at 1:55 PM, Certified Nurse Aide #15 was observed going inside Resident #46's room and proceeded to provide incontinence care. Certified Nurse Aide #15 stated they changed the resident as resident had a bowel movement. Certified Nurse Aide #15 did not wear a personal protective equipment (PPE) gown during care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/13/25 at 2:45 PM Certified Nurse Aide #15 stated they were aware of the enhance barrier precaution sign posted outside Resident #69 room and aware of the bin that contained personal protective equipment outside the resident's room. Certified Nurse Aide #15 further stated that they were supposed to wear a gown before going inside the room to provide care. Certified Nurse Aide #15 stated that she did not follow enhance barrier precautions. During an interview on 1/13/2025 at 3:08 PM, the Infection Control Preventionist stated staff needed to wear personal protective equipment (PPE), gown, gloves and mask when giving care to residents on enhance barrier precautions. Infection Control Preventionist stated that Certified Nurse Aide #15 did not follow enhance barrier precautions during resident care. 51214 2) The Facility Policy titled Urinary Catheter Care reviewed 7/6/2023 documented that the purpose of the procedure is to prevent urinary catheter associated complications, including urinary tract infections. The infection control section documented to be sure that the catheter tubing and drainage bag are kept off the floor. Resident #121 had diagnoses including Neurogenic Bladder, Chronic Foley, and Methicillin Resistant Staphylococcus Aureus infection. The Admission Minimum Data Set (assessment tool) dated 2/28/24 documented the resident had moderate cognitive impairment and an indwelling urinary catheter. The Comprehensive Care Plan titled Indwelling Foley Catheter dated 4/27/24 documented the resident would be free from signs and symptoms of infection and urinary retention. Interventions included to ensure Foley catheter collection bag was in privacy bag and off the floor. Physician orders dated 9/9/24 documented to ensure Foley catheter is off the floor with privacy cover in place. During an observation on 1/06/25 at 10:18 AM, Resident #121 was in bed with urinary catheter bag uncovered and directly on the floor. During an interview on 1/07/25 at 8:35 AM, Resident #121 stated they had the Foley catheter for many years, could not urinate without it, and had recurrent urinary tract infections. During an interview on 1/10/25 at 12:46 PM Registered Nurse #39 stated the Foley catheter bag should not have been on the floor. During an interview on 01/14/25 at 9:05 AM, the Infection Control Nurse stated Foley catheters should be in a privacy bag and off the floor. 40686 3) Resident #25 had diagnoses of schizophrenia, unstageable pressure injury and Stage 3 pressure injury. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #25 had a significant change in condition, mild cognitive impairment, 2 unstageable pressure injuries present upon admission/reentry to facility, used a pressure reducing device for the chair and bed, received pressure ulcer care, and was totally dependent on assistance of 1 to 2 people for transfers from bed to chair. The Comprehensive Care Plan related to skin integrity initiated 11/18/2024 documented Resident #25 had a deep tissue injury to their right and left heel from admission on 10/28/2024. Care plan note dated 12/18/2024 documented Resident #25's right heel wound was reclassified as a stage 3 injury measuring 2 X 2 X .2 cm with moderate drainage and left heel wound measured 1.5 X 1 X 0 cm and had no drainage on 12/12/2024. Physician's Orders documented orders starting 11/3/2024 to place a pillow daily and as needed to offload Resident #25's bilateral heels. On 11/12/2024, orders were placed for skin prep to Resident #25's left heel daily and as needed. Treatment orders were initiated 11/27/2024 for Santyl ointment to Resident #25's right heel daily and as needed. On 1/3/2025, Resident #25's right heel was ordered to be cleansed with normal saline, treated with Silvadene 1% topical cream, and covered with dry protective dressing daily and as needed to address deep tissue damage. On 1/10/2025, an order was placed for Resident #25's left to be cleansed with normal saline, treated with Medi Honey 100% topical paste, and covered with sterile gauze protective dressing daily and as needed to address pressure-induced deep tissue damage. The Wound Note dated 1/2/2025 documented Resident #25 had a Stage 3 wound to their right heel measuring 1 X 5 X .1 centimeters (length x width x depth) with minimal serous drainage and 100% granulation tissue. Apply Silvadene cream daily and as needed. Resident #25's left heel had a deep tissue injury measuring 1 X 1 X 0 centimeters with no drainage and maroon in color. Apply skin prep daily and as needed. On 1/13/2025 at 3:38 PM, the Wound Care Nurse was observed gathering supplies from the treatment cart in the hallway outside of Resident #25's room. The Wound Care Nurse entered the room and placed a blue plastic sheet on the bed next to Resident #25's feet. The Wound Care Nurse cleared a place on an overbed table, did not sanitize the overbed table and placed the blue plastic sheet from the resident's bed on the overbed. The Wound Care Nurse rinsed their hands at the sink in the resident's room for 5 seconds and did not use soap, grabbed their phone to make a phone call, left the room and was seen touching the treatment cart in the hallway. The Wound Care Nurse reentered the room and placed supplies on the overbed table and 2 sheets of paper with Physician's Orders for treatment on Resident #25's bed. The Wound Care Nurse did not don gloves and grabbed Resident #25's lower legs and lifted them to look at the resident's heels. Both heels were uncovered and soiled bandages covered with brown and yellow drainage were observed on the bed under Resident #25's legs. The Wound Care Nurse did not don a gown, donned gloves, poured normal saline into gauze packages, placed the gauze packages on the bed, removed their gloves, washed their hands at the sink, dried their hands, and turned off the faucet with bare hands before donning new gloves. The Wound Care Nurse used one gauze to wipe Resident #25's heel, changed their gloves without washing their hands, and applied Silvadene ointment. The Wound Care Nurse placed a large abdominal gauze on Resident #25's right heel, reached into their pocket for tape, and used the tape to secure the gauze to Resident #25's heel. After the Wound Care Nurse completed the wound care for both of Resident #25's heels, they left the soiled bandages and gloves in an open garbage container near the sink in the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 1/13/2025 at 4:04 PM, the Wound Care Nurse was interviewed and stated they were supposed to wash their hands for at least 20 seconds with soap in between each glove change and did not consistently do this while providing wound care to Resident #25. The Wound Care Nurse stated they were supposed to use a paper towel to turn off the sink faucets after washing their hands and they did not do this during wound care treatment for Resident #25. The Wound Care Nurse stated they should have donned a gown for enhanced barrier precautions during the wound care treatment for Resident #25 and did not do so. The Wound Care Nurse also stated they should have washed their hands after touching non-sterile surfaces like the door handle, their phone, and the treatment cart during wound care treatment for Resident #25. 10 NYCRR 415.19(b)(4)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 50816 Based on record review and interviews conducted during a Recertification survey from 1/6/2025 to 1/14/2025, the facility did not implement an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. Specifically, the facility could not provide documentation as requested on 1/10/2025 of tracking antibiotic use which included appropriate use of antibiotics, results of laboratory tests and duration of antibiotic treatment for November 2024, December 2024, and January 2025. The findings are: The Policy on Antibiotic Stewardship updated in 2024 documented the purpose of Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. When a culture and sensitivity (C & S) is ordered laboratory results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued. During an interview on 1/10/2025 at 1:08 PM, the Infection Control Preventionist stated it was their responsibility to track antibiotic use which included appropriate use of antibiotics and duration of antibiotic treatment. They further stated that they kept track of residents that had infections and were on antibiotic therapy. During the interview documentation of line list for November 2024, December 2024 and January 2025 was requested. The Infection Control Preventionist provided a list of residents on antibiotic therapy, list was reviewed and lacked infection onset dates, results of laboratory tests, frequency/duration of antibiotic therapy and the indication for antibiotic therapy. The Infection Control Preventionist stated the line list was missing a lot of information and they would modify the line list to include the missing information. During an interview on 1/13/2025 at 11:25 AM and on 1/14/2025 at 2:33 PM, the Director of Nursing stated they supervised the Infection Control Preventionist. The primary person for Antibiotic Stewardship Program was the Infection Control Preventionist and they were responsible for maintaining the line list, getting information routinely from laboratory, looking at trends of organisms and how the resident was responding to the antibiotic treatment. They further stated that the Infection Control Preventionist was responsible for coordinating with the Physicians and Nurse Practitioners if resident did not respond to treatment. The Director of Nursing stated the Infection Control Nurse was behind in tracking antibiotic use. 10 NYCRR 415.19 (a)(1,3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335365	A. Building 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 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49255 Based on observations, interviews and record reviews conducted during the Recertification survey 1/6/25 to 1/14/25 the facility did not maintain an effective pest control program so that the facility was free of pasts. Specifically, the facility kitchen was observed to have live and dead roaches. Findings are: The facility policy and procedure titled Pest Control updated December, 2024 documented the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. During a kitchen observation on 1/8/25 at 11:37 AM, with the Food Service Director, one live roach was crawling on the wall and one dead roach was found on the floor next to the kitchen tray line. During an interview on 1/8/25 at 11:39 AM Food Service Director stated that they could recognize a roach on the floor. They stated that the facility had bi-weekly pest control treatments. Review of the Pest Management Service Inspection Reports from 10/13/24 to 12/26/24 documented on 12/12/24 unable to service kitchen, kitchen was closed and locked, on 12/26/24 service observed minimal activity, with recommendation to increase sanitary practices in the kitchen. During an interview on 1/10/25 at 1:25 PM, the Director of Maintenance stated the pest control services provide monthly services including all kitchen areas. 10 NYCRR 415.29(j)(5)